East Sussex Healthcare
NHS Trust

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Tel: 0300 131 4500
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FOI REF: 23/806

20th December 2023

FREEDOM OF INFORMATION ACT

I am responding to your request for information under the Freedom of Information Act. The answers to your specific questions are as follows:

Can you please provide me with the following or advise me if such information does not exist:

1) Patient charter or details setting out what a patient can reasonably expect in terms of how they and their relatives are treated during time at the hospital.

Please see attached East Sussex Healthcare NHS Trust's 'Visiting Policy' - 02049.

2) The Hospital's "values" on how it will treat patients and their relatives/carers etc.

I can confirm that we hold the information requested above. However, the information is exempt from disclosure under Section 21 of the Freedom of Information Act 2000. This is because the information is accessible to you, as it is already in the public domain and can be accessed by the following link:

What you can expect – East Sussex Healthcare NHS Trust (esht.nhs.uk)

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

3) Protocols for dealing with those reported to:

a) Have addiction issues.

We are currently in the process of writing a policy in respect of the above.

Cont…/

b) Have mental health issues.

Please see the attached Safeguarding Adults Policy and procedures - 00822.

c) Be suicidal.

The Trust does not have a policy specifically for suicide, but we do have a mental health act policy, please see attached - 01500.

4) Protocol on relaying relevant information on the above matters to relatives who attend with the patient and / or have reported the issues.

Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (4C) - 01246.

5) Patient confidentiality:

a) What a patient can expect to have shared with relatives without their consent.

Please see attached policy - 01747 - Information Governance and Data Protection Policy and 01860 - Delivering Accessible Information.

b) What a relative can expect to be told both in the presence of the patient and in their absence.

If a patient has capacity, the usual expectation would be that they would speak to relatives themselves, without capacity it would depend on if the relative holds Lasting Power of Attorney for Health decisions, if they do then they would be involved in all discussions.

6) Guidance for staff responding to issues about patient care.

Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (4C) - 01246.

If I can be of any further assistance, please do not hesitate to contact me.

Should you be dissatisfied with the Trust's response to your request, you have the right to request an internal review. Please write to the Freedom of Information Department (esh-tr.foi@nhs.net), quoting the above reference, within 40 working days. The Trust is not obliged to accept an internal review after this date.

Cont…/

Should you still be dissatisfied with your FOI request, you have the right of complaint to the Information Commissioner at the following address:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF

Telephone: 0303 123 1113

Yours sincerely

Linda Thornhill (Mrs)
Corporate Governance Manager
esh-tr.foi@nhs.net

East Sussex Healthcare NHS Trust

Safeguarding Adults Policy and Procedures
(Formally known as the Safeguarding Adults at Risk Policy)

Document ID Number	822
Version:	V4
Ratified by:	Clinical Documentation and Policy Ratification Group
Date ratified:	10 May 2022
Name of author and title:	[redacted], Named Nurse Safeguarding Adults, Gail Gowland, Head of Safeguarding
Date originally written:	September 2011
Date current version was completed	March 2022
Name of responsible committee/individual:	Corporate Safeguarding
Division/Speciality:	Corporate: Safeguarding
Date issued:	11 July 2022
Review date:	March 2025
Target audience:	All Staff
Compliance with CQC Fundamental Standard	Regulation 9: Person Centred Care
Compliance with any other external requirements (e.g. Information Governance)	Safeguarding Adults Board: Safeguarding Policies. Intercollegiate Document: Adults Safeguarding, Roles and Competencies for Health Care Staff, 1st Edition August 2018
Associated Documents:	Guidance for Staff on the Implementation of the Mental Capacity Act (MCA) 2005 Guidance for Staff on the Implementation of the Deprivation of Liberty Safeguards 2009 Implementation of the Mental Capacity (Amendment) Act 2019 Policy for the use of the Mental Health Act 1983

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of the procedural document and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.2011246	September 2011		New Document	
V1.1 2011276	October 2011			Minor Amendments to reflect role changes
V1.2 2012292	October 2012			Minor amendments to reflect structure changes, addition of Domestic Violence information. Minor changes ratified by Director of Nursing
V1.3 2014116	June 2014	Brenda Lynes-O'Meara	Updated (CME Chair's Action)	Appendices updated. Minor amendments to text relating to updated Trust structure.
V2.0 2015155	July 2015	Brenda Lynes-O'Meara	Updated in response to The Care Act 2014	Changes throughout this policy to reflect the statutory requirements of The Care Act.
V2.1	July 2018	Sue Curties	Routine Review	Changes to the structure of the Safeguarding Team.
V3.0	January 2019	[redacted] Sue Curties	New policy in response to the Intercollegiate document and a need to modernise	Introduction of Pathways, Removal of appendices and hyperlinks introduced.
V3.1	February 2021	Sue Curties	Addition statement for Covid-19	Covid-19 Statement added to the policy
V3.2	July 2021	Gail Gowland	Change of personnel and changes to training	Training changed due to Covid 19 and the implementation of the Think Family approach. Changes to staffing within the safeguarding team
V4	February, 2022	[redacted]	Change to Safeguarding team personnel, Covid Guidance and Legislation updates	Some Covid 19 restrictions are still in place within our Healthcare Trust. Changes to Staffing within the Safeguarding team Addition of legislation changes- Domestic Abuse Act 2019 and the Liberty Protection Safeguards- implementation on hold

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Assistant Directors of Nursing	Clinical Units	August 2011
Heads of Nursing	Clinical Units	August 2011
Ward Matrons	Clinical Units	August 2011
Nursing & Midwifery Committee		September 2011
Adult Safeguarding Service		May 2014
Heads of Nursing, Assistant Directors of Nursing. Allied Health Professionals	All Clinical Units through TNMAG	May 2014
Heads of Nursing / Assistant Directors	All Clinical Units through TNMAG	June 2015
Adult Safeguarding Service		May 2015
Adults Safeguarding Team		August 2018
Safeguarding Adults & Children's Operational Group Members		December 2018
Safeguarding Adults & Children's Strategic Group Members		February 2019
Safeguarding Adults & Children's Strategic Group Members		February 2021
Safeguarding Adults & Children's Strategic Group Members		March 2022
Safeguarding Adults & Children's Operational Group Members		March 2022
Policy Ratification Group		May 2022

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

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Whilst government advice and legislation has changed with regard to the Covid 19 infection staff must continue to remain vigilant and act in line with trust guidance.
It is important to consider that many in the population may remain vulnerable and there is evidence that social isolation increases the likelihood of abuse. Many older and disabled people spend long periods at home alone under normal circumstances. People who are more vulnerable to COVID-19 are once again shielding and have been advised to avoid going out.

At a time of international crisis, those who seek to exploit these vulnerabilities are quick to act. We will all have been warned of new scams offering help and advice on COVID-19 or with financial assistance. Many of us will have concerns for family members who may fall prey to fraudsters. If you have concerns about a patient of family member please ensure that you contact the Safeguarding Team, Adult Social Care or refer to the link below for more information.

Safeguarding adults during the COVID-19 crisis (scie.org.uk)

1. **Introduction**
   East Sussex Healthcare NHS Trust (ESHT) recognises its fundamental responsibilities in relation to keeping all those who have contact with our organisation safe. This Safeguarding Adults Policy and Procedures applies to all employees of ESHT including individuals with honorary contracts, such as work experience, or are working through within ESHT with temporary contracts or locum Agencies.

   It is important to reiterate that this Policy and Procedure document is to be used in conjunction with the Sussex Safeguarding Boards Adults Safeguarding Policy which can be accessed alongside other resources of the East Sussex safeguarding Adults web pages.
   Sussex Safeguarding Adults Policy and Procedures | Welcome to Sussex Safeguarding Adults Policy and Procedures

   Furthermore NHS England Safeguarding Policy also produces a policy which can be accessed via https://www.england.nhs.uk/publication/safeguarding-policy and incorporates mandates in line with The Care Act 2014. Sections on procedures will explain what to do when a concern should be raised, responding to concerns and ESHT Safeguarding fully supports the use of the NHS England Safeguarding App via https://www.england.nhs.uk which can be downloaded through smartphones

   The Care Act 2014 was a major step forward in safeguarding adults who are experiencing, or are at risk of, abuse or neglect, and are unable to protect themselves. Sections 42 to 47 of the Care Act set out the legal duties and responsibilities in relation to adult safeguarding. The legal framework for the Care Act 2014 is supported by Care and Support Statutory Guidance which provides information and guidance about how the Care Act should operate in practice. The guidance has statutory status which means that there is a legal duty to have regard to it when working with adults with needs for care and support and carers.

   Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about working together to support people to make decisions about the risks they face in their own lives and protecting those who lack the mental capacity to make those decisions.

2. **Purpose**
   The purpose of this policy and procedures is to provide the organisation with an overarching framework to ensure a proportionate, timely and professional approach is taken, and that adult safeguarding is co-ordinated across all relevant agencies and organisations. This is essential for the prevention of harm and abuse. Within East Sussex there is the Safeguarding Board Safeguarding Adults Policy Sussex Safeguarding Adults Policy and Procedures | Welcome to Sussex Safeguarding Adults Policy and Procedures which supports those working with Safeguarding. It is necessary to update our internal policy in accordance with the Care Act 2014 https://www.legislation.gov.uk/ukpga/2014/23/contents and the Care and Support Statutory Guidance https://www.gov.uk/government/publications/care-act-statutory-

guidance/care-and-support-statutory-guidance which should be read in conjunction. ESHT Policy has been updated to also reflect the recent lessons learnt from Local Safeguarding Adults Reviews, Audits and practice.

2.1 Rationale

Within ESHT we have a culture of safeguarding which means protecting and adult's right to live in safety, free from abuse and neglect. For us it is about working together to support patients to make decisions about the risks they face in their own lives and protecting those who lack the mental capacity to make those decisions. The aims of safeguarding adults are to.

- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
- Stop abuse or neglect wherever possible
- Safeguard adults in a way that supports them in making choices and having control about how they want to live
- Promote an approach that concentrates on improving life for the adults concerned
- Raise public awareness so that communities, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect
- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or wellbeing of an adult.

2.2 Principles

In order to achieve these aims it is essential that everyone, both individuals and organisations, is clear about their roles and responsibilities regarding safeguarding policy and procedures. Individual services and organisations should ensure their internal adult safeguarding policy and procedures reflect these Sussex Safeguarding Adults Policy and Procedures, which includes the Care Act 6 Principles. This includes an expectation to report in a timely way any concerns or suspicions that an adult is at risk of being, or is, being abused. Where abuse or neglect takes place, it needs to be dealt with promptly and effectively, and in ways which are proportionate to the concern, ensuring that the adult stays in as much control of the decision-making as possible.

2.3 Scope

This policy and Procedure document is available to all ESHT employees.

3. Definitions

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. the type of safeguarding enquiry undertaken depends on the nature of the circumstances of the adult. Under the Care Act 2014, specific adult safeguarding duties apply to any adult (18 years or over) who:

- has care and support needs and
- is experiencing, or is at risk of, abuse or neglect and
- is unable to protect themselves because of their care and support needs

Local authorities also have safeguarding responsibilities for Carers and a general duty to promote the wellbeing of the wider population in the communities they serve, Safeguarding duties apply regardless of whether a person's care and support needs are being met, whether by the local authority or anyone else. They also apply to people who pay for their own care and support services. An adult with care and support needs may be but not limited to:

- A person with a physical disability, a learning difficulty or a sensory impairment,
- Someone with mental health needs, including dementia or a personality disorder
- A person with a long-term health condition
- Someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to day living.

In its definition of who should receive a safeguarding response, the legislation could also include people who are victims of sexual exploitation, domestic abuse and modern slavery.

These are all largely criminal matters, and safeguarding duties would not be an alternative to police involvement, and would only be applicable where an adult is not able to protect themselves due to their care and support needs. Adult safeguarding duties apply in whatever setting people live, with the exception of prisons and approved premises such as bail hostels. They apply regardless of whether or not someone has the ability to make specific decisions for themselves at specific times, There may be times when an adult ha care and support needs and is unable to protect themselves for a short, temporary period – for example, if they were significantly unwell due to an infection. People with care and support needs are not inherently vulnerable, but they may come to be at risk of abuse or neglect at any point due to:

- physical or mental ill-health
- becoming disabled
- frailty
- not having support networks
- inappropriate accommodation
- financial circumstances or
- being socially isolated

Abuse can happen anywhere, for example:

- at home
- in a care home, hospital or day service
- at work or college, or
- in a public place or in the community

Abuse can be caused by anyone, for example:

- a partner, carer, relative, child, neighbour or friend
- a health, social-care or other worker, whether they are paid or a volunteer
- a stranger, or
- an Adult with care and support needs

Family and friends as carers may be involved in situations which require a Safeguarding Response, for example:

- A carer may witness or speak up about abuse or neglect
- A carer may experience intentional or unintentional harm from the adult they are trying to support, or from professionals and organisations they are in contact with
- A carer may intentionally, or unintentionally, harm or neglect the adult they support on their own or with others.

Assessment of both the carer and the adult they care for must include consideration of the wellbeing of both of them. In these situations the aim of any safeguarding response will be to support the carer to provide support and help to make changes in order to decrease the risk of further harm to the person, such as the child, they are caring for.

4. Statutory Safeguarding Principles

The Care Act 2014 states that safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs
- is experiencing, or at risk of, abuse or neglect
- because of those care and support needs is unable to protect themselves from either the risk of or the experience of abuse or neglect

The framework for statutory adult safeguarding set out within the Care Act states that local authorities are required to:

- Lead a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect, and stop it quickly when it happens
- Make enquiries, or ensure others do so, when they believe that an adult is subject to, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to stop or prevent abuse or neglect, and if so, by whom
- Establish a Safeguarding Adults Board (SAB) with core membership from the local authority, the police and the National Health Service, (NHS) (specifically the local Clinical Commissioning Groups (CCG's) with the power to include other relevant bodies such as ESHT.
- Arrange, where appropriate, for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or Safeguarding Adults Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate adult to help them.
- Cooperate with each of its relevant partners in order to protect adults who are experiencing, or at risk of, abuse or neglect.

5. When should a safeguarding concern be raised?

Where the 3 Key Tests in the Care Act appear to be met, a safeguarding concern should always be raised, these are:

- An adult who has needs for care and support (whether any of those needs are being met); AND
- An adult who may be experiencing, or at risk of, abuse or neglect; AND
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

In cases where it is unclear if this is the case, consideration should always be given to raising a safeguarding concern; adult social care should be contacted for advice. This is notwithstanding the importance of talking to the adult regarding their views, wishes and actions they may wish to take as per the Care Act "Making Safeguarding Personal" (MSP) however this will not override the responsibility of staff working with the adult to raise a safeguarding concern.

Information for staff is available via the Safeguarding Adults pages of the Intranet Safeguarding Adults - tasks and guides (esht.nhs.uk) and the flow chart provides the pathway to follow:

http://nww.esht.nhs.uk/wp-content/uploads/2014/12/How-to-Raise-a-Safeguarding-Adults-Concern.pdf

6. Defining Abuse

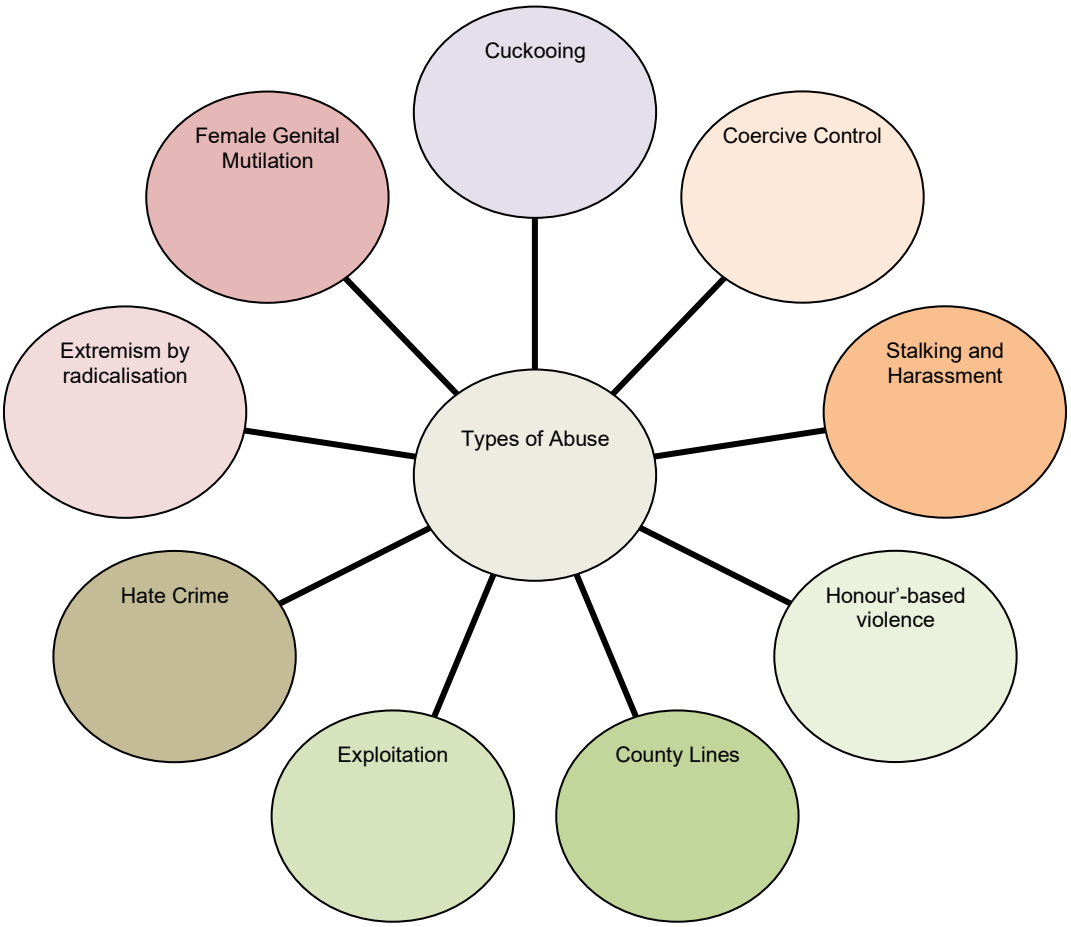
When making a referral it is important to understand the type of abuse you are concerned about. This can be sometimes one or several forms of abuse that a patient is experiencing. The Care Act 2014 outlines the different types and patterns of abuse and neglect and the different circumstances in which they may take place. This is not intended to be an exhaustive list but a guide as to the sort of issues or behaviour which could give rise to a safeguarding concern.

6.1 Abuse can include the following:

Abuse type:	Behaviour includes:
Physical	Being pushed, shaken, pinched, hit, held down, locked in a room, restrained inappropriately, or knowingly giving an adult too much or not enough medication.
Sexual	An adult being made to take part in sexual activity when they do not, or cannot, consent to this. It includes rape, indecent exposure, inappropriate looking or touching, or sexual activity where the other person is in a position of power or authority
Financial	Misusing or stealing an adult's money or belongings, fraud, postal or internet scams tricking adults out of money, or pressuring an adult into making decisions about their financial affairs, including decisions involving wills and property.
Neglect or acts of Omission	Not meeting an adult's physical, medical or emotional needs, either deliberately, or by failing to understand these such as not providing them with essential things to meet their needs, such as medication, food, water, shelter and warmth.
Self-neglect	being unable, or unwilling, to care for their own essential needs, including their health or surroundings (for example, their home may be infested by rats or very unclean, or there may be a fire risk due to their obsessive hoarding) https://sussexsafeguardingadults.procedures.org.uk/search?kw=SElf-Neglect
Psychological or emotional	Being shouted at, ridiculed or bullied, threatened, humiliated, blamed for something they haven't done, or controlled by intimidation or fear. It includes harassment, verbal abuse, cyber-bullying (bullying which takes place online or through a mobile phone) and isolation.
Discriminatory	Forms of harassment, ill-treatment, threats or insults because of an adult's race, age, culture, gender, gender identity, religion, sexuality, physical or learning disability, or mental-health needs. Discriminatory abuse can also be called 'hate crime'.
Modern slavery	an adult being forced to work for little or no pay (including in the sex trade), being held against their will, tortured, abused or treated badly by others. For further information: https://www.gov.uk/government/collections/modern-slavery https://www.rcn.org.uk/clinical-topics/modern-slavery
Domestic Abuse	1. Behaviour of a person 'A' towards another person 'B' is 'Domestic Abuse' if a). A and B are each aged 16 years or over and are personally connected to each other, and b). the

	behaviour is abusive. 2. Behaviour is 'abusive' if it consists of any of the following; a. Physical or sexual abuse b. Violent or threatening behaviour c. Controlling or coercive behaviour d. Economic abuse- any behaviour that has a substantial adverse effect on B's ability to acquire, use or maintain money or other property or obtain goods or services. 3. Psychological, emotional or other abuse It does not matter whether the behaviour consists of a single incident or a course of conduct It also includes so called 'Honour' Based Violence, Forced Marriage t or undergo Female Genital Mutilation-FGM. Any concerns regarding FGM should be raised to Maternity Safeguarding esht.maternity-safeguarding-team@nhs.net There is also available a separate ESHT Domestic Abuse, policy 01502_P.pdf (esht.nhs.uk)
Organisational	Neglect and providing poor care in a care setting such as a hospital or care home, or in an adult's own home. This may be a one-off incident, repeated incidents or on-going ill-treatment. It could be due to neglect or poor care because of the arrangements, processes and practices in an organisation.

6.2 Other forms of abuse that is also reportable: (see Glossary for explanations)



7. Raising a safeguarding concern

As NHS employees all health professionals have a statutory duty and responsibility to safeguard and promote the welfare of vulnerable adults. This should be an integral part of the care we offer (Care Act, 2014). Furthermore, all staff who come into contact with any vulnerable adults and their families should know what to do if they have concerns about an adult without delays. All ESHT staff and volunteers have a responsibility to inform the appropriate person of any concerns that an 'Adult at Risk' is being, has been or is at risk of being abused or neglected ESHT has various adult protection procedures and guidelines which can be found on the Safeguarding Adult page of the intranet. These guidelines are not stand alone documents for this Trust and they have been compiled following Sussex Adult Protection Policies and Procedures along with the Multiagency Local Safeguarding Adult Board if you have a safeguarding concern you must ensure the adult at risk's immediate safety, in immediate danger contact emergency services, if a crime has been committed contact the police and don't confront the alleged/suspected abuser. Document any crime reference number given by the Police.

Complete the Health and Social Care (HSCC) referral form on Extranet and email to **esh-tr.hscc@nhs.net** or telephone **Health and Social Care Connect 0300 678 0010**

Health and Social Care Connect Referral Form

Please email the ESHT Safeguarding team your concerns or forward a copy of the HSCC for to the generic Safeguarding Adult generic email **esh-tr.SAAR@nhs.net.**

A DATIX should be raised alongside a Safeguarding referral if the criteria of the DATIX meets Domain Three or above in the DATIX reporting system. Complete the DATIX form and forward a copy of the DATIX WEB number to the Safeguarding team for information via the generic email esh-tr.SAAR@nhs.net

The Safeguarding team are available to discuss any concerns or Safeguarding referrals by either emailing the generic email address esh-tr.SAAR@nhs.net or telephone a member of the team, all contact numbers are listed on the intranet.

- Sometimes it is a complaint regarding care and not a safeguarding incident and therefore we should signpost to the complaints email **esh-tr.complaints@nhs.net**

It is essential that you:

- Report concerns to your line manager
- Document using Patients own words.

7.1 Good Practice Guidance to disclosure

- Talk with the adult as soon as possible unless this would put them, others or you at risk
- Speak in a private and safe place
- Accept what the adult is saying without judgement
- Don't 'interview' the adult – just gather information to establish the basic facts. This will help when you inform Adult Social Care or the police. Ask the adult what they would like to happen.
- Never promise the adult that you'll keep what they tell you confidential; explain who you will tell and why
- If there are grounds to override an adult's consent to share information, explain what these are
- Explain to the adult how they will be involved and kept informed
- Provide information and advice on keeping safe and the safeguarding process
- Keep an accurate record of your conversations, and actions or decisions taken by you and others

7.2 Balancing individual choice and risk

An adult's right to make choices about their own safety has to be balance with the rights of others to be safe. Information must only be shared on a 'need to know' basis when it is in the interests of the adult. If it is not possible to have obtained informed consent and other adults are at risk of abuse or neglect, it may be necessary to override the requirement to share information. The individual / practitioner will have to assess whether providing the information will be necessary and consider the risk of not sharing the information. In these situations the adult must always be:

- Advised about what information will be shared, with whom and the reasons for this
- Advised that their views and wishes will be respected as far as possible by the local authority or other agencies in relation to any response they may have a duty to make
- Provided with relevant information regarding what happens when a local authority is advised of a safeguarding concern

If the adult has capacity to make an informed decision that they do not want the information to be shared, and there is no indication that they may be experiencing undue influence, then the

adult's wishes would be respected. However there are circumstances in which an adult's consent may be over ridden, including:

- If the adult is at significant risk of serious harm]
- If there is a risk to others
- If a criminal offence has taken place
- Where action is needed in the public interest, such as where a member of staff is in a position of trust.

7.3 Where a crime may have been committed

If it is suspected that a crime may have been committed, there should always be a conversation with the adult regarding whether they wish to police to be involved. If the adult does not want the police to be involved, this does not override a practitioner's responsibility to share information regarding a potential offence with them.

The adult should be advised that the police will be contacted, and assured that the police will be informed that the adult does not wish to pursue this matter or speak to the police. It is for the police to determine if they feel it is necessary for them to speak to the adult, or if there is further action they may need to take.

8.0 Allegations of Abuse against a Staff Member

There are specific guidelines when there is an allegation of abuse against a staff member which must be adhered to these can be found under the http://nww.esht.nhs.uk/wp-content/uploads/2018/08/01745_P.pdf

9.0 Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 was designed to protect and restore power to those vulnerable people who lack capacity. Where an adult is unable to make a specific decision for themselves, the Act sets out a clear process that must be followed before a decision can be made on the adult's behalf. Where an adult is found to lack capacity to make a specific decision any action taken must be taken in their best interests. Professionals and other staff need to understand and always work in-line with the Mental Capacity Act 2005.

There is a specific mental capacity folder available on the intranet with resources in addition to the Mental Capacity Policy.
Mental Capacity Act (MCA) - tasks and guides (esht.nhs.uk)

(http://nww.esht.nhs.uk/wp-content/uploads/2018/08/00933_P.pdf).

If the adult lacks capacity to make decisions about the incident and their ability to maintain their safety decline a safeguarding concern to be raised. An assessment would need to occur that is decision specific to consider their understanding of not raising a Safeguarding, and / or other action to be taken, professionals have a duty to act in their best interests.

Where there are concerns that an adult may lack capacity to make a specific decision – the person needs to be provided with all practicable support to enable them to make their own decision before it can be concluded that they lack capacity.
All reasonable adjustments to support decision-making MUST be clearly documented in the Mental Capacity Assessment documentation and recorded in the health notes of the respective person.
The BEST INTEREST's process is then entered into.

The Deprivation of Liberty Safeguards (DoLs) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a

way that does not inappropriately restrict their freedom. The safeguards set out a process that hospitals and care homes must follow if they believe it is in the person's best interests to deprive a person of their liberty, in order to provide a particular care plan. It is then the role of East Sussex Adult Social Care DoLs Office to arrange for assessments to ensure the deprivation of liberty is in the person's best interests.

In summary, the safeguards ensure:

- That the arrangements are in the person's best interest
- The person is appointed someone to represent them
- The person is given a legal right of appeal over the arrangements
- The arrangements are reviewed and continue for no longer than necessary

Cheshire West Supreme Court Decision, 2014 ruled that a deprivation of liberty occurs when:

- a person is under continuous supervision and control in a care home or hospital, and
- is no free to leave, and
- the person lacks capacity to consent to these arrangements.

This ruling is also referred to as the 'Acid Test'

Whether someone is deprived of their liberty depends on the person's specific circumstances. A large restriction may sometimes in itself be a deprivation of liberty or sometimes several small restrictions added together will amount to a deprivation of liberty. What needs to be assessed is the amount of control that the care home or hospital has over the person.

For more information about Deprivation of Liberty Safeguards (DoLs) please go to our intranet page. Please ensure that DoLs referrals are sent by email to our generic DoLs email address of esh-tr.DOLS@nhs.net . All DoLs applications will be reviewed prior to submission to the Local Authority DoLs office by the Safeguarding Team. If any amendments are required, the form will be returned to the clinical area in question for the amendments to be made to ensure a complete DoLs application is received from East Sussex Healthcare NHS Trust (ESHT) by the Local Authority.

If further advice is required regarding a DoLs application or an update of a DoLs authorisation please contact our ESHT Mental Capacity Lead via our generic email address for DoLs applications **esh-tr.DOLS@nhs.net**

Disputes when a person lacks capacity.

Consideration must be given when a person has been assessed as lacking mental capacity for a specific decision for health and care treatment and there are disputes regarding future care or treatment considerations must be given for an application to the Court of Protection – please refer to the ESHT Court of Protection Policy.

10.0 Promoting Wellbeing

The wellbeing of people who live and sleep on the street may need to be considered under a safeguarding response. Homelessness may be a consequence of health problems and is very commonly a cause of worsening health. Many people who 'sleep rough' may have significant needs in relation to physical health, mental health and substance misuse. Amongst the population of people who sleep rough there are significantly higher prevalence rates of organic and functional mental illness, substance use, acquired brain injury, autistic spectrum conditions and learning difficulties, and some communicable diseases. Any of these conditions can contribute to behaviours which can result in self–neglect.
At the time of this Safeguarding Adults Policy being updated- there is ongoing work within our Healthcare Trust alongside our local Housing Authorities and the Rough Sleepers Initiative

(RSI) to support the early identification of persons who are at risk of homelessness or who are current/former rough sleepers.

If a person has been identifying as at risk of homelessness or a rough sleeper- complete the Duty to Refer form (currently under revision) to support timely information sharing with the appropriate local housing authority. Timely liaison with the ESHT Discharge Hub is also advisable.

http://sussexsafeguardingadults.procedures.org.uksafeguarding-and-self-neglect &
https://sussexsafeguardingadults.procedures.org.uk/search?kw=SElf-Neglect

The impact upon ESHT employees when working with such cases should be fully recognised and support gained through our Occupational Health Department is always recommended alongside provision of Safeguarding Supervision.

Health Surveillance Policy for New and Existing Staff

11.0 Making Safeguarding Personal

Making Safeguarding Personal (MSP) is a key theme of the Care Act, 2014 and is a national approach to promote responses to safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them to identify the outcomes they want, with the aim of enabling them to resolve their circumstances and support their recovery. Making Safeguarding Personal is also about collecting information about the extent to which this shift has a positive impact on people's lives. In ESHT it is important that we view people as individuals with a variety of different preferences, histories, circumstances and lifestyles. Making Safeguarding personal emphasises the importance of a person-centred approach, adopting the principle of 'no decision about me without me'. Personalised care and support is for everyone, but some people will need more support that others to make choices and manage risks. A person led approach is supported by ESHT with where able personalised information and advice is provided and access to advocacy support where needed.

"Easy Read" documentation regarding safeguarding is available on the Safeguarding Adult page of the Extranet.

12.0 Accountabilities and Responsibilities

The legislative and regulatory safeguarding requirements set out duties for ESHT to co-operate and support wider system safeguarding practice with our statutory partners, the Local Authority and the Police. The Director of Nursing is a member of both the Local Safeguarding Adults and the Local Safeguarding Children's Boards in East Sussex. The Head of Safeguarding and members of the safeguarding team fully support the sub-committees, groups and processes of both safeguarding boards enabling ESHT to drive forward both the national and local safeguarding agenda in partnership. This supports ESHT to actively learn from safeguarding reviews, partner agency reports, national safeguarding challenges and local issues to drive improvements in our practice. There is an internal governance structure and processes for Safeguarding to ensure robust reporting and information sharing.

13.0 Training

All information regarding Mandatory Training is available from the Learning and Development Brochure. The Guidance on Supervision and Adult Safeguarding: Roles and Competencies for Health Care Intercollegiate Document outline our organisations requirements as follows:

Safeguarding Adults Level 1- All ESHT staff and volunteers must access the short e-learning module available via the Intranet.

Safeguarding Adults Level 2- This is mandatory for all front-line staff (multidisciplinary) Bands 1-4. The training is available online 374 Safeguarding Adults – Level 2 eLearning. This training requires updating every 3 years.

Safeguarding Adults Level 3- This is a mandatory course for all trained staff Band 5 and above front line (multidisciplinary) including Medical Staff whose job role brings them in contact with patients, staff, and members of the public. The training combines both Level 3 Adults and Children into THINK FAMILY and is a e-learning followed by 3.5-hour virtual training. This training requires updating every 3 years.

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards – Standard Level Online Training

For all healthcare practitioners and support workers: This training needs updating every 3 years.

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards – Advanced Level Masterclass 3 Hour Webinar

For all Patient facing staff at Band 6 since DoLs applications can be being undertaken by ANY trained nurse – that would include Band 5 practitioners and above. For professionals who make decisions about medical interventions and treatments, and for those who may have to support or advice those making significant, complex, or high-risk decisions. With the introduction of Liberty Protection Safeguards in 2023 this will include all clinicians who care for any patients over the age of 16.

14.0 Glossary

14.1 Controlling or Coercive Behaviour is a range of acts designed to make a person subordinate and/or dependant by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Section 76 of the Serious Crime Act 2015 has created an offence in relation to coercive control within domestic abuse, and sets out the importance of recognising the harm and cumulative impact on the victim caused by these patterns of behaviour. The new Domestic Abuse Act, 2021 supports that acts of coercion and control are included post-separation of a relationship.

14.2 Stalking and Harassment: Stalking refers to unwanted, persistent or obsessive attention by an individual or group towards another person causing fear, anxiety, emotional or psychological distress to the victim. Harassment can include repeated attempts to impose unwanted communications and contact upon a victim in a manner which causes fear or distress to the victim. Stalking and harassment behaviours may include nuisance telephone calls, sending excessive emails, regularly sending gifts, following the person or spying on them and making death threats. The Protection from Harassment Act 1997 makes stalking a specific offence,

14.3 Hate Crime is defined as any crime that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability. It should be noted that this definition is based on the perception of the victim or anyone else and is not reliant on evidence. Such incidents may constitute a criminal offence.

14.4 Cuckooing is a form of crime in which drug dealers take over the home of a vulnerable person in order to use it as a base for criminal activity. Organised criminal groups are increasingly targeting adults with care and support needs in this way, and the level of coercion and control involved with cuckooing often leaves the victims with little choice but to cooperate with the perpetrators.

14.5 County Lines is the police term for groups who are supplying drugs to suburban areas and market and coastal towns using dedicated mobile phone lines or “deal lines”. It can involve child criminal exploitation and using adults who are vulnerable to move drugs and money.
Groups establish a base in the market location, typically by taking over the homes of local adults by force or coercion in a practice referred to as ‘cuckooing’. the Home Office County Lines guidance describes county Lines as a major, cross-cutting issue involving drugs, violence, safeguarding, criminal and sexual exploitation, modern slavery, and missing persons. The response to tackle this activity involves the police, the National Crime Agency, a wide range of government departments, local government agencies, voluntary and community organisations and groups. County Lines activity and the associated violence, drug dealing and exploitation have a devastating impact on young people, adults at risk of exploitation and local communities.

14.6 “Honour” Based Violence - is a crime or incident which may have been committed to protect or defend the perceived “honour” of the family and/or community. Women are predominantly (but not exclusively) the victims and the violence is often committed with a degree of collusion from family members and/or the community. Many victims are so isolated and controlled that they are unable to contact the police or other organisations.

14.7 Forced Marriage is a term used to describe a marriage in which one or both of the parties are married without their consent or against their will. A forced marriage differs from an arranged marriage, in which both parties consent to the assistance of their parents or a third party in identifying a spouse. Forced marriage can be a particular risk for people with learning disabilities and people lacking capacity.

14.8 Female Genital Mutilation (FGM) involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life. The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is first born, during childhood or adolescence, just before marriage or during the first pregnancy. FGM constitutes a form of abuse and violence against women and girls.
In England and Wales the practice is illegal under the Female Genital Mutilation Act 2003.

14.9 Sexual Exploitation involves exploitative situations, contexts and relationships where adults at risk (or a third person or persons) receive “something” (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. It affects men as well as women. People who are sexually exploited do not always perceive that they are being exploited. Those exploiting the adult have power over them such as by virtue of their age, gender, physical strength, and economic or other resources. There is a distinct power imbalance in the relationship.

14.10 Extremism by Radicalisation: PREVENT is a key part of the government’s counter-terrorism strategy. Its aim is to stop people becoming terrorists, or supporting terrorism, including preventing the exploitation of susceptible people who are at risk of being drawn into violent extremism by radicalisation.

http://nww.esht.nhs.uk/wp-content/uploads/2014/03/Sussex-Prevent-Channel-Referral-Form.doc

http://nww.esht.nhs.uk/wp-content/uploads/2020/08/02080_P.pdf

Prevent and wrap training are mandatory every three years and available via Learning and Development

15.0 Relevant Article Documents

Sussex multi-agency procedures: To support people who self-neglect

Domestic Violence: safeineastsussex.org

Self-Neglect procedure
https://sussexsafeguardingadults.procedures.org.uk/search?kw=SElf-Neglect

Adult Safeguarding: Roles and Competencies for HEALTH Care Staff. First Edition August 2018.
Intercollegiate Document

MCA Code of Practice
https://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/menincap/legis.htm

DoLS Code of Practise
https://www.cqc.org.uk/sites/default/files/Deprivation%20of%20liberty%20safeguards%20code%20of%20practice.pdf

Multi-Agency Risk Management (MARM) Protocol

Sussex Adult Death Protocol
https://www.eastsussexsab.org.uk/documents/sussex-adult-death-protocol/

East Sussex Safeguarding Adults Board Resolution Protocol

East-Sussex-SAB-Resolution-Protocol-2019.pdf (eastsussexsab.org.uk)

16.0 Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Correct use of Safeguarding policy – process followed correctly	Assistant Director of Nursing for Professional Practice and Standards	Clinical Quality Review Group – Data Set	monthly	Director of Nursing	Director of Nursing Assistant Director of Nursing	Asistant Director of Nursing for Professional Practice and Standards

17 Equality and Human Rights Statement

Appendix A: EIA Form

East Sussex Healthcare NHS Trust

Equality Impact Assessment Form

1. Cover Sheet

Please refer to the accompanying guidance document when completing this form.

Strategy, policy or service name	Safeguarding Adults Policy & Procedures
Date of completion	March 2022.
Name of the person(s) completing this form	[redacted], Named Nurse Adults.
Brief description of the aims of the Strategy/ Policy/ Service	This Safeguarding Adults Policy and Procedures applies to all employees of ESHT including individuals with honorary contracts, such as work experience, or are working through within ESHT with temporary contracts or locum Agencies.
Which Department owns the strategy/ policy/ function	Corporate Safeguarding
Version number	V 3.3
Pre Equality analysis considerations	This is essential for the prevention of harm and abuse to Adults under ESHT Care.
Who will be affected by this work? **E.g. staff, patients, service users, partner organisations etc.**	All staff patients, service users, partner organisations of ESHT.
Review date	March 2025
If negative impacts have been identified that you need support mitigating please escalate to the appropriate leader in your directorate and contact the EDHR team for further discussion.	To whom has this been escalated? N/A Name: Click here to enter text. Date: Click here to enter a date.
Have you sent the final copy to the EDHR Team?	N/A

2. EIA Analysis

<table>
<tr><td></td><td>☺ 😐 ☹</td><td>Evidence:</td></tr>
<tr><td>Will the proposal impact the safety of patients', carers' visitors and/or staff?

Safe: Protected from abuse and avoidable harm.</td><td>Choose</td><td>No</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
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</td></tr>
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<table>
<tr><td>Is the proposal of change effective?

Effective: Peoples care, treatment and support achieves good outcomes, That staff are enabled to work in an inclusive environment. That the changes are made on the best available evidence for all involved with due regards across all 9 protected Characteristics</td><td>choose</td><td>N/A</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table>
<tr><th>Race</th><th>Gender</th><th>Sexual orientation</th><th>Age</th><th>Disability & carers</th></tr>
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</table></td></tr>
<tr><td>What impact will this have on people receiving a positive experience of care?</td><td>Choose</td><td>No</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table>
<tr><th>Race</th><th>Gender</th><th>Sexual orientation</th><th>Age</th><th>Disability & carers</th></tr>
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<table>
<tr><td>Does the proposal impact on the responsiveness to people's needs?</td><td>Choose</td><td>NO</td></tr>
<tr><td>Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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<tr><td>What considerations have been put in place to consider the organisations approach on improving equality and diversity in the workforce and leadership?</td><td>Choose</td><td>N/A</td></tr>
<tr><td>Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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</td></tr>
<tr><td colspan="3">Access
Could the proposal impact positively or negatively on any of the following:</td></tr>
<tr><td>• Patient Choice</td><td>Choose</td><td>No</td></tr>
<tr><td>• Access</td><td>Choose</td><td>No</td></tr>
<tr><td>• Integration</td><td>Choose</td><td>No</td></tr>
<tr><td>Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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Engagement and Involvement How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:	Choose	
Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)		<table><tr><td>**Race**</td><td>**Gender**</td><td>**Sexual orientation**</td><td>**Age**</td><td>**Disability & carers**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>**Gender reassignment**</td><td>**Marriage & Civil Partnership**</td><td>**Religion and faith**</td><td>**Maternity & Pregnancy**</td><td>**Social economic**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>
Duty of Equality Use the space below to provide more detail where you have identified how your proposal of change will impact.	Choose	

Characteristic	**Rating** ☺ ☹ 😐	**Description**
Race	😐	
Age	😐	
Disability and Carers	😐	
Religion or belief	😐	
Sex	😐	
Sexual orientation	😐	
Gender re-assignment	😐	
Pregnancy and maternity	😐	
Marriage and civil partnership	😐	

Human Rights

Please look at the table below to consider if your proposal of change may potentially conflict with the Human Right Act 1998

Articles		Y/N
A2	Right to life	Y/N
A3	Prohibition of torture, inhuman or degrading treatment	Y/N
A4	Prohibition of slavery and forced labour	Y/N
A5	Right to liberty and security	Y/N
A6 &7	Rights to a fair trial; and no punishment without law	Y/N
A8	Right to respect for private and family life, home and correspondence	Y/N
A9	Freedom of thought, conscience and religion	Y/N
A10	Freedom of expression	Y/N
A11	Freedom of assembly and association	Y/N
A12	Right to marry and found a family	Y/N
Protocols		
P1.A1	Protection of property	Y/N
P1.A2	Right to education	Y/N
P1.A3	Right to free elections	Y/N

East Sussex Healthcare NHS Trust

Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (4C)

Document ID Number	1246
Version:	V4.1
Ratified by:	Clinical Documentation and Policy Ratification Group.
Date ratified:	13 June 2023
Name of author and title:	Amy Pain, Head of Patient Experience
Date originally written:	October 2003
Date current version was completed	November 2023
Name of responsible committee/individual:	Amy Pain
Division/Speciality:	Complaints
Date issued:	19 June 2023
Review date:	May 2026
Target audience:	All staff
Compliance with CQC Fundamental Standard	Receiving and acting on complaints Good governance
Compliance with any other external requirements (e.g. Information Governance)	The National Health Service Complaints (England) Regulations (2009) (The Regulations)
Associated Documents:	N/A

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of the procedural document and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1 2003038	October 2003	Complaints Team	New document	
V2 2004102	October 2004	Complaints & Legal Services		
V3 2006029	January 2006	Complaints & Legal Services		
V3.1 2006255	October 2006	[redacted]		
V4 2007020	January 2007			
V4 2008155	July 2008	Complaints Team		
V5 2009107	May 2009	Complaints Team		
V6 2010005 (Complaints Management Policy & Procedure)	January 2010	Complaints & Legal Services		
V1.1 2012105	May 2012	Anita Smith		
V1.3 2012159	August 2012	Anita Smith		
V2.0 2015128	June 2015	Amy Reilly	Updated	Major change to reflect organisational (structure) changes new requirements and legislation
V3.0 2017281	October 2017	Amy Reilly	Updated	Changes to reflect new processes
V3.1	August 2018	Amy Reilly	Updated	Amended to reflect the process of learning from complaints
V3.2	October 2018	Darren Langridge-Kemp	Updated	Change to wording of section 5.6.5
V3.3	June 2022	Darren Langridge-Kemp	Complaints have moved from under Hazel Tonge to Richard Milner	Richard Milner would like this document to have a full review and re-write. Extension to review date from November 2020 to December 2022
V4	January 2023	Amy Pain [redacted]	Updated	Amended to reflect change in division

				alignment and processes.
V4.1	November 2023	[redacted]	Updated	Amended timeframe and title change

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Patient Experience Team	Patient Experience Team	5 May 2023
[redacted]	Deputy Patient Experience Manager	May 2023

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

East Sussex Healthcare NHS Trust (ESHT) is committed to continuously improving the outcomes for patients and achieving excellence in patient care and the patient experience. ESHT recognises that it is accountable for the services it provides and is dedicated to promoting and adhering to ESHT values and it therefore openly encourages the views, comments and suggestions of patients, their carers and the public.

Complaints are viewed positively as a valuable form of feedback, playing an important role in ESHT Governance and Quality Improvement processes, by maintaining and improving the quality of services provided. It is therefore important that there is a consistent and orderly process for the receiving and handling of such feedback, making positive use of the information gained to avoid similar occurrences by identifying lessons learnt, sharing that learning and to generally improve services. ESHT has adopted the 4C approach for managing patient experience. The 4C approach consists of complaints, compliments, comments and concerns.

This document is written to underpin the delivery of The National Health Service Complaints (England) Regulations (2009) (The Regulations) and the NHS Constitution.

2. Purpose

The purpose of this policy is to support the organisation to use comments, concerns and complaints as an opportunity to improve and develop our services and enable our staff to learn and improve the quality of care we deliver. It sets out clear expectations to embed an open, non-defensive approach to learning from feedback.

2.1 Rationale

ESHT has a statutory and regulatory duty to ensure that systems are in place for responding to complaints, comments, and concerns in accordance with national and local guidance. ESHT is committed to improving services and reducing the impact of any risks, which could affect the organisation. By appropriately managing and responding to complaints, comments, concerns and compliments (only compliments addressed to the Chief Executive) ESHT is able to learn from them and where necessary put in place controls or mitigating actions in place.

2.2 Principles

When patients, carers or visitors raise concerns where things have gone wrong, or where we have failed to deliver the level of care or treatment we promised to, we commit to:

- Saying sorry they are unhappy with the service they feel they have experienced.
- Providing an honest and open response to all the issues raised, in a way which is preferred by them and is accessible.
- Providing a thorough and detailed explanation about events leading up to the complaint or concern.
- Being honest about where things might have gone wrong and say sorry or provide clarity on points of misunderstanding.
- Providing a response stating what the organisation will learn from the experience, with reassurance that we have acted to prevent it from happening again.
- Adhering to the PHSO Principles of Remedy where they may outline the obligation to make a financial contribution to the complainant if they have suffered a financial loss as a direct consequence.

2.3 Scope

This policy applies where the person affected is a person for whom ESHT has responsibility as a healthcare provider, or as a public body and covers complaints relating to the services, facilities and environment provided by ESHT.

This policy must be followed by all staff who are employed by ESHT and those on contracts for services, temporary or honorary contracts, secondments, bank staff, volunteers, and students.

Independent contractors are responsible for the development and management of their own procedural documents and for ensuring compliance with relevant legislation and best practice guidelines. ESHT will provide advice and support as required.

3. Definitions

Being Open

- Acknowledging, explaining and apologising when things go wrong;
- Conducting a thorough investigation into the concern/complaint;
- Reassuring patients, their families, and carers that lessons learnt will help prevent, wherever possible, complaints from reoccurring;
- Healthcare organisations are required to acknowledge, explain and apologise when a patient is harmed or has died as a result of a patient safety incident. (see our “Being Open” Policy).

Care Quality Commission
The independent regulator of all health and social care services in England.

Comment
A comment can be a remark or observation that does not require a formal response, but still requires acknowledging and recording.

Complaint
A complaint is an expression of dissatisfaction about any aspect of the services which ESHT provides, or the environments they are provided in, for which an investigation and response must be provided in accordance with The Regulations.

Compliment/Plaudit
An expression of gratitude as a result of services provided to service users, relatives, carers or members of the public by ESHT staff.

Concern
A concern is an issue that can be dealt with quickly and informally by the Patient Experience Team (PALS) via local resolution with the relevant clinical area/unit or department.

Consent
Where the complainant is not the patient, it is necessary to request consent from the patient (or evidence of appropriate authority to act if the patient is unable to provide it; for example, due to lack of capacity or if the patient is deceased) to confirm the patient (or their Estate if deceased) is happy for a complaint to be investigated and responded to with disclosures of confidential care being made to someone acting on their behalf.

Datixweb
Integrated risk management system (software) which is used for centrally recording incidents, complaints, concerns, comments and claims (amongst other risk-based information).

Duty of Candour
Regulations which make it a statutory requirement for health service bodies to act in an open and transparent way with relevant persons in relation to care and treatment provided to service users.

Independent Sector Complaints Adjudication Service (ISCAS)
ISCAS provide an independent self-referral service to private patients when they feel that a private health service has not investigated a complaint properly, fairly or to their satisfaction.

Investigation
Detailed, systematic review of records and collation of statements to uncover facts and determine the truth of the factors (who, what, when, where, why and how) of complaints.

Patient Experience Team (PALS)
The Patient Advice and Liaison Service (PALS), part of our wider Patient Experience Team, was established in 2001 to provide confidential advice, information, and support regarding NHS services, including concerns and complaints.

Parliamentary and Health Service Ombudsman (PHSO)
Also known as the Health Service Ombudsman, they provide an independent self-referral service to the public when they feel that an NHS body has not investigated a complaint properly, fairly or to their satisfaction.

The Advocacy People
Provide an independent advocacy service to support people (e.g. writing complaint letters), who would like to make a complaint about their NHS treatment. The service is totally independent of the NHS and is free and confidential to all NHS service users.

4. Accountabilities and Responsibilities

Chief Executive
The Chief Executive has the overall responsibility for the complaint's procedure, including reviewing and signing of complaints. The responsibility of signing complaints can be delegated to a nominated Executive Director.

Chief of Staff
The Chief of Staff is responsible for overseeing the governance function of all Patient Experience procedures including the handling of concerns, comments, and complaints.

Chief Nurse
The Chief Nurse will oversee report for ESHT Board or Committees outlining complaints and will meet with complainants as required.

The Board
The Board has responsibility for ensuring that there are robust systems and processes in place that allow patients, relatives, and carers to raise concerns and complaints. That they are investigated and responded to in a timely manner and that lessons are learnt from both feedback and complaints.

The Board will receive information on complaints, concerns, comments, and compliments monthly and may request additional reports on themes, trends and learning from complaints and concerns.

The Chief Executive and the Board, through the Quality and Safety Committee, are accountable for ensuring that complaints and concerns are investigated and analysed, to prevent their recurrence. They must implement changes and review their effectiveness and disseminate learning to healthcare staff.

Quality and Safety Committee
The Quality and Safety Committee has responsibility for ensuring complaints and concerns have been investigated and responded to in accordance with the policy. The Quality and Safety Committee will receive a bi-monthly report on patient experience including complaints. An in-depth report will be submitted quarterly. This will include patient, and carer feedback to identify any themes or trends. These will then be reported to the ESHT Board along with recommendations for further improvements to ensure lessons are learnt.

Assistant Directors of Nursing
Assistant Directors of Nursing have responsibility for:

- Ensuring that their Service Managers (SM) and Heads of Nursing (HoN)/Allied Healthcare Professionals (AHP) are appropriately trained in investigating and responding to complaints.
- Reviewing all responses to complaints related to their services.
- Ensuring that improvement plans arising from complaints/concerns are implemented appropriately and effectively and shared with regulatory bodies when requested.
- Ensuring that learning from patient experience feedback is shared via the Directorate Groups.

Service Managers (SM) and Heads of Nursing (HoN)/Allied Healthcare Professional (AHP)
SM's and HoN's/AHP's must ensure that any complaints or concerns about their service are reported to the Patient Experience Team promptly. Whenever possible, SM's and HoN's/AHP's must call and offer, where appropriate, to meet with complainants in the first instance as part of resolving the complaint or concern and share this with the Patient Experience Team.

SM's and HoN's/AHP's must ensure that their staff are aware of how to deal with concerns and complaints made by patients, or their relatives or carers. Face to face or virtual training is provided by the Patient Experience Team for managers and team leaders.

SM's and HoN's/AHP's are responsible for seeking advice from Safeguarding or the Patient Safety Team (for possible Serious Incidents), prior to carrying out investigations into complaints or concerns. They also collect and provide statements which will support the Patient Experience Team to draft a response to the complainant.

SM's and HoN's/AHP's are responsible for ensuring that complaints and concerns are investigated within ESHT timescales. To gain support SM's and HoN's/ AHP's should attend complaints training as defined within ESHT training needs analysis relevant to their role.

SM's and HoN's/AHP's should take the key role in any local resolution meeting held; including leading the meeting, ensuring the complainant feels able to have their say, supporting the staff members to explain and respond, and ensuring evidence of the discussion at the meeting is captured.

SM's and HoN's/AHP's are responsible for ensuring that the staff investigating a complaint, or subject to a complaint, are provided with support during and after the investigation. This may include counselling, clinical supervision and/or training. Final response letters sent to complainants should also be shared with relevant staff as part of the learning.

SM's and HoN's/AHP's are responsible for drawing up improvement plans where the investigation identifies this is needed and adding any potential risk to ESHT's risk register.

The improvement plans must be specific with clear timescales and are monitored through to completion by the Patient Experience Team.

SM's and HoN's/AHP's are responsible for sharing feedback within their teams and via appropriate quality meetings when there are lessons to be learned.

The Patient Experience Team
The Standard Operating Procedure in Appendix B details the responsibilities of the Patient Experience Team during the process of receiving feedback.

Produce weekly and monthly reports on complaints and patient experience data for key ESHT forums (local requirements should be served by the relevant Governance Team) working towards sharing and identifying learning.

Providing case studies for patient stories for the Board to assist with learning from complaints.

Delivery of appropriate training on complaints' processes and how best to review patient experience feedback.

Complaint Investigator(s)
A person identified/appointed to lead, oversee and as necessary respond to complaint issues. They should have the appropriate level of training or experience to competently investigate the complaint or seek and complete training as necessary.

They must keep in regular contact with the issuing Patient Experience Officer (Complaints) and adhere to ESHT timescales to help the Patient Experience Officer (Complaints) draft a formal response for the appointed Executive to review and sign.

All staff
All staff are expected to:

- Adhere to this policy.
- Watch the complaint handling video on MyLearn.
- Report all complaints, concerns or plaudits to their manager and to the Patient Experience Team upon receipt.
- Co-operate with any investigation into a concern or complaint.
- Give patients, their relatives, and carers information about the complaints' process in the format of their choice and information on where to seek advice, including advocacy support.
- Not to discriminate against, or treat unfairly, a patient or their representative who has made a complaint, comment or raised a concern.

5. Process

5.1 Identifying the Correct Approach
It is important to listen and react appropriately when patients, carers or relatives express a concern or make a complaint. Not everything that patients, carers or relatives raise as a concern is necessarily a complaint and many of these can and should be resolved informally by the people to whom they are addressed or by their immediate manager. All possibilities should be explored in an attempt to resolve the complaint or concern in a positive and non-judgemental way.

ESHT seeks to distinguish between requests for assistance in resolving a problem locally and informally and an actual complaint that may require an in-depth investigation and written response from our Executive Team. Enquiries and comments from patients, relatives or carers

seeking assistance will be dealt with in a flexible manner, appropriate to the nature of the problem. Concerns and complaints will be dealt with in accordance with the procedures set out in this policy.

5.2 Concerns and Complaints

Concerns and complaints may be made using our online contact form, made verbally by telephone or in person, via email or in writing through our Patient Experience Team. The online form is available in Easy Read.

A concern or a complaint taken verbally, over the telephone or during a face to face meeting, is just as valid as a written complaint and should be treated with the same consideration and sensitivity. Care should be taken to ensure that sufficient details are gained to allow the issue(s) to be investigated and responded to appropriately.

If the issues cannot be resolved immediately by the service/unit or via the Patient Experience Team (PALS), then the complaint should be escalated to the formal process. Their decision should be based upon information provided by staff about the resolutions available.

All formal complaints must be acknowledged within three working days. Where a complaint has been made directly to a service or individual, the service or individual should immediately forward the complaint to the Patient Experience Team upon receipt.

In addition to the acknowledgement, all complainants will be sent a copy of the 'Making a Complaint' factsheet, which explains what can be expected from the complaint's process and can be provided in alternative formats upon request (Appendix C), together with an information sheet on local advocacy services.

ESHT timescale for replying to a concern is 15 working days and 60 working days from receipt for formal complaints. The timescale for replying to complaints regarding our private unit, Sussex Premier Health, is 20 working days from receipt. If patient consent or evidence of appropriate authority to act for the patient has not been received by the time the complaint investigation has been completed, ESHT will issue a no consent response to respect patient confidentiality.

All complaints are graded (Appendix D) and triaged by the Patient Experience Team to ensure the nature of the issues raised are easily recognised and to establish how it will be handled.

All concerns and complaints will be recorded on ESHT's incident management system (Datix) by the Patient Experience Team.

Where patients find it difficult to complain or are unable to complain, ESHT welcomes complaints from a family member or a patient representative (such as an advocate). When someone complains on behalf of a patient, the Patient Experience Team will need to be satisfied that the patient is aware of the complaint and consents to disclosures of confidential care being provided to the complainant for the purposes of investigation and resolution of the complaint. Where there is doubt about consent, either mental capacity to consent or any suspicion of duress, advice may be sought from the legal or safeguarding teams as appropriate. There are consent forms to be completed; however, the patient may give consent verbally to the Patient Experience Team if they are unable to write or see the form (Appendix E).

Every effort should be made to resolve concerns and complaints as quickly and as easily as possible. Complainants should always be contacted as soon as possible to fully understand the complaint and to offer a meeting where it is deemed helpful and appropriate to do so in the best interests of resolving the issues.

Where a written response is required, the Patient Experience Officer (Complaints) will draft a response and send it to the service for divisional approval before submitting it for Executive Team review and signing. Responses must be written clearly and in plain language, with terminology briefly explained, to answer all issues raised. ESHT can provide the response in accessible formats upon request, including Easy Read, Braille and audio.

Information received from a complainant will remain confidential and be communicated only to those staff who need to know.

If the complainant is dissatisfied with ESHT's response then in the first instance, further attempts to resolve the complaint will be made including the offer of a further written response or a face-to-face meeting in person or via a video call. If this does not resolve the complaint, then the complainant has the right to take their complaint to the Parliamentary and Health Service Ombudsman for NHS complaints or to ISCAS for private healthcare complaints re Sussex Premier Health and request that they investigate their complaint independently.

5.3 Concerns/Complaints Involving Multiple Organisations

Complaints relating to more than one NHS organisation or including the involvement of Local Authority Social Services should be investigated jointly, but with one organisation acting as the Lead Agency to provide the complainant with a single co-ordinated response. The Lead Agency is usually the organisation receiving the complaint or the one where the larger proportion of issues for investigation and response sit.

The overarching principle for joint working is that the focus will always be on the complainant and all work will be undertaken with due regard to the agreement, understanding and acceptance of the complainant.

5.4 Who Can Raise a Comment, Concern or Complaint?

A comment, concern or complaint can be made by:

- A patient or any person affected by or likely to be affected by the action, omission or decision of the NHS body or Sussex Premier Health, that is the subject of the complaint.
- Someone acting on behalf of another person may make a complaint or enquiry on behalf of that person, where that person is unable to make the complaint themselves or has asked the person to make the complaint on their behalf.
- Where the person is an adult but unable to make a complaint themselves, their representative will need to have or have had sufficient interest in the service user or patient's welfare and be an appropriate person to act on their behalf.
- Where the person has asked another person to make the complaint or enquiry on their behalf, ESHT will require the patient's written consent to reply. In these instances, ESHT will send a consent form to the patient requesting they sign and return it to authorise the representative to act on their behalf and for ESHT to reply to the representative on the issues raised in the concern or complaint, making disclosures of confidential care as necessary.
- If the patient has capacity but is physically unable to sign the form, the Patient Experience Team will discuss alternative solutions which may include the acceptance of verbal consent directly from the patient and recording this.
- If the patient does not have capacity to give consent, the Patient Experience Team will request evidence that the patient's representative has the authority to act or is acting in the 'best interest' of the patient to support their healthcare needs.
- If the complaint relates to a patient who has died, or who dies during the investigation of a complaint, ESHT will work with the complainant to obtain an appropriate level of authority in order to make disclosures of confidential care as part of the formal response and to respect the rights of the patient.

- If an informal concern is raised via the Patient Experience (PALS) team on behalf of the patient, only verbal consent is required from the patient in this instance.
- A member of parliament (MP) may contact the Trust on behalf of a constituent wishing to raise informal concerns or a formal complaint. In these instances the MP will provide signed consent from the constituent to allow the Trust to make enquiries on their behalf. If informal concerns are raised, these are managed and responded to by the Corporate Business Manager to the Chief Executive. If a formal complaint is required, then this will be managed by the Patient Experience Team, and response sent directly to the constituent with a copy provided to the MP.

5.5 Time Limits on Making a Complaint
The Regulations state at Regulation 12 that a complaint should be made within 12 months of the date of the incident that is the source of the complaint or within 12 months of the date of discovering the source of the complaint. This is for NHS complaints.

However, the Patient Experience Team have the ability to make a Regulation 12 exception if they are satisfied as to why the complaint could not be made earlier and where it is still possible to investigate the facts of the case effectively. In these instances, the Patient Experience Team will explain to the complainant that whilst an investigation and response can be undertaken, this might be limited in detail due to the passage of time and because staff involved may no longer work for ESHT.

Please note that for complaints relating to private healthcare, this should be within six months from the date of the event.

Where it is decided the complaint is out of time and will not be investigated, this will be confirmed in writing and the complainant will be advised of their right to take their complaint to the PHSO (for Sussex Premier Health patients this would be ISCAS).

5.6 Concerns and Complaint Records
Complaint records should be kept separate from health records, subject to the need to record information which is strictly relevant to the patient's health.

Complaint records must be treated with the same degree of confidentiality as normal medical records and would be open to disclosure in legal proceedings.

Complaint records will be retained for a period of ten years before being considered for destruction as set out at point (4) of the NHS England Corporate Records, Retention and Disposal Schedule.

5.7 Support for Complainants
ESHT will be supportive of those who may find it difficult to complain or raise a concern and will ensure that patients, their relatives, or carers, are not discriminated against as a result of raising a concern or complaint.

ESHT will communicate with complainants in the way that best meets their needs. This may be by telephone, email, in writing, or a combination of all of these, or by meeting with them in person if it is helpful and appropriate to do so.

ESHT communications will be provided in a format to meet the complainants needs, for example Easy Read or Braille in line with the Accessible Information Standard.

Communication may need to be in a language other than English. We will provide an interpreting and translation service to assist complainants where required.

Patients and their families should be encouraged to speak openly and freely about their concerns and should be reassured that whatever they say will be treated with the appropriate confidentiality and sensitivity, and will not adversely affect their care and treatment.

5.8 Support for Staff
Staff who may be the subject of a complaint or asked to contribute to a complaint investigation may be understandably upset, anxious or distressed, or unclear what to do. In these instances, they should seek advice and support from their manager, a member of the Patient Experience Team or by referring to the "Policy for Supporting Staff Involved In Incidents, Complaints or Claims" on the Extranet.

The Patient Experience Team will also ensure, wherever appropriate and possible, that drafts of complaint responses are shared with the staff involved to comment on the accuracy of the content at the approval stage and that final versions are shared with staff.

5.9 Reporting and Learning from Comments, Concerns, and Complaints
Comments, concerns, and complaints are recorded on Datix, which is ESHT's risk management system. Data on this activity, which includes themes and trends, is provided weekly and monthly to divisions and a variety of ESHT forums to review the information and improvement plans to ensure that the organisation is learning from concerns and complaints and updating risk registers as appropriate.

The Patient Experience Team ensures that the KO41a data return is submitted annually to NHS Digital as part of national complaint reporting.

The Annual Patient Experience Report is shared widely within ESHT at Patient Safety and Quality Group (PSQG) and Quality and Safety Committee (QSC) and on the ESHT website.

5.10 Unreasonable or Unreasonably Persistent Behaviour
Please refer to the Procedure for Management of Unreasonable or Unreasonably Persistent Behaviour.

6. Special Considerations
This policy and its principles cannot be used:

- By health organisations or Local Authorities to make a complaint about another health authority or organisation.
- By staff working within ESHT or contracted to it to complain about any aspect of their employment, contractual or pension issues.
- To commence legal proceedings.
- If a complaint is also part of an on-going police investigation or legal action it will be discussed with the relevant police authority or legal advisor and only continue as a complaint if it does not compromise the police investigation or legal action
- To investigate a matter that has already been investigated under The Regulations. It cannot be used to investigate matters which are being or have been investigated by the Parliamentary and Health Service Ombudsman.
- To complain about a matter arising out of an alleged failure to comply with a request for information under the Freedom of Information Act 2000. Such complaints should be referred to the Chief of Staff.
- It cannot be used to complain about ESHT's recruitment or employment policies or practices.
- Where the complaint relates to alleged theft of a patient's property or verbal or physical assault of a patient, the service/unit/Patient Experience Team must advise the complainant to alert the police and the service/unit/Patient Experience Team must seek advice from the Safeguarding Team and Human Resources. Complaints of this

nature will be logged as an incident and investigated using ESHT's management investigation and/or safeguarding procedures. The complainant will retain the right to take their complaint to the PHSO (for Sussex Premier Health patients this would be ISCAS) if they believe ESHT has not investigated or responded appropriately. The Patient Experience Team may act as a point of contact for the complainant at the request of the service.

- Where ESHT believes that a complaint does not fall within the remit of The Regulations in this policy, we will provide a written explanation to the complainant setting out the reasons for not dealing with the complaint and advising them on the other options available to them.

Please also refer to The Regulations for exclusions.

7. Evidence Base/References

- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- The NHS Constitution

8. Competencies and Training Requirements

The Patient Experience Team will deliver "Patient Experience – Introduction to Complaints, PALS & Plaudits" and/or "Introduction to Complaint Handling" training to staff groups which have been identified by either Learning and Development or divisions. There is also a training video available on MyLearn.

The Patient Safety Team also offer "Root Cause Analysis" training which would complement those who undertake the "Introduction to Complaint Handling" training.

9. Monitoring Arrangements

Please see table.

Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
% of complaints responded to within agreed timeframe	Head of Patient Experience	Datix/Datixweb	Weekly Monthly	Patient, Safety and Quality, Individual Performance Review	Head of Patient Experience	Patient Safety and Quality Group
Number of complaints overdue (not responded to in time)	Head of Patient Experience	Datix/Datixweb	Weekly Monthly	Patient, Safety and Quality, Individual Performance Review	Head of Patient Experience	Patient Safety and Quality Group
Number of complaints reopened / referred to the PHSO/ISCAS	Head of Patient Experience	Datix/Datixweb	Weekly Monthly	Patient, Safety and Quality, Individual Performance Review	Head of Patient Experience	Patient Safety and Quality Group

Appendix A: EIA Form

East Sussex Healthcare NHS Trust

Equality Impact Assessment Form

1. Cover Sheet

Please refer to the accompanying guidance document when completing this form.

Strategy, policy or service name	Policy and Procedure for the Recording, Investigation and Management of Complaints, Comments, Concerns and Compliments (4C)
Date of completion	May 2023
Name of the person(s) completing this form	Amy Pain
Brief description of the aims of the Strategy/ Policy/ Service	This document is written to underpin the delivery of The National Health Service Complaints (England) Regulations (2009) (The Regulations) and the NHS Constitution.
Which Department owns the strategy/ policy/ function	Patient Experience
Version number	4
Pre Equality analysis considerations	None
Who will be affected by this work? **E.g. staff, patients, service users, partner organisations etc.**	Staff, patients, carers and external organisations
Review date	
If negative impacts have been identified that you need support mitigating please escalate to the appropriate leader in your directorate and contact the EDHR team for further discussion.	To whom has this been escalated? Name: Click here to enter text. Date: Click here to enter a date.
Have you sent the final copy to the EDHR Team?	

2. EIA Analysis

<table>
<tr><td></td><td>☺ 😐 ☹</td><td>Evidence:</td></tr>
<tr><td>Will the proposal impact the safety of patients', carers' visitors and/or staff?

Safe: Protected from abuse and avoidable harm.</td><td>Choose Neutral</td><td>Click here to enter text.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table></td></tr>
<tr><td>Is the proposal of change effective?

Effective: Peoples care, treatment and support achieves good outcomes, That staff are enabled to work in an inclusive environment. That the changes are made on the best available evidence for all involved with due regards across all 9 protected Characteristics</td><td>Choose Neutral</td><td>Click here to enter text.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table></td></tr>
</table>

What impact will this have on people receiving a positive experience of care?	Choose Neutral	Click here to enter text.
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		**Race** ☐ **Gender** ☐ **Sexual orientation** ☐ **Age** ☐ **Disability & carers** ☐ **Gender reassignment** ☐ **Marriage & Civil Partnership** ☐ **Religion and faith** ☐ **Maternity & Pregnancy** ☐ **Social economic** ☐
Does the proposal impact on the responsiveness to people's needs?	Choose Neutral	
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		**Race** ☐ **Gender** ☐ **Sexual orientation** ☐ **Age** ☐ **Disability & carers** ☐ **Gender reassignment** ☐ **Marriage & Civil Partnership** ☐ **Religion and faith** ☐ **Maternity & Pregnancy** ☐ **Social economic** ☐
What considerations have been put in place to consider the organisations approach on improving equality and diversity in the workforce and leadership?	Choose Neutral	Click here to enter text.
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		**Race** ☐ **Gender** ☐ **Sexual orientation** ☐ **Age** ☐ **Disability & carers** ☐ **Gender reassignment** ☐ **Marriage & Civil Partnership** ☐ **Religion and faith** ☐ **Maternity & Pregnancy** ☐ **Social economic** ☐
Access Could the proposal impact positively or negatively on any of the following:		
• Patient Choice	Choose	Neutral
• Access	Choose	Neutral
• Integration	Choose	Neutral

Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		<table><tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>
Engagement and Involvement How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:	Choose Neutral	
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		<table><tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>
Duty of Equality Use the space below to provide more detail where you have identified how your proposal of change will impact.	Choose Neutral	
Characteristic	**Rating** ☺ ☹ 😐	**Description**
Race	Choose Neutral	
Age	Choose Neutral	
Disability and Carers	Choose Neutral	
Religion or belief	Choose Neutral	
Sex	Choose Neutral	
Sexual orientation	Choose Neutral	
Gender re-assignment	Choose Neutral	
Pregnancy and maternity	Choose Neutral	
Marriage and civil partnership	Choose Neutral	

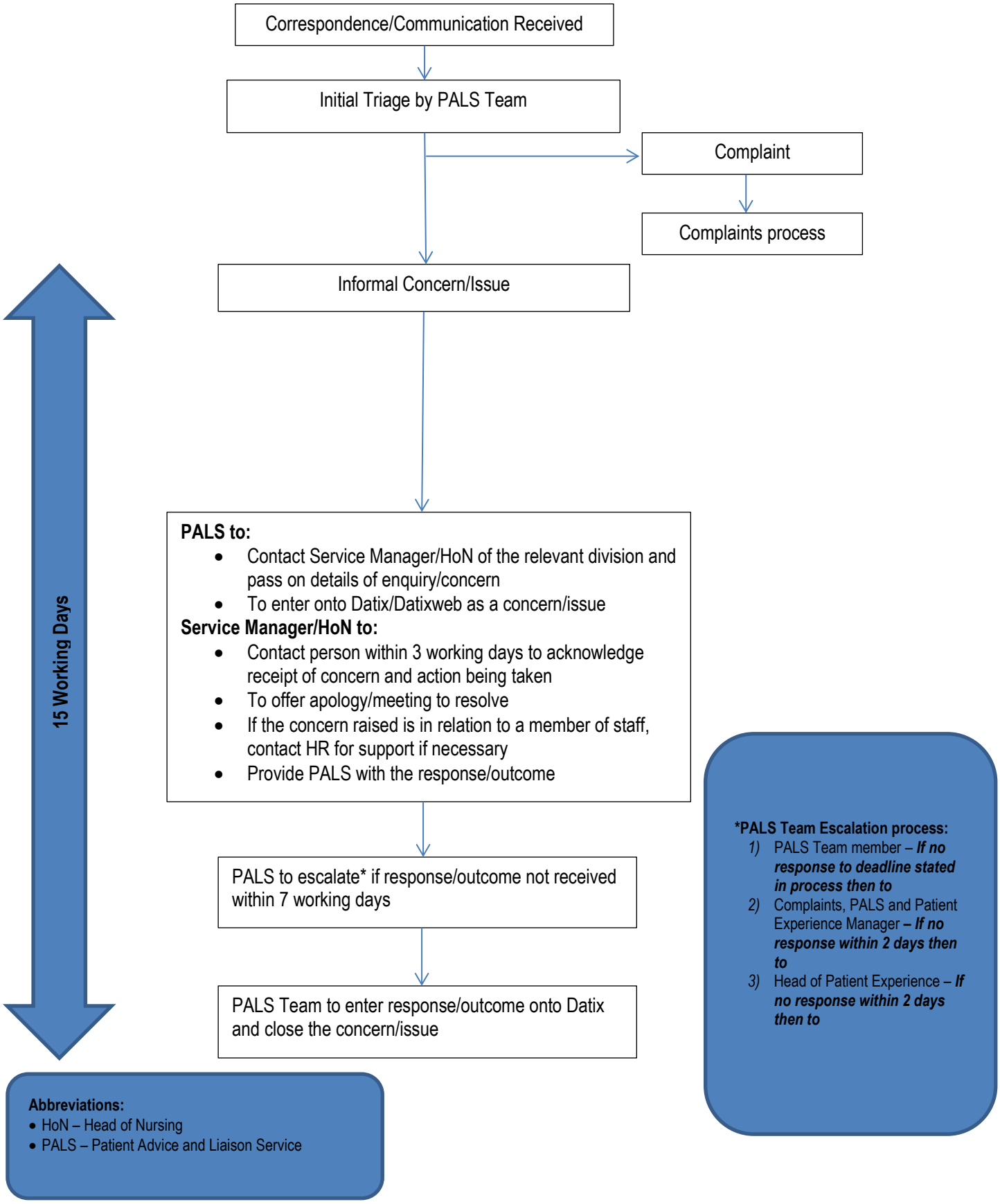
Human Rights

Please look at the table below to consider if your proposal of change may potentially conflict with the Human Right Act 1998

Articles		Y/N
A2	Right to life	**N**
A3	Prohibition of torture, inhuman or degrading treatment	**N**
A4	Prohibition of slavery and forced labour	**N**
A5	Right to liberty and security	**N**
A6 &7	Rights to a fair trial; and no punishment without law	**N**
A8	Right to respect for private and family life, home and correspondence	**N**
A9	Freedom of thought, conscience and religion	**N**
A10	Freedom of expression	**N**
A11	Freedom of assembly and association	**N**
A12	Right to marry and found a family	**N**
Protocols		
P1.A1	Protection of property	**N**
P1.A2	Right to education	**N**
P1.A3	Right to free elections	**N**

Appendix B: Process for patient feedback

Enquiry Process – PALS Team



Handling Formal Complaints – Standard Operating Procedure (SOP)

Day(s) Are Measured in Working Days	Action
Day 1 – Complaint Received	The complaint is received by the Patient Experience Team (Complaints) and assessed to ensure it is something for our organisation, determine if it is something that could be handled by the Patient Experience Team (PALS) for a faster and more local resolution, and if we are the appropriate agency to lead if it spans multiple agencies. Once complaint competencies are met, the Patient Experience Administrator will:
	1. Log the complaint in Datix under the patient's name, adding the complainant's details if they are not the patient, to include address (postal and email if provided), date of birth, hospital number, and assign it a complaint status.
	2. Create an electronic file in the Digital Complaints Folder for all documentation generated/received during the complaint investigation.
	3. If the patient's medical records are not on Evolve, log a request on iFit for the medical notes to be despatched to the Patient Experience Administrator or telephone Apex Way to log a request.
	4. If the patient's episode of care is related in part or in full to an Emergency Department, review NerveCentre.
	5. Assign to the Patient Experience Officer (Complaints) aligned with the primary division.
	6. The original complaint is scanned and inserted into the Datix record and saved in the relevant electronic file.
Day 1-3	1. The Patient Experience Administrator will, via Datix, send the complainant a formal letter of acknowledgement, signed by the Chief Executive which sets out the complaint response timescale; the type of letter sent will be dependent on any requirement for patient consent/authorisation. The letter encloses a copy of our Complaints Factsheet and a leaflet on how to access advocacy services.
	2. If patient consent is required, we will also write to the patient directly to request that they complete and return a consent form.
	3. If the patient does not have capacity to give consent or is deceased, the complainant will be asked to provide evidence of authority to act on the patient's behalf.
	4. If consent is required to share the complaint with a third party (for example GP, Ambulance Service or Adult Social Care) as part of the investigation (and to permit us to share with them a copy of our response), we will also ask the complainant to complete and return a third-party consent form to enable us to do this.
	5. All letters (manually created or generated by Datix) are saved in the relevant electronic file, and Progress Notes entry is updated.
	6. Generate a triage log in Datix and save in the relevant section of the electronic file, capturing the: - Complaint number; - Patient's hospital number; - Date the complaint was received; - Date the division response is due by; - Patient's name; - Complainant's name if not the patient.

	7. Generate a draft response template in Datix and save in the relevant section of the electronic file.
By Day 5	1. The Patient Experience Officer (Complaints), using a combination of the complaint and the patient's medical records, Evolve and NerveCentre as relevant/appropriate, will review the complaint, grade it in accordance with the Complaints Grading Matrix and record this in the "description" field, and then using the triage log saved in the relevant electronic file to record the: - Risk grading (high, moderate or low); - WEB number if there is an associate SI; - Name of the Lead Investigator; and - The question(s) that will form the basis of the investigation and response, together with a record of which staff have been identified as needing to answer it/them. If staff cannot be identified, the Patient Experience Officer (Complaints) will speak to the Lead Investigator to seek clarity/confirmation.
	2. The Patient Experience Officer (Complaints) according to the Complaints Grading Matrix shares the complaint with the relevant senior staff as appropriate giving a one-line explanation on the rationale for the risk rating. A copy of the email is saved in the relevant electronic file and Progress Notes entry is updated. - High risk (a complaint where the action or omission of Trust staff has placed a patient at risk of or suffered significant harm). - Moderate risk (a complaint involving aspects of clinical care). - Low risk (a complaint that does not involve any aspect of clinical care).
	3. The Patient Experience Officer (Complaints) will make attempts to contact the complainant by telephone if a number has been provided, or email if provided and there is no reply to attempts to reach them by telephone, to introduce themselves, clarify any issues if needed and discuss the complaint/process that will be undertaken. Progress Notes entry is updated.
	4. The triage log, original complaint, "Complaints Handling Hints and Tips" guide and "Saying Sorry" leaflet (created by NHS Resolution) is sent by the Patient Experience Officer (Complaints) from the generic Complaints mailbox to the staff who have been identified as needing to answer the questions, copied to key/senior staff as requested by each division, by email; the email also sets out the date by which their response must be received by the Patient Experience Team (Complaints). A copy of the distribution email is saved in the relevant electronic file, and Progress Notes entry is updated.
	5. Staff statements/responses are, as received, saved in the relevant electronic file by the Patient Experience Administrator, Progress Notes entry is updated, and staff are linked in the Datix record as necessary.
	6. When consent and/or evidence of authority to act is received, this is saved in the relevant electronic folder by the Patient Experience Administrator and a letter of acknowledgement is sent to confirm receipt. Progress Notes entry is updated.
	7. Once all statements/responses are received and saved in the relevant electronic folder, the Patient Experience Officer (Complaints) will draft the response. Progress Notes entry made to confirm date the response was ready to draft. The content of the draft response is dependent on whether consent and/or evidence of authority to act has been received.
Day 35	1. If staff statements/responses are outstanding, the Patient Experience Officer (Complaints) chases staff who have not answered their question(s). 2. Progress Notes entry is updated.

Day 40	1. If staff statements/responses are outstanding, the Patient Experience Officer (Complaints) chases staff who have not answered their question(s). 2. The Patient Experience Officer (Complaints) provides the complainant with an update on their complaint. 3. Progress Notes entry is updated.
Day 45	1. If staff statements/responses are outstanding, the Patient Experience Officer (Complaints) will escalate all outstanding issues to the Deputy Patient Experience Manager (Complaints) to chase staff who have not answered their question(s). 2. Progress Notes entry is updated.
By Day 50	1. The draft response should now have approvals from the investigation team, divisional Assistant Director of Nursing and, if appropriate, Chief of Service and Clinical or Professional Lead, and be submitted to the Chief Executive (for high risk rated complaints) or Chief of Staff (for low and moderate risk rated complaints) with a link to the relevant electronic file for review and approval to sign and send out. 2. Progress Notes entry is updated to confirm date of draft response approvals, and the date sent to the Chief of Staff or Chief Executive.
	3. A summary of the complaint investigation and an outcome code are recorded in Datix. 4. If the investigation has identified SMART action(s), the Patient Experiencer Officer (Complaints) will record these in Datix to ensure implementation of identified action(s) are followed up and evidenced.
	5. The Patient Experience Officer (Complaints) provides the complainant with an update on their complaint. 6. If the draft response is not ready for signing by the Chief of Staff at this stage, the Deputy Patient Experience Manager (Complaints) will chase again, Progress Notes entry is updated. The Deputy Patient Experience Manager (Complaints) also advises the Head of Patient Experience of potential target date breach.
By Day 55	1. The complaint response is reviewed by the Chief Executive (for high risk rated complaints) or Chief of Staff (for low and moderate risk rated complaints). 2. Once approved, the Chief Executive or Chief of Staff will authorise the Patient Experience Administrator to add their digital signature.
	3. The Patient Experience Administrator adds the Chief Executive's or Chief of Staff's digital signature to the complaint response, amends the date as necessary, saves the signed version of the letter in Word and PDF formats in the relevant electronic file, prints, and posts it out including a leaflet about our post complaint survey, stamped "First Class".
	4. The complaint record is closed by the Patient Experience Administrator in Datix using the date the complaint response is sent out. Progress Notes entry is updated to reflect the date the complaint response and any copies required were sent out. A PDF version of the response is also saved in Datix.
By Day 60	1. Any complaint response which needs to be shared with a third party (and only where consent has been acquired) is sent out by the Patient Experience Administrator.
	2. A copy of the signed complaint response is emailed to the relevant Governance Team to share with staff and ensure any actions or learning agreed is implemented.

Complaints Escalation Process

60 Working Day Case	Action	By Whom
Day 35	If complaint investigation findings/statements are outstanding, a telephone/Teams call is made to staff who have not answered their question(s) to chase, and followed up with an email. A note of the chaser is made in Progress Notes.	Patient Experience Officer (PEO) (Complaints)
Day 40	If complaint investigation findings/statements are outstanding, a further telephone/Teams call is made to staff who have not answered their question(s) to chase, and followed up with an email on the back of the first chaser email. The complainant is provided with an update on their complaint A note of the chaser and update is made in Progress Notes.	Patient Experience Officer (Complaints)
Day 45	If complaint investigation findings/statements are outstanding, the Patient Experience Officer (Complaints) escalates the case to the Deputy Patient Experience Manager (Complaints) on the back of the second chaser email. A note of the file escalation is made in Progress Notes. A chaser (third) by email is sent by the Deputy Patient Experience Manager (Complaints). A note of the third chaser is made in Progress Notes.	Patient Experience Officer (Complaints) Deputy Patient Experience Manager (DPEM)
Day 50	A telephone/Teams call is made to staff who have not answered their question(s) to chase, and followed up with an email on the back of the third chaser email. The Deputy Patient Experience Manager (Complaints) alerts the Head of Patient Experience of a potential target date breach. A note of the fourth chaser is made in Progress Notes. The Patient Experience Officer (Complaints) provides the complainant with an update on their complaint.	Deputy Patient Experience Manager Patient Experience Officer (Complaints)
Day 55	If the complaint draft response is not ready for signing by the Chief Executive or Chief of Staff, the Deputy Patient Experience Manager (Complaints) chases again (and escalates to the relevant Assistant Director of Nursing), Progress Notes entry is updated.	Deputy Patient Experience Manager

Appendix C: Complaints Factsheet

East Sussex Healthcare NHS Trust

Complaints Factsheet

This factsheet explains what we will do with the complaint you have raised about your experience, or that of a relative, friend or loved one, in respect of the care, treatment, services or amenities provided by the Trust. We treat all complaints seriously, and aim to resolve them within the timescales set out in the acknowledgement letter that accompanies this factsheet. You can also be assured that making a complaint will never affect ongoing or future care or treatment at the Trust, and complaints are never filed in a patient's medical records.

What can I expect from raising a complaint?

We acknowledge all complaints received within three working days and after reviewing your complaint (in conjunction with your medical records if necessary), we will undertake a full investigation. If you have given us your telephone number or email address, we will also try to contact you to discuss your complaint.

We will then ask appropriate members of staff to provide a response to the complaint issues you have raised, and we may ask for a review of clinical care to be undertaken where appropriate. We will also endeavour to provide you with an update on the progress of your complaint and if we experience any delays in completing the complaint investigation, we will contact you to advise of this.

Once the investigation has been finished, the Patient Experience Team will prepare a written response. The Chief Executive will read your complaint, the investigation records and then the written response that has been prepared and if the response is satisfactory, it will be signed and sent to you. If the Chief Executive has questions about the investigation or the response, it will be returned to the Patient Experience Team to address these and ensure that the final response meets our quality standards.

What will you learn from my complaint?

You will be assured to know that we find complaints to be a very helpful source of feedback and any actions and/or learning identified as a result of your complaint will be shared with the relevant staff, wards or units. We have internal processes to ensure these actions and/or learning are logged, tracked and implemented to prevent similar issues from happening in the future, as it is important that no-one else has the same experience you have had cause to complain about.

What can I do if I am not happy with your response?

If you are not happy with our response to your complaint, please contact the Patient Experience Team in the first instance to let us know.

We can, in discussion with you, re-open your complaint and look again at any issues you feel we have not dealt with to your satisfaction or that require further clarification. We can also

arrange for you to speak with relevant managers or clinical staff (subject to any restrictions), as this may provide further explanations or clarifications you need to help answer your questions.

It is important to us that we make every effort to resolve your complaint locally and, as far as it is possible, to your satisfaction. However, there may be occasions when we are unable to achieve this and in these cases, you have the right to ask the Health Service Ombudsman to review your complaint. The contact details for the Parliamentary and Health Service Ombudsman are set out below.

Write To: Parliamentary and Health Service Ombudsman
Millbank Tower
Millbank
London
SW1P 4QP

Telephone: 0345 015 4033

Email: phso.enquiries@ombudsman.org.uk

Website: www.ombudsman.org.uk

Other formats

If you require this leaflet in a different format, such as large print or an alternative language, please contact the Patient Experience Team:

Dial 0300 13 14 500 and select extension 770358.

Appendix D: Complaints Grading Matrix

Risk Grading	Descriptor	Share Complaint With
HIGH	• a complaint where the action or omission of Trust staff has placed a patient at risk of or suffered significant harm, up to and including death; and/or • a complaint raising safeguarding concerns against the Trust; and/or • a complaint presenting a significant reputational risk to the Trust.	Division, Joe Chadwick-Bell, Richard Milner, Vikki Carruth, Simon Merritt, Amy Pain, Copy to: - Legal Team
MODERATE	• a complaint involving aspects of clinical care, but where the above criteria has not been met.	Division, Vikki Carruth (If Nursing), Simon Merritt (If Medical), Amy Pain
LOW	• a complaint that does not involve any aspect of clinical care and where the above criteria has not been met.	Division Only

Appendix E: Complaints Handling – Helpful hints and Tips

Complaints Handling
Helpful Hints and Tips

Our health, and that of our loved ones, is a highly emotive subject; sometimes, we are talking about recent health and well-being, whilst at other times we are talking about the difference between life and death or more tragically, when death has occurred. The feelings everyone has about their health, and that of loved ones, can trigger all sorts of reactions and behaviours which are not always rational or appropriate. But they happen, and we should try and avoid being defensive if someone complains about the care or treatment they have been given.

The reason we have a formal complaints process is twofold; firstly, it is a statutory requirement (laid before Parliament and coming into effect in July 2004) that we have a process for handling and investigating complaints, and secondly it is an opportunity for us as part of our commitment and willingness to receive and be open and transparent about feedback, including complaints, and our response to it.

So if you find yourself in the position of being asked to comment on or provide a response to a complaint, please think about and consider the following:

- it's really hard, but try not to start off by taking it personally or being defensive – everyone is entitled to raise a complaint about something that concerns or upsets them and the complaint is their perspective or a reflection of their feelings as a result of an event, valid or otherwise. This is why we undertake complaint investigations to understand what happened from both sides, what the evidence tells us, and if systems or processes need to change as a result;

- before you start any investigation, think about what you need and what support you might want – do you want to have a chat with someone in the Complaints Team, or a peer, a supervisor, a manager in your senior team? Don't feel you are on your own – ask for help or support if you want it;

- always be open, truthful and transparent – sometimes we find just saying "I am sorry X happened" is often all a complainant wants, and the "Saying Sorry" leaflet published by NHS Resolution in 2017 (which is attached to the same email as this factsheet) tells you more about what saying sorry does and does not mean;

- be factual and only respond with what can be evidenced because that very evidence may be called upon by the Complaints Team or the Health Service Ombudsman at a later date. Don't refer to anything if you cannot evidence it – as the saying goes, if it's not written down it didn't happen;

- use a laypersons language when providing your response – the Complaints Team are not clinically trained and need to be able to explain your comments in simple terms that patients and relatives can understand. But if you need to refer to a clinical diagnosis or procedure, please give us a very brief explanation as to what it is as that will help, as will explaining clinical abbreviations that may be straightforward in your head, but mean nothing to those without your clinical expertise;

- remember that just because a clinical event has happened to a patient or has been explained to them/their relative doesn't mean they know or will remember what it is/means, so as before, please use laypersons terms;

- only provide information in your response that is relevant to the question(s) you have been asked - so for example you don't need to reference patient observations or test results unless they are actually related to the question(s) asked or the complaint;

- always provide your statement as quickly as you can – the Trust has to comply with strict response timescales for complaints that are monitored at Trust Board level and measured by providers such as Clinical Commissioning Groups (CCG's) – if you can't provide your statement straightaway, please tell the Complaints Team so they know what is happening, when you can provide it and offer any help you may need;

- never make derogatory remarks about the content of the complaint, the complainant and/or their relatives or about your colleagues, and do not use inappropriate language in emails or statements – every single communication in respect of a complaint investigation is held on the complaint file and if the complainant or a regulatory body such as the Health Service Ombudsman or the Care Quality Commission (CQC) request a copy of the complaint file, your remarks will be made available to them (which might not make you or the Trust look particularly professional); and

- lastly, if you are ever in doubt about what to do or what to say, or even where to begin with a complaint, please get in touch with the Complaints Team – unfortunately, complaints will not go away if you ignore them and by leaving your response to the last minute does not help you or the Trust, particularly if the lateness of your response makes the formal response overdue.

The Complaints Team are always available, ready and willing to help!!!

Appendix F: Complaints Form

NHS
East Sussex Healthcare
NHS Trust

The Trust is committed to learning from all the feedback that it receives, and concerns complaints can often help to identify where changes or improvements to standards or practices may be required to enhance the experience of patients and their relatives.

We want it to be easy for patients or relatives to make a concern or complaint and so if you have any questions or require assistance completing this form, please telephone our Patient Experience Team on 0300 131 4784 or 0300 131 5309.

Patient Details	**Your Details (If You Are Not The Patient)**
Title: Mr/Mrs/Miss/Ms/Other (Please State)	Title: Mr/Mrs/Miss/Ms/Other (Please State)
First Name:	First Name:
Surname:	Surname:
Address:	Address:
Postcode:	Postcode:
Telephone Number:	Telephone Number:
Email Address:	Email Address:
Date of Birth:	Relationship To Patient:

NB: if you are not the patient, we will need evidence that you have the authority to receive details of confidential patient care and treatment in order to answer your complaint.

What Is The Date(s) Of The Incident That Is The Source Of Your Concern Or Complaint?	Date(s):
Which Site(s) Does Your Concern Or Complaint Relate To?	Conquest Hospital Eastbourne District General Hospital Other Hospital (Please State) At Home/In The Community (Please State)
Which Department(s) Does Your Concern Or Complaint Relate To?	Department(s):
Please give us a summary of your concern or complaint below; it will help us if you can be as specific as you can about key details.	

Thinking about the concern or complaint you have made, what are the specific questions you would like us to investigate and respond to you on?

Once you have completed this form, you can email it to us as an attachment (please do not send it in a photographic format) at esh-tr.patientexperience@nhs.net or post to:

The Chief Executive
Patient Experience Team (Complaints)
East Sussex Healthcare NHS Trust
St Anne's House
729 The Ridge
St. Leonards-on-Sea
East Sussex
TN37 7PT

If you need your correspondence from the Patient Experience Team in a larger font, different format or a different language, please indicate below:

□ In a larger size font (please tell us below what size font)

□ In a different format (please tell us below what format this is)

□ In a different language (please tell us below which language)

Do you have any other specific communication needs? Please let us know so we can assist you.

East Sussex Healthcare NHS Trust

Use of the Mental Health Act 1983 (MHA) Policy

Document ID Number	1500
Version:	V3.2
Ratified by:	Clinical Documentation and Policy Ratification Group.
Date ratified:	11 January 2022
Name of author and title:	Mental Health Law Practice Development Manager – SPFT with oversight from ESHT Head of Safeguarding
Date originally written:	November 2017
Date current version was completed	December 2021
Name of responsible committee/individual:	Mental Health Act Committee-SPFT & ESHT Head of Safeguarding and Safeguarding Operational Group
Division/Speciality:	Corporate, Safeguarding
Date issued:	21 September 2022
Review date:	December 2024
Target audience:	All ESHT Staff
Compliance with CQC Fundamental Standard	Person Centred Care (Regulation 9) Dignity and Respect (Regulation 10) Need for Consent (Regulation 11) Safe Care and Treatment (Regulation 12) Safeguarding service users from abuse and improper Treatment (Regulation 13)
Compliance with any other external requirements (e.g. Information Governance)	N/A
Associated Documents:	ESHT Safeguarding Adults Policy,

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of the procedural document and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V2.0	November 2017	Practice Development Officer (Mental Health Law) Sussex Partnership NHS Foundation Trust	Review	Content updated to reflect current practice
V2.1	July 2018	Sue Curties, Head of Safeguarding	To conform to the current format	Amendments to the new template
V2.2	April 2019	Sue Curties Head of Safeguarding	Amend	.Mental Health Act (MHA) Process added.
V3.0	July 2021	Mental Health Law Practice Development Manager (Sussex Partnership NHS Foundation Trust)	Review	Content updated to reflect current practice.
V3.1	December 2021	Mental Health Law Practice Development Manager (Sussex Partnership NHS Foundation Trust)	Final Review and update	Content updated to reflect current practice
V3,2	September 2022	Mental Health Law Practice Development Manager (Sussex Partnership NHS Foundation Trust	Amended to reflect current practice	Giving of Rights advice by SPFT MH Liaison / CAMHS Liaison And update of Appendix G Contact details

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
SPFT MHA Service Team		November 2017
SPFT MH Liaison Team		November 2017
ESHT Safeguarding Team	Head of Safeguarding	June 2018
ESHT Safeguarding Team		July 2021
ESHT Clinical Site Team		July 2021
SPFT MH Law Services		July 2021
SPFT Mental Health Liaison Service		July 2021
Sussex Police		July 2021
East Sussex Adult Social Care		July 2021
East Sussex Healthcare NHS Trust	Safeguarding Adults and Children Operations Group	September 2021
East Sussex Healthcare NHS Trust	Safeguarding Adults and Children Strategic Group	October 2021

Table of Contents

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

1. Introduction

This policy is intended to provide assistance to East Sussex Healthcare NHS Trust ("ESHT") employees when involved with the admission, care and treatment, transfer and discharge of patients who are detained under the Mental Health Act 1983 ("MHA").

The MHA governs the detention, treatment, discharge and aftercare of people with a mental disorder.

To be compulsorily detained and treated under the MHA, a person must be assessed to have a mental disorder (although this is widely defined) and there must be an element of risk either to themselves or others. Those detained under the MHA may also have physical health problems, but these cannot be treated under the MHA except in very limited circumstances (usually determined by a court) where the physical health problems are closely linked to the person's mental health problems. Physical health problems unrelated to a person's mental health problems (if they have any) may come within the scope of the Mental Capacity Act 2005 ("MCA") if the person is assessed to lack mental capacity to make a particular decision at a particular time in relation to their care or treatment. The MCA is a separate piece of legislation from the MHA, with different aims, rules and procedures.

2. General Principles

It is essential that all those undertaking functions under the MHA understand the five sets of overarching principles, outlined in the Code of Practice to the MHA, which should always be considered when making decisions in relate to care, support of treatment provided under the MHA.

The five overarching principles are:

Least restrictive option and maximising independence
Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

Empowerment and involvement
Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

Respect and dignity
Patients, their families and cares should be treated with respect and dignity and listened to by professionals.

Purpose and effectiveness
Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

Efficiency and Equity
Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supported discharge from detention

3. Duties

All ESHT healthcare professionals should comply with this policy. Healthcare professionals are responsible for reporting any incidents or complaints related to the use of this policy via the appropriate Trust systems.

Matrons and ward managers are responsible for implementing this policy within individual clinical areas and investigating any incidents related to the use of this policy.

Sussex Partnership NHS Foundation Trust ("SPFT") will provide support and advice in the implementation of this policy and the investigation into any incidents related to the use of this policy.

4. Definitions and Abbreviations used within the MHA

Term	Definition
AC	Approved Clinician. This is usually a consultant psychiatrist but may also be a psychologist, nurse, occupational therapist or social worker who has completed the appropriate training.
AMHP	Approved Mental Health Professional. Within Sussex, this is usually a social worker who is warranted to assess and make an application for detention. An AMHP may also be an appropriately warranted nurse, occupational therapist or psychologist.
Associate Hospital Managers Panel	A panel with the power to discharge detained patients composed of three volunteers appointed for that purpose.
Hospital Managers	The Trust Board or other body responsible for the detention of patients in a particular hospital. Applications for detention must be addressed to the managers of the hospital where the patient is to be detained (i.e. ESHT where the patient is to be detained in Eastbourne District General Hospital or the Conquest Hospital). An application for detention must name a specific hospital. If a patient's detention is formally transferred out of ESHT (e.g. to SPFT), then the transfer form must specify the full name and address of the new managers (Trust or independent hospital).
Mental Health Tribunal	An independent panel with the power to discharge detained patients composed of a legally qualified Tribunal judge, a medical member and a lay member.
Nearest Relative	This is a relative of a detained patient defined via a mechanism within the MHA. The Nearest Relative, if not already known, is identified by the AMHP on detention. The Nearest Relative has certain powers and responsibilities within the MHA. The Nearest Relative is not automatically the next of kin.
RC	Responsible Clinician. This is the Approved Clinician with overall responsibility for a detained patient's case. For ESHT, the RC will be a consultant psychiatrist working for Mental Health Liaison.

5. The Hospital Managers

5.1 Definition

The term "Hospital Managers" within the MHA refers to the organisation with power to detain and responsibility for detaining people with mental disorders in a particular hospital (e.g. ESHT or SPFT).

Where patients are detained to ESHT (i.e. where the AMHP makes the application for detention out to ESHT – see below), the "Hospital Managers" are the Trust Board of ESHT. By contrast, where patients are detained to SPFT (but, for example, given leave of absence to attend an ESHT hospital while remaining detained to SPFT – see below), the SPFT Trust Board are the "Hospital Managers". "Hospital Managers" are not the same as "Associate Hospital Managers" (see below) (see MHA Code of Practice, 2015 (3rd ed.), chapters 37 and 38).

The MHA Code of Practice states: "Hospital managers have the authority to detain patients under the Act. They have the primary responsibility for seeing that the requirements of the Act are followed. In particular, they must ensure that patients are detained only as the Act allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights" (MHA Code of Practice,2015 (3rd ed.), para. 37.3).

5.2 Powers, responsibilities, and duties

Hospital managers have statutory powers, responsibilities, and duties under the MHA in relation to the:

- Receipt and scrutiny of detention documentation
- Detention of patients and the giving of information to patients
- Notification of the Nearest Relative
- Appropriate care and treatment of the patient in accordance with the provisions of the MHA
- Review of continuing detention under the MHA
- Discharge of detention patients

In practice, the decisions and powers of the hospital managers will be exercised by individuals on their behalf (see table, below).

This table highlights the responsibility of ESHT and SPFT as set out under the terms of the agreed contract for the provision of MHA Services ("the Contract"):

Function	Responsibility of
Receipt and scrutiny of documents	ESHT (Training provided by SPFT) Supported by MH Liaison team, SPFT as required.
Detention of patients and the giving of rights advice to patients regarding their detention	SPFT MH Liaison / CAMHS Liaison.
Notification of the Nearest Relative	MHA Administration, SPFT
Appropriate care and treatment of the patient in accordance with the provisions of the MHA	ESHT (Compliance monitored by SPFT)

Review of continuing detention under the MHA and management of any patient appeals against detention or hearings	MHA Administration, SPFT MH Liaison, SPFT
Recognition of any Safeguarding issues and referral to Adult / Child Social Care	ESHT

5.3 Discharge of patients

Under section 23 MHA, Hospital Managers have the power to review and discharge most detained patients. Any panel convened for this purpose must consist of three or more people and may be made up of Non-Executive Directors of ESHT or Associate Hospital Managers ("AHMs"). Any reviews or appeals against detention to ESHT's hospital managers will be managed by SPFT under the Contract.

The AHMs are independent volunteers who are appointed by a Trust for the specific purpose of reviewing detentions under the MHA. They must not be employees of the organisation or have any financial interest in it. Consequently, AHMs are independent of the management and clinical teams assessing and treating detained patients. Under the Contract, AHMs are recruited and managed by SPFT on behalf of ESHT. Expenses paid to AHMs to attend panel reviews are paid by SPFT under the terms of the Contract.

6. Common Sections of the MHA

Section	Title	Duration	Detail
5(2)	Doctor's holding power in respect of a patient already in hospital	Max 72 hours	Where a patient is already in hospital but tries to leave, a doctor graded FY2 and above may complete a report (Form H1) to 'hold' the patient until a MHA Assessment can be arranged if that doctor believes the patient
2	Admission for assessment and treatment	Up to 28 days and cannot be renewed	A patient may be detained in hospital and compulsorily treated following an application by an AMHP supported by 2 medical recommendations (1 must be by a section 12 approved doctor)
3	Admission for treatment	Up to 6 months and can be renewed indefinitely	A patient may be detained in hospital and compulsorily treated following an application by an AMHP supported by 2 medical recommendations (1 must be by a section 12 approved doctor)
132	Information about patient rights	Ongoing	Patients must be given information about their detention and provided with the appropriate patient leaflet. Information must be given to the patient orally and

			in writing. Attempts to give the patient information regarding their Detention should be recorded on the section 132 rights recording form (Appendix D). See Section 132 protocol (Appendix C).
17	Authorised l e a v e of absence for detained patients	Variable	Detained patients may be granted section 17 leave by their Responsible Clinician to leave the ward or hospital. Leave may be granted to leave an SPFT ward or unit to attend an ESHT hospital for medical treatment of a physical condition. The patient remains detained to SPFT. See Section 17 leave form (Appendix E).
19	Transfer of a detained patient between hospitals with different hospital managers (i.e. different NHS Trusts or independent hospitals).	Variable	A detained patient may be formally transferred from one NHS Trust or independent hospital to another. The patient will then be detained to the new organisation and the new Trust Board/independent hospital management will take over responsibility for them. Compare section 17 leave (above). These are different processes which apply to specific situations.
136	Police power to remove a person to a place of safety.	Up to 24 hours but may extended by a further 12 hours in exceptional circumstances.	An emergency power which allows for the removal of a person to a place of safety if the person appears to a police officer to be suffering from mental disorder and to be in immediate need of care or control, if the police office believes it necessary the interests of that person, or for the protection of others.
135	Warrant to search for and remove patients		To provide police officers with a power of entry to private premises. A Section 135(1) warrant must be applied fo by an AMHP for a person who is not already detained under the

			MHA. A Section 135(2) warrant may be applied for by a person authorised by the detaining hospital for a patient who is already liable for detention.

7. Section 5 (2) MHA

This is a holding power (not detention) which a single doctor (FY2 or above) can exercise to hold a patient who is already admitted to hospital (not in the Emergency Department or Clinical Decision Unit), but not detained, for up to 72 hours. The purpose is to provide sufficient time to arrange for an MHA Assessment of the patient.

Please refer to the Section 5(2) protocol (Appendix B) for further information. Training is provided by SPFT to all ESHT junior doctor intakes on both hospital sites.

Staff should also consider whether there are any Safeguarding issues and follow due process as defined in the safeguarding policies. http://nww.esht.nhs.uk/wp-content/uploads/2018/08/00822_P.pdf

7.1 Statutory Form

FORM H1 ; The section 5(2) power is exercised by the doctor completing Part 1 of the statutory form. The form must then be checked (see Section 5(2) MHA checklist, Appendix B) and Part 2 must be completed by a Clinical Site Manager (out of hours) or Matron (in hours), with support from Mental Health Liaison as required.

In addition to the traditional method of being handwritten and signed, the H1 form can now be completed and signed electronically by both the doctor and Clinical Site Manager/Matron/MH Liaison.

Errors on Section 5(2) MHA Form H1 cannot be rectified, so it is extremely important that the form is completed correctly and checked at the time.

8. Section 2 MHA

Section 2 MHA permits the compulsory admission to hospital and detention of a person for assessment, which may be followed by treatment for mental disorder. Detention can last up to a maximum of 28 days and cannot be renewed, although a section 2 may be converted to a Section 3 MHA detention for further treatment (see below).

An application to detain a patient under section 2 will usually be made by an AMHP. Two medical recommendations must support the application, completed by two doctors. One of the doctors must be section 12 MHA approved (which in summary means they have psychiatric qualifications). The doctors must examine the patient either together or separately but within 5 days of each other. The doctors must not be from the same team.

8.1 Relevant Statutory Forms

All section papers must be received by the Clinical Site Manager and checked for accuracy (a checklist is provided). Copies of the statutory forms must be made by ESHT and filed in the patient's clinical file. The original section papers, if they are in paper format, must be sent to the MHA Administration Office by post and email without delay (see Contact Details in Appendix G) and if electronic please follow the process in F.

Form A2 – Application by AMHP
Form A4 – Single medical recommendation completed by each doctor
Form H3 - Record of Admission completed by Clinical Site Manager (ESHT)
("A2 stands for "Application"
Statutory forms are available in the Clinical Site Managers' office, Accident & Emergency and MH Liaison, as well as from the local MHA Administration Office. They are also available electronically on the ESHT intranet.

In addition to the traditional method of being handwritten and signed, the statutory forms can now be completed and signed electronically.

The application and single medical recommendations may be completed on a s.12 Solution platform and submitted by email. The AMHP will discuss and agree an email address in advance with the ward/Clinical Site Manager to ensure safe receipt. Please see Appendix F for further guidance on process and acceptance.

The MHA Administration Office only has 14 days beginning on the day of detention to rectify any identified errors. Errors or omissions cannot be rectified beyond this period and the detention may be invalidated as a result.

8.2 Treatment

Treatment for the patient's mental disorder (but not usually any physical disorder, see above) can lawfully be given without the patient's consent during the first three months of the patient's detention under section 63 MHA. However, the RC should ensure a capacity to consent to treatment assessment is completed and documented. The RC will try to obtain the patient's consent where possible.

For advice or further information, please contact the local MHA Administration Office or MH Liaison (see Contact Details, Appendix G).

8.3 Discharge

The patient can be discharged at any time before the end of the 28 day period:

- By the RC
- By the Mental Health Tribunal at a hearing
- By the Associate Hospital Managers at a hearing
- By the Associate Hospital Managers at a hearing or by the RC following an application for the patient to be discharged by the Nearest Relative

For advice or further information, please contact the MHA Administration Office (see Contact Details, Appendix G).

9. Section 3 MHA

Section 3 permits the compulsory admission to hospital and detention of a person for treatment of a mental disorder. The patient can be detained initially for up to 6 months. The section can be renewed for a further 6 months and then for periods of one year at a time provided the patient continues to meet the Section 3 criteria for detention.

An application to detain a patient under section 3 will usually be made by an AMHP. Two medical recommendations must support the application, completed by two doctors. One of the doctors must be section 12 MHA approved (which in summary means they have psychiatric qualifications). The doctors must examine the patient either together or separately but within 5 days of each other. The doctors must not be from the same team.

9.1 Relevant statutory forms include:

Form A6 – Application by AMHP
Form A8 – Single medical recommendation completed by each doctor
Form H3 – Record of admission completed by Clinical Site Manager or Matron (ESHT)

All section papers must be received by the Clinical Site Manager/Matron and checked for accuracy (a checklist is provided). Copies of the statutory forms must be made by ESHT and filed in the patient's clinical file. The original section papers must be sent by email and post to the MHA Administration Office at the address below without delay (see Contact Details, Appendix G).

Statutory forms are available in the Clinical Site Managers' office, Accident & Emergency and MH Liaison, as well as from the local MHA Administration Office. They are also available electronically on the ESHT intranet.

In addition to the traditional method of being handwritten and signed, the statutory forms can now be completed and signed electronically.

The application and single medical recommendations may be completed on a s.12 Solution platform and submitted by email. The AMHP will discuss and agree an email address in advance with the ward/Clinical Site Manager to ensure safe receipt. Please see Appendix F for further guidance.

The MHA Administration Office only has 14 days beginning on the day of detention to rectify any identified errors. Errors or omissions cannot be rectified beyond this period and the detention may be invalidated as a result.

9.2 Treatment

Treatment for the patient's mental disorder (but not usually any physical disorder, see above) can lawfully be given without the patient's consent during the first three months of the patient's continuous detention (whether under section 3 or section 2 followed immediately by section 3) under section 63 MHA. However the RC must ensure a capacity to consent to treatment assessment is completed and documented. The RC will try to obtain the patient's consent where possible.

Beyond the 3 month initial period of detention, the patient cannot continue to be administered with treatment for their mental disorder, unless:

- The patient is assessed as having capacity to consent to the treatment and is consenting, in which case the RC will complete Form T2, listing the relevant treatment, **OR**
- The patient is assessed as lacking capacity to consent to the treatment, in which case the RC will request a Second Opinion Appointed Doctor (SOAD) to assess the patient. If the SOAD is satisfied that the treatment proposed is appropriate, they will complete Form T3, authorising the relevant treatment, **OR**
- The patient is assessed as having capacity to consent to the treatment but is refusing it, in which case the RC will request a SOAD who will complete Form T3 if satisfied (as above), **OR**
- The RC completes a Section 62 (urgent treatment) form, authorising treatment to continue pending the arrival of a SOAD (where this is necessary)

("T" stands for "Treatment")

Specific rules apply to Electro-Convulsive Therapy (ECT) and certain specific (rare) treatments. For advice or further information, please contact the local MHA Administration Office or MH Liaison.

9.3 Discharge

The patient can be discharged:

- By the RC (at any time)
- By the Mental Health Tribunal at a hearing (one appeal per period of detention)
- By the Associate Hospital Managers at a hearing (generally one appeal per period of detention)
- By the Associate Hospital Managers at a hearing or by the RC following an application for the patient to be discharged by the Nearest Relative. (One application per period of detention)
- By the Associate Hospital Managers (at a renewal hearing, which takes place every time the detention is renewed by the RC)

For advice or further information, please contact the local MHA Administration Office (see Contact Details, Appendix G).

10. Section 132 MHA

Under section 132 MHA, ESHT must take all practicable steps to ensure that patients understand the provisions of the MHA under which they are detained and their rights to appeal against their detention. The information must be given both orally and in writing. Patient information leaflets are available in the Clinical Site Managers' office, Emergency Departments and MH Liaison, as well as from the local MHA Administration Office. They are also available electronically on the ESHT intranet and SPFT public website.

10.1 Documenting rights advice

A record must be kept of when rights advice has been given to a detained patient.

- Rights advice recording sheet (see Section 132 MHA protocol, Appendix C)
- Keep the recording sheet with the patient's clinical record
- Different rights advice applies to sections 5(2), 2 and 3
- Document in ward diary (or equivalent) when rights advice must next be given (see policy)
- When rights advice must next be given depends on both the patient's comprehension and the requirements of section 132 MHA

Please refer to the Section 132 MHA protocol (Appendix C) for more information on rights advice and recording.

11. Section 17 MHA

Detained patients may only leave the ward/unit to which they are detained if they have been granted section 17 MHA leave of absence. This can only be granted by their RC (or authorised acting RC). The RC should also consider whether there are any Safeguarding issues both for the patient and broader community.

Typically, if a patient is detained to another Trust/independent hospital (such as SPFT) for ongoing mental health treatment but requires short-term physical health treatment at an ESHT hospital, it will not be appropriate to transfer the entire section 2 or 3 to ESHT (so

ESHT becomes the organisation formally responsible for the patient's detention). In these circumstances, the patient should remain detained to (for example) SPFT but be given temporary permission (section 17 MHA leave of absence) to be somewhere other than the SPFT ward to which they are detained (in this case, an ESHT ward).

Where the patient is coming from SPFT, the ESHT Clinical Site Manager should request and receive a copy of the SPFT section 17 MHA leave form to ensure they are aware of any conditions attached to the leave. Copies of the patient's detention papers, and any relevant information must also be provided. Where the patient is escorted from SPFT to ESHT, copies of the relevant risk assessment(s) should be provided and any arrangements for the patient to be escorted while receiving treatment at ESHT should be agreed between SPFT and ESHT prior to the detained patient's arrival at an ESHT hospital. The SPFT section 17 MHA leave form should be filed in the patient's notes and remain accessible to all staff. In an emergency, the Section 17 MHA Leave of Absence form may be provided retrospectively, but as soon as practicable.

Please also refer to the "Transfer of Patients Requiring Care in a Local General Hospital" policy, developed by SPFT with involvement from ESHT.

11.1 Section 17 MHA Leave documentation

- **SPFT Section 17 MHA Leave of Absence form (non – statutory) (Appendix E**)

See MHA Administration Flowchart 2 (Appendix A) for more information.

12. Section 19 MHA

Detained patients may be formally transferred from one hospital to another using section 19 MHA.

Section 19 formally passes responsibility for the mental health care of the patient from one Trust to another.

If a patient was originally detained to ESHT during a time when the patient required physical health treatment and this treatment is no longer required, but the patient requires ongoing mental health treatment, ESHT's authority to detain the patient should be formally transferred to SPFT (for example).

Where a detained patient receiving ongoing mental health treatment needs to be transferred to an ESHT hospital for short-term physical health treatment, in the vast majority of cases this should be carried out by the use of section 17 MHA leave of absence (see above). A section 19 MHA transfer can only be made to an admission ward, not to the Emergency Department.

12.1 Statutory Form

· Form H4

A detained patient transfer between NHS Trusts or independent hospitals is documented using Form H4. Appropriate arrangements should have been made prior to the transfer date. The transferring hospital will have completed Part 1 of Form H4 prior to transfer. It is important to include the Trust names of any NHS Trusts or Foundation Trusts (as the Trust Board is the organisation responsible for detaining the patient). Upon admission, Part 2 is completed on behalf of the receiving hospital, confirming the transfer of the section to the new organisation.

Where ESHT is transferring a patient, a Clinical Site Manager should complete Part 1 of the Form H4 and send copies of the statutory forms to the receiving hospital. The person accompanying the patient should request completion of Part 2 at the receiving hospital (ward staff or MHA Administration staff). If the transfer is to SPFT, the MHA Administration Office may already hold the original statutory documentation. If not, the MHA Administration Office will forward the original statutory documentation to the relevant hospital authority.

When a detained patient is being formally transferred to ESHT (which should be rare), a Clinical Site Manager should receive the completed statutory forms (which may be copies), including a completed Form H3 (see above for details of forms for each section) and complete Part 2 of the Form H4. Copies of the statutory documentation should be made by the ward and filed in the patient's clinical file. The original section papers (if received – these may be sent direct) must be sent to the MHA Administration Office without delay (see Contact Details, Appendix G). **The MHA Office will only have 14 days beginning on the day of admission to rectify any identified errors**. **Errors or omissions cannot be rectified beyond this period and the detention may be deemed invalid.**

As well as the traditional method of handwriting and signing, this statutory may also now be completed and signed electronically.

13. Absence without Leave

Patients are considered to be Absent Without Leave (AWOL) when they have left the hospital in which they are detained without leave being agreed.

Responsibility for the safe return of patients rests with the detaining hospital. Where the patient is detained to ESHT, then ESHT will be responsible for ensuring the safe return of the patient.

Detained patients who are AWOL may be taken into custody and returned by any member of the hospital staff or anyone authorised in writing by the hospital managers. The police should be asked to assist in returning a patient to hospital where there is considered an immediate risk to life. If the patient's location is known, the role of the police should, wherever possible, only be to assist a suitably qualified and experienced mental health professional in returning the patient to hospital.

In these circumstances a police officer may also have the authority to take a patient into custody where the detaining hospital has obtained a warrant under Section 135(2) of the MHA (see Chapter 14 below).

If a patient is absent without leave staff should also consider any Safeguarding risks and refer to Adult/Child Social Care in accordance with procedures.

14. Section 135 MHA

This section provides for a magistrate to issue a warrant authorising a police officer to enter premises, using force, if necessary, for the purpose of either removing a mentally disordered person to a place of safety, or if the premises specified in the warrant are a place of safety, keep the person in the premises for the permitted period of detention outlined in Section 136.

Section 135(2) provides for the issue of a warrant to enter premises for the purposes of taking or retaking a patient who is already liable to be detained into custody. When executing the warrant, the police officer may be accompanied by a doctor or any other person, such as an AMHP, who is authorised to take or retake the patient when executing

the warrant.

A “place of safety” would usually be considered a Sussex Partnership “Section 136 Hospital place of safety”. However, if the police have concerns about the physical health of the person, the patient could be taken directly to the local Emergency Department.

For further detail please refer to the “Assessment of persons under Section 135 and 136 of the Mental Health Act 1983” pan Sussex policy.

15. Section 136 MHA

This section of the Mental Health empowers a police officer to either remove a person to a place of safety or, if the person is already at a place of safety, keep the person at that place, or remove them to another place of safety. The power can only be exercised if the police officer considers that the person is suffering from mental disorder and is in immediate need of care or control. The power can be invoked anywhere including railway lines, cars, cinemas, caravans, hospital wards, accident and emergency departments and offices, but would exclude any house, flat or room where that person or any other person is living, or any yard, garden, garage or outhouse that is used in connection with the house, flat or room.

A “place of safety” would usually be considered a Sussex Partnership “Section 136 Hospital place of safety”. However, if the police have concerns about the physical health of the person, the patient could be taken directly to the local Emergency Department. In this scenario, arrival in Emergency Department would trigger the 24 hour detention period even if the Emergency Department do not take responsibility for the person. The police officers will either stay with the person or will leave while treatment is provided, but this must be in consultation with the Emergency Department, and on the understanding that the police officers will return on request.

The circumstances in which police custody may be used as a Place of Safety are defined within the Mental Health Act 1983 (Place of Safety) and are very limited. The person must be aged 18 years or over and the following three conditions satisfied; (1) the behaviour of the person poses an imminent risk of serious injury or death to that person or others; (2) because of the risk posed, no place of safety other than a police station in the relevant police area can reasonably be expected to detain the person; and (3) so far as is reasonably practicable, a healthcare professional is present and available to the detainee throughout the period in which he or she is detained at the police station.

A child (anyone 17 years or below) must never be removed to, kept at or taken to, a Place of Safety that is a police station

Once the person is in or arrives at the place of safety, the permitted period of detention is 24 hours, although this can be extended for a further 12 hours with the agreement of the registered medical practitioner. The authorisation of a senior police officer of rank of superintendent or above is also required if the person is held in a police station.

During the period of detention, the person will be examined by a doctor and interviewed by an AMHP.

The power to detain under this section will lapse as soon as the person has been examined and it is considered that no further arrangements need be made for his treatment or care. If it is determined that such arrangements have to be made, the person can continue to be detained, subject to the permitted period, while the arrangements are put in place.

Whilst the detained person will remain in the custody of the police officer(s) whilst subject

to the s.136, general support for the well-being of the person will be collaborative between the police officers and health staff.

For further detail, including location of recording forms, please refer to the "Assessment of persons under Section 135 and 136 of the Mental Health Act 1983" pan Sussex policy.

16. SUSSEX PARTNERSHIP NHS FOUNDATION TRUST

Under the Contract, the SPFT MHA Administration Office is responsible for:

- processing the statutory MHA detention documentation,
- rectifying mistakes or omissions on statutory documentation where this is lawful and practicable (under section 15 MHA),
- informing the Nearest Relative as required by section 132 MHA (where appropriate),
- co-ordinating Mental Health Tribunal hearings,
- co-ordinating AHM hearings, and
- monitoring detentions under the MHA.

SPFT will also provide training to ESHT staff, including Clinical Site Managers and Matrons, Band 6, 7 and 8 staff and all junior doctor intakes, where they have specific responsibilities in relation to this policy and generally in relation to the agreed processes and policies to be adopted in relation to the MHA in ESHT.

The MHA Administration Office, supported by the SPFT MHA Senior Team, will provide advice and assistance to ESHT staff on request.

17. Informal Patients

Informal patients are not detained under the provisions of the MHA. This includes patients who have until recently been detained but have now been discharged from detention. Note that patients subject to section 5(2) MHA (the doctors' holding power) are not detained, but are being prevented from leaving pending a MHA Assessment. They cannot be compulsorily treated for mental disorder. Equally, neither section 17 MHA leave of absence nor section 19 MHA transfer apply to informal patients, since these only apply to patients detained under the MHA.

Informal patients (and patients under the section 5(2) doctors' holding power) may be treated only with their consent, under the MCA or under common law powers in an emergency (which must be used proportionately and for the shortest possible time). Any treatment provided and the rationale for it must be properly documented.

Patients can only be detained under the MHA if the legal criteria for detention are met in their case. This might not happen because (at the time of the assessment) they are assessed as not having a mental disorder or as not posing sufficient risk to themselves or others. Alternatively (at the time of the assessment), the patient may agree to hospital admission voluntarily or agree to accept treatment (in or out of hospital). However, given that the situation can change over time, a later assessment may come to a different conclusion.

18. Evidence Base/References

Mental Health Act 1983

Department of Health. Mental Health Act 1983: Code of Practice. (3rd edition, 2015)

Jones, Richard. (2020) Mental Health Act Manual. (23rd edition, 2020). Sweet & Maxwell:

London.

"Assessment of persons under Section 135 and 136 of the Mental Health Act" – pan Sussex policy

"Transferring Patients Requiring Care in a Local General Hospital" – Sussex Partnership NHS Foundation Trust policy.

19. Competences and Training Requirements

All specified staff must receive appropriate training through Learning and Development. Under the contract, SPFT will provide training as required, including regular training updates for the Clinical Site Management team, key medical and nursing staff and junior doctors. Please visit the Learning & Development website for further detail.

20. Monitoring Arrangements

Monitoring of activity is provided by SPFT under the Contract. An annual report is provided for the Trust Board. Bi-Monthly meetings are held with the Director of Nursing and Assistant Director of Nursing for Safeguarding to provide assurance of compliance with this policy.

21. Safeguarding

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect.
The type of safeguarding enquiry undertaken depends on the nature of the circumstances of the adult. Under the Care Act 2014, specific adult safeguarding duties apply to any adult (18 years or over) who:
• has care and support needs and,
• is experiencing, or is at risk of, abuse or neglect and,
• Is unable to protect themselves because of their care and support needs.

Where the 3 Key Tests as defined in the Care Act (2014) appear to be met, a safeguarding concern should always be raised

In cases where it is unclear if this is the case, consideration should always be given to raising a safeguarding concern; adult social care should be contacted for advice. This is notwithstanding the importance of talking to the adult regarding their views, wishes and actions they may wish to take, however this will not override the responsibility of staff working with the adult to raise a safeguarding concern

Children

Patient's receiving care under the Mental Health act may also have caring responsibilities for children under the age of 18.
The Trust has a statutory responsibility as set out in the Children Act (2004) to safeguard the welfare of children.

Thus a referral to Children's Social Care may need to be considered to ensure that ESHT meets its obligations to safeguard children as defined within Working Together (2018):

• Protecting children from maltreatment
• Preventing impairment of child's health and development
• Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
• Enabling children to have optimum life chance and to enter adulthood successfully.

22. Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Compliance against all areas of this policy	Head of Safeguarding	Bi-Monthly Report from SPFT	Bi - Monthly	Mental Health Act Committee	Mental Health Act Committee	Deputy Director of Nursing

Appendix A

MHA ADMINISTRATION FLOW CHART 1

NEW SECTIONS 2 AND 3 IN EAST SUSSEX HEALTHCARE NHS TRUST

Process	Responsibility	Outcome/check
Ward Matrons (in hours) contact Mental Health Liaison Team to request an assessment for ESHT in-patient. In hours, the MH Liaison Team will contact the Approved Mental Health Professional (AMHP) Service, providing the patient's details. (Out of hours, Site Manager will contact AMHP service.)	The Ward Matron (in hours) or Site Manager (out of hours) are responsible for contacting the MH Liaison Team.	The patient will be assessed by 2 doctors – 1 must be section 12(2) approved and one must ideally know the patient – and an AMHP
If the decision is made by the AMHP and 2 doctors to detain the patient under section 2 or 3 and they complete an application (AMHP) and 2 medical recommendations (doctors), the AMHP will give these to the Ward Matron (in hours) or Site Manager (out of hours). *For electronic form acceptance – see Appendix E.* The Ward Matron (in hours) or Site Manager (out of hours) will complete receipt & scrutiny checklist and Form H3. Support is available from Mental Health Act Office or MH Liaison Team (in office hours). If the patient does not meet the criteria for detention, they will remain an informal patient on the ward.	The Ward Matron (in hours) or Site Manager (out of hours) are responsible for completing the receipt and scrutiny checklist and Form H3 and updating the patient's notes.	All statutory paperwork to be received and scrutinised to ensure all relevant documentation is present: AMHP Application + 2 x Medical Recommendations + Form H3 + Completed checklist
What to do with the section papers: 1. Always keep copies when sending paperwork out! 2. Originals are to be sent BY EMAIL AND POST to the Mental Health Act Office 3. One copy is to be put into the patient's clinical notes 4. Phone Mental Health Act Office to inform them verbally of the detention	The Ward Matron (in hours) or Site Manager (out of hours) are responsible for copying and posting the section papers.	Mental Health Act Office notified of detention. Originals sent and copies on file.
Advising the patient of their rights: The sire manager must notify the MH Liaison Team that the patient is detained. The MH Liaison team / CAMHS Liaison are responsible for advising the patient of the right under S.132. The S.132 rights monitoring form must be completed.	The MH Liaison/ CAMHS Liaison team are responsible for discussing the S.132 rights with the patient and recording the discussion on the monitoring form.	The S.132 rights monitoring form is completed and filed in the ESHT Clinical file.
Potential next steps – see additional flowcharts • Patient is regularly assessed by Responsible Clinician to ensure they continue to meet the detention criteria and appropriate treatment is given • Patient is given section 17 leave of absence • Patient is transferred to a Sussex Partnership (psychiatric) bed • Patient appeals against their detention • Patient is discharged from detention / detention is renewed	Responsible Clinician (with care team and MH Liaison Team) is responsible for regularly assessing patient and ensuring ongoing detention and treatment is appropriate.	Patient's clinical notes to be updated regularly by the care team. See additional flowcharts for further action.

MHA ADMINISTRATION FLOW CHART 2

SECTION 17 LEAVE OF ABSENCE TO EAST SUSSEX HEALTHCARE NHS TRUST

Process	Responsibility	Outcome/check
Only applies to patients detained to Sussex Partnership under section 2 or 3 (NOT patients under section 5(2) holding power) Section 17 leave is the only lawful way a detained patient can leave the ward or unit where they are detained, for example if they need treatment in an ESHT general hospital	Only the Sussex Partnership Responsible Clinician (the doctor in charge of the patient's treatment) can authorise Section 17 leave of absence	A Section 17 leave form stating the type and limits of leave signed by the Sussex Partnership Responsible Clinician or their authorised deputy
The patient remains detained to Sussex Partnership but becomes the responsibility of ESHT while in their care A copy of the Section 17 leave form is to be provided with the patient on transfer to ESHT and placed in the patient's clinical notes	The Ward Matron (in hours) or Site Manager (out of hours) is responsible for ensuring the Section 17 leave form is received and placed in the patient's notes	Copy of the patient's Section 17 leave form in the clinical notes
Treatment 1. Physical health treatment (e.g. broken leg) with consent, under Mental Capacity Act 2005 or common law 2. Mental health treatment (e.g. psychotropic medication) with consent or under Mental Health Act 1983 or common law 3. Physical treatment which is linked to the patient's mental disorder (e.g. a severe overdose taken as an attempt at suicide by a patient with a personality disorder) can be carried out compulsorily under the Mental Health Act where the patient is held under a section which authorised treatment for mental disorder.	The Ward Matron (in hours) or Site Manager (out of hours) is responsible for checking there is legal authority to treat the patient, if necessary by checking with the MH Liaison Team or Mental Health Act office where authority comes from the Mental Health Act	Clear documentation in patient's clinical notes of treatment given and legal authority to treat (e.g. Mental Health Act 1983 detention papers or T2, T3, Section 62 statutory forms if beyond 3 months since start of detention)
Other considerations 1. Security – patient escorts and cover while on the Acute Hospital ward – dependent on the risk posed 2. Return to Sussex Partnership – negotiation with Bed Management regarding psychiatric unit bed availability	Security and bed management to be discussed and negotiated with Sussex Partnership	Appropriate security to be provided for patient Bed to be identified prior to return of patient to Sussex Partnership
Potential next steps – see additional flowcharts 1. Patient develops serious physical illness – consider transferring patient's section to the Acute Trust (using Form H4) or discharging patient from detention 2. Return the patient to Sussex Partnership on section 3. Patient is discharged by Responsible Clinician 4. Patient's detention is renewed by Responsible Clinician 5. If patient has been detained for nearly 3 months, extra-legal authorisation must be obtained (T2, T3 or Section 62 forms) in order for treatment to be continued	The Ward Matron (in hours) or Site Manager (out of hours) must liaise with the patient's Responsible Clinician to ensure appropriate action is taken	Appropriate statutory forms must be completed by the Responsible Clinician, Mental Health Act Office staff and placed on the patient's notes by the Ward Matron (in hours) or Site Manager (out of hours)

MHA ADMINISTRATION FLOW CHART 3

TRANSFER OF DETAINED PATIENT INTO EAST SUSSEX HEALTHCARE NHS TRUST

Process	Responsibility	Outcome/check
Only applies where a patient who was detained to an external NHS Trust/private hospital is re-detained to ESHT (NOT where detained patient is transferred to ESHT on Section 17 leave of absence – see Flowchart 2). Where detained patient is transferred from psychiatric hospital to ESHT: inform Mental Health Liaison Team (in hours)	The Ward Matron (in hours) or Site Manager (out of hours) is responsible for informing the MH Liaison Team	Copies of patient's section papers from external NHS Trust or private hospital and Part 1 of transfer Form H4 completed by external NHS Trust or private hospital
Do not accept the patient without either the original or copies of the section papers. Do not accept the section papers without the patient. Any problems: contact Mental Health Act office or Mental Health Liaison Team (in hours) or Site Manager (out of hours)	The Ward Matron (in hours) or Site Manager (out of hours) is responsible for ensuring the patient, section papers and Form H4 are received	Detained patient and statutory paperwork (copies or originals) received
Ward Matron (in hours) or Site Manager (out of hours) must complete Part 2 of transfer Form H4 (Part 1 will have been completed by external NHS Trust or private hospital). Contact Mental Health Act Office or MH Liaison Team for support (in hours)	The Ward Matron (in hours) or Site Manager (out of hours) to complete Part 2 Form H4	Correctly completed original Form H4 to be checked by MHA Office or MH Liaison (in hours)
1. Copy the original Form H4 2. Send original Form H4 to Mental Health Act office 3. Give one copy to the staff transferring the detained patient to take back to external NHS Trust/private hospital 4. Put another copy in the patient's notes	The Ward Matron (in hours) or Site Manager (out of hours) to ensure copies are made and original Form H4 is emailed and posted to MHA Office	Form H4 to be sent to MHA Office
Advising the patient of their rights (Section 132): The MH Liaison Team/CAMHS Liaison Team are responsible for ensuring the patient is advised of their rights under S.132 and for completing the S132 Monitoring Form.	The MH Liaison / CAMHS Liaison Teams are responsible for ensuring that the patient understands their rights.	The S132 rights monitoring form is completed and a copy placed in the ESHT clinical records.
Potential next steps – see additional flowcharts 6. Patient is transferred back out to NHS Trust or private hospital from which they came (using Form H4 again) 7. Patient's treatment is changed by Responsible Clinician 8. Patient is discharged by Responsible Clinician 9. Patient's detention is renewed by Responsible Clinician 10. If patient has been detained for nearly 3 months, extra legal authorisation must be obtained (T2, T3 or Section 62 forms) in order for treatment to be continued	The Ward Matron (in hours) or Site Manager (out of hours) must liaise with the patient's Responsible Clinician to ensure appropriate action is taken	Appropriate statutory forms must be completed by the Responsible Clinician, Mental Health Act Office staff and placed on the patient's notes by the Ward Matron (in hours) or Site Manager (out of hours)

MHA ADMINISTRATION FLOW CHART 4

TRANSFER OF DETAINED PATIENT OUT OF EAST SUSSEX HEALTHCARE NHS TRUST

Process	Responsibility	Outcome/check
Only applies where a patient who was detained to the Acute Trust is re-detained to an external NHS Trust/private hospital (NOT where detained patient was transferred to ESHT on Section 17 leave of absence – see Flowchart 2). Where detained patient is transferred from the ESHT to psychiatric hospital: inform MHA Office and Mental Health Liaison Team (in hours)	The Ward Matron (in hours) or Site Manager (out of hours) is responsible for informing the MHA Office and MH Liaison Team of the pending transfer out	Copies of patient's section papers to be obtained from patient's Acute Trust clinical notes
The Ward Matron (in hours) or Site Manager (out of hours) must: 1. Complete Part 1 of transfer Form H4 (Part 2 will be completed by the hospital receiving the patient) 2. Make a copy and place this in the patient's notes 3. Send the original Form H4 with the patient to the external NHS Trust or private hospital	The Ward Matron (in hours) or Site Manager (out of hours) is responsible for ensuring the transfer Form H4 is completed and sent with the patient	Correctly completed original Form H4 sent with the patient
If the transfer is to a ward/unit/bed within Sussex Partnership NHS Foundation Trust, the Ward Matron (in hours) or Site Manager (out of hours) must inform the Mental Health Act office as well as the Mental Health Liaison Team (in hours or next working day)	The Ward Matron (in hours) or Site Manager (out of hours) must ensure the Mental Health Act office is informed if transfer is to Sussex Partnership	Mental Health Act office informed of pending transfer to Sussex Partnership
Where the transfer is to an external NHS Trust or private hospital which is NOT Sussex Partnership, staff conveying the patient must obtain a copy of the fully completed Form H4 from the receiving hospital after they have completed Part 2. The Ward Matron (in hours) or Site Manager (out of hours) must ensure the fully completed transfer Form H4 must be sent to the Mental Health Act office and another copy is placed in the patient's notes.	The Ward Matron (in hours) or Site Manager (out of hours) must ensure copies of the completed transfer Form H4 are sent to the Mental Health Act office and placed in the patient's notes.	The completed Form H4 is sent to the Mental Health Act office and a copy placed in the patient's notes.
Next steps Where the patient is to be detained in an external NHS Trust or private hospital, the Mental Health Act office will send the original section papers to the receiving hospital. Where the patient is to be detained in a Sussex Partnership hospital, the original section papers will continue to be held by the Mental Health Act office. Copies of the Form H4 will be sent to the relevant wards for information. Where a Form H4 is completed, the patient ceases to be detained to one Trust/private hospital and becomes detained to another Trust/private hospital.	The Mental Health Act office will ensure the original papers are sent to the correct ward or unit	Patient is transferred and original statutory paperwork follows the patient to the correct Trust or private hospital Mental Health Act office.

MHA ADMINISTRATION FLOW CHART 5

SECTION 5(2) DOCTOR'S HOLDING POWER

Process	Responsibility	Outcome/check
To be completed by the doctor in charge of the patient's treatment using Form H1. May be used by junior doctors but not FY1s. The patient cannot be transferred while on Section 5(2) or given Section 17 leave of absence. Section 5(2) cannot be used one after the other without a time gap in between. Purpose is to enable a hospital in-patient to be assessed for detention under the Mental Health Act 1983	May be used by doctor in charge of the patient's treatment (e.g. the patient's consultant) or their nominated deputy	Fully completed statutory form Form H1, with both Parts 1 & 2 fully completed Form H1 cannot be amended once completed
Doctor to complete Form H1, Part 1 including Trust name and hospital name and address, doctor's qualifications, type of patient's mental disorder, that patient is trying to leave and risk if patient does leave. Doctor should NOT put Form H1 in internal post, but hand it to Site Manager to complete Part 2.	Doctor to complete Part 1 of Form H1 and hand it to Site Manager to complete Part 2	The patient can be prevented from leaving as soon as the decision is made to hold them – there is no need to wait until the Form H1 is completed
The Site Manager must: 1. Complete Part 2 of Form H1, including the time completed 2. Make a copy of the Form H1 and place in notes 3. Email the completed Form H1 to the Mental Health Act office 4. Post the original Form H1 to the Mental Health Act office 5. Inform the Mental Health Liaison Team that the patient is held under Section 5(2)	The Site Manager is responsible for ensuring the MHA office and MH Liaison Team are aware of the Section 5(2) as soon as it is in place	Mental Health Act office and MH Liaison Team are aware of Section 5(2)
The MH Liaison/CAMHS Liaison with involvement from consultant psychiatrist will contact the AMHP duty service to organise MHA Assessment.	MH Liaison Team/ CAMHS liaison refer for MHA Assessment	Referral made for MHA assessment.
Advising the patient of their rights: The MH Liaison/CAMHS Liaison team will discuss rights with the patient under s.132 and record when this takes place on the s.132 rights monitoring form. The monitoring form is to be filed on the ESHT clinical notes.	MH Liaison/CAMHS Liaison	The Section 132 (Rights Advice) form is completed and filed on the ESHT clinical notes.
The patient's Section 5(2) will end if: 11. Patient recovers and is discharged from hospital 12. Patient is assessed and detained under Section 2 or 3 13. Patient is assessed but not detained 14. Patient is seen by the clinician in charge of the patient's treatment who decides no assessment is necessary 15. The maximum time limit for a Section 5(2) (72 hours) expires without the patient being detained 16. The patient is discharged from hospital (e.g. is arrested and removed to police custody) or transferred out	MHA Assessment team / Consultant Psychiatrist.	Assessments completed by the consultant psychiatrist/MHA assessment team to determine if further detention required.

MHA ADMINISTRATION FLOW CHART 6

APPEALS FROM DETENTION AT EAST SUSSEX HEALTHCARE NHS TRUST

Process	Responsibility	Outcome/check
Advising a detained patient of their rights: Section 2 or 3 only (NOT Section 5(2)) As part of the s.132 rights discussion the MH Liaison/CAMHS Liaison team will advise the detained patient of their right to appeal to the Mental Health Tribunal and/or to the Hospital Managers Panel	MH Liaison/CAMHS liaison	The Section 132 (Rights Advice) monitoring form is completed and an entry made in the notes
If the detained patient wishes to appeal against their detention, the MH Liaison/CAMHS Liaison must complete the Appeal Form and List of Solicitors with the patient.	MH Liaison/CAMHS Liaison	The Appeal Form and List of Solicitors forms are completed.
MH Liaison/CAMHS Liaison must immediately notify the MHA office by telephone and then email and post the Appeal Form and List of Solicitors to the Mental Health Act Office as soon as possible, placing a copy on the ESHT patient's notes.	MH Liaison/CAMHS Liaison	The Mental Health Act Office receives the Appeal Form and List of Solicitors
Next steps The Mental Health Act Office will organise Tribunal and/or Hospital Managers Hearing, arrange for the solicitor to visit the patient in hospital and see the patient's notes, identify a venue for the hearing and who will write medical, nursing and social circumstances reports for the hearing Patient may be discharged from detention prior to the appeal hearing by their Responsible Clinician Patient may be discharged from detention at the appeal hearing by Tribunal or Hospital Managers	The Mental Health Act Office is responsible for organising the Tribunal or Hospital Managers Hearing	The Tribunal or Hospital Managers Hearing takes place and the detained patient is discharged or not discharged (patient may be discharged by Responsible Clinician prior to the hearing)

MHA ADMINISTRATION FLOW CHART 7

RENEWALS AND DISCHARGES

Process	Responsibility	Outcome/check
RENEWALS Section 2 lasts up to 28 days and cannot be renewed Section 3 lasts up to 6 months and is renewable initially for a further 6 months and then annually The Mental Health Act Office will advise the detained patient's Responsible Clinician when the Section 2 or Section 3 is approaching expiry	The Mental Health Act Office is responsible for advising the patient's Responsible Clinician of the section expiry	The Mental Health Act Office emails the Responsible Clinician
To continue to detain a patient after their Section 2 has expired, the patient must be placed on Section 3 by an Approved Mental Health Professional and 2 doctors – See New Sections 2 and 3 in Acute Trusts Flowchart The Responsible Clinician must complete a Form H5 to renew a Section 3 within the last 2 months before the section expiry	The RC must ensure a referral for MHA assessment is submitted, or will complete a Form H5 to renew the Section 3 (as appropriate)	Mental Health Act Assessment leading to the patient being re-sectioned from Section 2 to Section 3 or process started to renew the Section 3
Where the Responsible Clinician completes a Form H5 and the Section 3 is renewed, the Mental Health Act Office will arrange a Hospital Managers "Renewal" Hearing	The Mental Health Act Office arranges a Hospital Managers Renewal hearing	Hospital Managers confirm the renewal of the patient's Section 3
DISCHARGE FROM DETENTION can be via: 1. The Responsible Clinician completing a Section 23 form 2. The Tribunal or Hospital Managers discharging the patient at a hearing 3. The patient's Nearest Relative applying for the patient's discharge in writing and the Responsible Clinician complying with the Nearest Relative's application	The Site Manager / Liaison Psychiatry/CAMHS Liaison must inform the MHA office immediately of any Nearest Relative application for discharge	Where the patient is discharged from detention they cannot be compulsorily treated or prevented from leaving the hospital NB: Discharge from detention is not the same a discharge from hospital
Potential next steps Patient's detention is renewed by Responsible Clinician and patient remains detained in hospital Patient is discharged from detention by Responsible Clinician and remains in hospital informally Patient is discharged from detention and from hospital by Responsible Clinician and leaves hospital If patient's Nearest Relative applies for discharge, the Site Manager (next working day) must inform the Mental Health Act office immediately by email and phone	The Responsible Clinician must liaise with MH Liaison/CAMHS Liaison, Site Manager team and the MHA office as to actions/outcomes.	Outcome is known by Liaison, the Site Team and the MHA office, with all necessary paperwork in place (as appropriate). All are aware of patient's new legal status under the MHA.

MHA ADMINISTRATION FLOW CHART 8

CONSENT TO TREATMENT UNDER MENTAL HEALTH ACT 1983

Process	Responsibility	Outcome/check
ADMINISTERING MEDICATION DURING THE FIRST 3 MONTHS OF DETENTION UNDER SECTION 2 OR 3 The Responsible Clinician will assess the patient's capacity to consent to treatment and set out the treatment plan on the Section 63 assessment of capacity form Treatment can be given without the patient's consent Any change of treatment requires a new capacity assessment and a new Section 63 Form to be completed	Site Manager with support from MH Liaison/CAMHS liaison are responsible for checking medication for mental disorder matches the Section 63 Form before the medication is administered.	The patient's treatment plan and capacity status is documented on Sussex Partnership Section 63 Form which is kept in the ESHT patient clinical record and attached to the medication card.
ADMINISTERING MEDICATION AFTER THE FIRST 3 MONTHS OF DETENTION UNDER SECTION 2 OR 3 The Responsible Clinician assesses the patient's capacity using the Section 58 assessment of capacity form If the patient has capacity to consent to treatment and is consenting, the Responsible Clinician completes Form T2 If the patient lacks capacity to consent to treatment or is refusing treatment, the Responsible Clinician requests a Second Opinion Appointed Doctor (SOAD) who, if satisfied, completes Form T3 If the SOAD is delayed, treatment may still be given on an emergency basis if the Responsible Clinician a Section 62 Form (urgent/emergency treatment form)	Site Manager with support from MH Liaison/CAMHS liaison are responsible for checking that any medication for mental disorder given to the patient after the first 3 months of detention matches either a Form T2, a Form T3 or a Section 62 Form that must attached to the patient's prescription card before administering medication	Medication which has been authorised for the patient will be documented on either a Form T2, a Form T3 or a Section 62 Form The original Form T2, Form T3 or Section 62 form will be kept in the Mental Health Office, with a copy attached to the prescription card and a copy filed in the patient's notes Forms should list all relevant drugs by BNF category, dose, route and if within BNF limits
ADMINISTERING ELECTRO-CONVULSIVE THERAPY (ECT) AT ANY TIME The Responsible Clinician assesses the patient's capacity using the Section 58A assessment of capacity form If the patient has capacity to consent to ECT and is consenting, the Responsible Clinician completes Form T4 If the patient lacks capacity to consent to treatment, the SOAD may complete Form T6	Site Manager with support from MH Liaison/CAMHS Liaison /ECT team are responsible for checking that before ECT is given either a Form T4, a Form T6 or a Section 62 Form are completed ECT may not be given to a patient with the capacity to refuse ECT who is refusing (except in an emergency)	ECT which has been authorised for the patient will be documented on the Sussex Partnership ECT Section 58A assessment of capacity form, Form T4, Form T6 or Section 62 Form
If there is any change of capacity status or change of treatment plan, the authorisation for medication or ECT must be re-assessed	Responsible Clinician to action or request SOAD to action	New treatment forms to be issued

APPENDIX B – SECTION 5(2) MHA (Doctors Holding Power) Protocol

1. INTRODUCTION

There are occasions when an inpatient of a general hospital, thought to be suffering from mental illness, tries to leave and the doctor responsible for the patient's care thinks that if the patient is allowed to self-discharge, there will be a severe risk to the patient's health and/or safety or to the safety of others.

Section 5(2) MHA provides a "holding power" (which is not the same as detention under the MHA) which can be exercised by doctors of FY2 grade and above. The holding power authorises staff to prevent the patient from leaving the hospital for up to 72 hours so that a MHA assessment in relation to the patient's mental health needs can be carried out.

To exercise the power, it is necessary for one doctor to complete Part 1 of Form H1 and for a Clinical Site Manager to complete Part 2 of Form H1. This will start the 72 hour holding period. However, staff can prevent the patient from leaving as soon as the doctor has informed the patient that they are subject to the holding power (i.e. there is no need to wait until the Form H1 has been completed).

2. SCOPE

Section 5(2) MHA should be used if, at the time, it is not possible or safe to take the steps necessary for an assessment for an application to be made under the MHA, as the person is purposefully and persistently trying to leave the ward.

Doctors should only exercise the section 5(2) holding power after they have personally examined the patient.

A Form H1 authorising detention under section 5(2) should never be completed in advance for others to use in a doctor's absence nor should instructions be left by the doctor in charge of a patient's treatment for a nominated deputy (i.e. junior doctor) to use section 5(2) on a particular patient in particular circumstances.

It would be good practice for a doctor to seek a second opinion from a professional who knows the patient before exercising the section 5(2) holding power, or if this is not practicable at the time, as soon as possible after the s5(2) holding power has been applied.

2.1 Definition of "Inpatient"

In this context a hospital in-patient means any person who is receiving in-patient treatment in a hospital. IT does not apply to a patient who is already liable to be detained under section 2 or 3 of the MHA, or a person who is being kept in a hospital as a place of safety under section 135 or 136. It includes patients who are in hospital by virtue of a deprivation of liberty authorisation under the Mental Capacity Act 2005. It does not matter whether or not the patient was originally admitted for treatment primarily for a mental disorder. The patient could be receiving in-patient treatment for a physical condition.

In ESHT, patients in the Emergency Department and Clinical Decision Unit are not considered inpatients. Patients on wards, including the Medical Assessment Unit and the Acute Medical Unit are considered to be inpatients.

2.2 Treatment

The power under section 5(2) is a holding power and not a treatment order. Holding patients under section 5(2) does not confer any power under the MHA to treat them without their

consent.

Treatment can only be administered to patients under a section 5(2) holding power with their consent (where the patient has capacity to consent to the treatment), under the authority of the Mental Capacity Act 2005 (MCA) in the person's best interests (where the patient has been assessed to lack capacity to consent to the treatment) or under common law powers in an emergency (which must be used proportionately and for the short possible time, where MHA or MCA powers are not available). Where a patient lacks capacity to consent to treatment, staff must investigate whether or not the patient has made an Advance Decision to Refuse Treatment (ADRT), a Lasting Power of Attorney for Health and Welfare (LPA) or has a Court of Protection-appointed deputy.

2.3 Section 5(2) and Transfer

A patient cannot be transferred to another hospital under Section 5(2) MHA. If the patient leaves the hospital, the section 5(2) will end. Formal transfer would need to wait until the patient had been formally detained under Section 2 or 3 MHA following an MHA Assessment. The patient could then be transferred using Section 19 MHA.

2.4 Section 5(2) and Leave

A patient held under s5(2) cannot leave the hospital and cannot be given leave under section 17 MHA leave for absence, which applies to patients detained under sections 2 and 3 only.

3. PROCESS

A Form H1 must be completed by the doctor in charge of the patient's care, who must be of grade FY2 or above. A Form H1 can be downloaded from the MHA pages on the Trust's intranet. The form can be handwritten and signed, or completed and signed electronically.

The doctor completing the Form H1 should have personally examined the patient. In Part 1 of Form H1 the doctor must complete the name and address of East Sussex NHS Healthcare Trust, including site and ward, print their name and delete the relevant options describing their role (a junior doctor should delete all but (b)(i)). The name of the patient must also be given.

On page 2 of the form, in the free text box the doctor must clearly evidence that in their clinical judgement:

1. The patient appears to be suffering from a mental disorder; and
2. The patient is attempting to leave or refusing to stay; and
3. The patient poses a risk to their own health or safety or to others.

If the doctor's reasons do not clearly cover all three of these criteria, the detention is likely to be rendered invalid.

It is not necessary for the doctor to state a mental health diagnosis for the patient if one is not known. It is sufficient for the patient's symptoms and behaviour to be stated, provided these may suggest the presence of a mental disorder.

Having completed Part 1 of the Form H1, the doctor MUST NOT put the form in the internal mail, but must hand it ("furnish" it) to a Clinical Site Manager, who is authorised to receive the form on behalf of the Trust's Hospital Managers (i.e. the ESHT Trust Board). See Flowchart 5 (Section 5(2) process) (Appendix A).

The Clinical Site Manager must complete Part 2 of Form H1 thereby accepting the holding

power on behalf of the ESHT Trust Board who have responsibility for the decision taken to hold the patient. It is therefore essential that as soon as Part 1 of Form H1 is completed it is handed to the Clinical Site Manager who must complete Part 2 of Form H1. If this is not done then the holding power will not have been lawfully exercised.

A copy of the Form H1 must be taken and filed in the patient's clinical file, the original must be immediately emailed and posted to the MHA office for processing and to ensure the detention is monitored.

4. ENDING A SECTION 5(2)

Once a Section 5(2) holding power is in place it can only be ended by one of the following outcomes:

- The patient recovers and is discharged from hospital, or
- A decision is taken to detain the patient under section 2 or 3 MHA following an MHA Assessment, or
- A decision is taken not to detain the patient following an MHA Assessment (an Ending of 5(2) form must be completed), or
- the doctor or AC in charge of the patient's treatment decides that no MHA Assessment for possible detention is required (an Ending of s5(2) form must be completed), or
- The 72 hour holding power time limit expires, or
- The patient is removed from hospital (for example, is arrested by police and taken into police custody at a police station) or transferred to another hospital.

The outcome of any MHA Assessment, reasons for ending the section 5(2) holding power and the date and time should be recorded in the patient's notes.

5. Section 5(2) MHA PATIENT RIGHTS ADVICE

Patients under section 5(2) MHA doctors' holding power **MUST** be given both written and oral information regarding their status.

Responsibility for discussing rights with a patient detained under section 5(2) of the MHA is with the MH Liaison Team / CAMHS Liaison Team. Evidence of the rights discussion must be documented on the S.132 right monitoring form and a note made to prompt when the rights advice discussion must next be held.

Information leaflets are available in the Clinical Site Managers' office, Emergency Department and MH Liaison, on the ESHT intranet, the SPFT public internet or via the local MHA office (see Contact Details, Appendix G) and are available in alternative formats. All information must be given in a way that is understandable by the patient. See Flowchart 5 (Section 5(2) Process) (Appendix A) and Section 132 MHA Protocol (Appendix C). When staff provide rights advice to section 5(2) patients, this must be documented on the Rights Advice Recording Form and a note made in the ward diary of when the rights advice must next be provided.

Patients should also be informed immediately when they are no longer under the holding power. Patients must be provided with new rights advice if they are detained under sections 2 or 3 MHA.

The patient's Nearest Relative, where known, must be informed of the detention and subsequent decision as soon as possible unless the patient objects. Contact the local MHA office for more information.

6. ABSENCE WITHOUT LEAVE

If a patient under a Section 5(2) holding power absconds from the hospital they can be retaken within the 72 hour period of the holding power. The patient cannot be brought back to hospital beyond the 72 hour holding period. Refer to Chapter 13 above.

7. HELP AND ADVICE

For help and advice in hours, please contact the local MHA Office (see Contact Details, Appendix G). Out of hours, please contact the Mental Health Liaison Team.

FORM H1 (SECTION 5(2) MENTAL HEALTH ACT 1983 – DOCTOR'S HOLDING POWER) COMPLETION CHECKLIST		
FORM H1 PART 1 – DOCTOR COMPLETES	**What to write on the form**	√
To the managers of [name and address of hospital] **EVEN THOUGH NOT ASKED FOR, THE FULL TRUST NAME MUST BE INCLUDED**	East Sussex Healthcare NHS Trust Full name and postal address of hospital/unit including postcode	
I am [PRINT full name]	First name and surname of doctor completing the form	
and I am **3 OF THE 4 OPTIONS MUST BE DELETED**	The doctor in charge of the patient's treatment should complete (a)(i) or (a)(ii) if they are an Approved Clinician A junior doctor ("the nominated deputy" under the Act) should normally complete (b)(i)	
In charge of the treatment of [PRINT full name of patient]	The patient's full name, including middle names if applicable	
It appears to me that an application ought to be made under Part 2 of the Act for this patient's admission to hospital for the following reasons--	Brief, clear written evidence to justify your clinical view that the patient: (a) appears to you to be suffering from a mental disorder (symptoms or behaviour associated with mental disorder, rather than a diagnosis would be sufficient) (b) is refusing to remain as a voluntary patient and (c) would be a risk to themselves or others if they were allowed to leave the hospital All 3 points must be addressed. Continue on a separate sheet if required.	
I am furnishing this report by: <Delete the phrase which does not apply>	The form should in all circumstances be handed directly to the nurse in charge of the ward. The form should never be placed in the internal mail. If very exceptionally the form must be sent to the MHA Office, the form must be copied before it is sent.	
Signed and dated	The doctor must sign and date the form. Doctors must wait while the nurse in charge checks the form.	
FORM H1 PART 2 – NURSE IN CHARGE COMPLETES	**What to write on the form**	√
To be completed on behalf of the hospital managers	The nurse in charge of the ward MUST complete this.	
This report was <Delete the phrase which does not apply>	Delete "Furnished to the hospital managers through their internal mail system". Check PART 1 has been correctly completed, signed and dated by the doctor. If not correctly completed , the information MUST be rewritten on a new form. The form cannot be amended in any way.	
Signed on behalf of the hospital managers, PRINT NAME, dated	The nurse in charge must sign and date the form. Inform the MHA Office, keep a copy and send the original FORM H1 to the Mental Health Act Office immediately.	

APPENDIX C – Section 132 MHA (Information for detained patients)

1. INTRODUCTION

This protocol outlines the formal process for informing patients detained under the MHA of their rights.

1.1 Purpose of protocol

This protocol outlines the legal requirements relating to the giving of information to patients detained under the MHA, as required by section 132 MHA. This protocol gives guidance on the completion of the section 132 monitoring form which must be used to evidence the giving of information.

1.2 Scope of protocol

This protocol applies to all those who are involved in the care and treatment of those subject to detention in hospital under the MHA.

1.3 Principles

Use of the MHA severely restricts the rights and freedoms of the person to whom it is applied, time must therefore be taken to ensure that information about how the MHA affects the person is given to them in a way that makes it possible for them to understand their situation. This is not a one-off exercise.

Everything should be done to overcome barriers to effective communication. Most patients will have difficulty understanding the complexity of the law, technical terms and jargon and some may:

- have a different perspective based on their cultural background or religion
- not speak English as a first language
- have a hearing / visual impairment
- have difficulty in reading or writing .

Independent advocates and interpreters must be used if necessary. These must not be members of the person's family and should not be members of staff.

2.0 PROCEDURE

2.1 The Duty to Give Information to Detained Patients

Sections 132 and 132A require that patients who are detained in hospital under the MHA are informed about how the MHA applies to them as soon as practicable after the start of the detention.

The information is required to be given **both orally and in writing**. These are not alternatives. All information must be conveyed in a way the patient understands.

It is also necessary to take such steps as are practicable to give the patient's Nearest Relative a copy of any information given to the patient in writing, under this section, unless the patient requests otherwise. This should happen at the time the patient is given the information or within a reasonable timescale thereafter.

Steps should be taken to find out whether a patient who lacks capacity has an attorney (under a Lasting Power of Attorney for health and welfare) or Court of Protection-appointed deputy with authority to make decisions for that person's welfare. Where there is such a person, they act as the patient's agent and should be informed in the same way as the patient themselves about matters within the scope of their authority.

2.2 When Should Information be Given?

On admission a patient must be given oral and written information regarding their status. All possible steps must be taken to ensure that patients are given and understand specific information relating to their detention as soon as practicable after the start of their detention.

If a patient does not understand their rights further attempts should be made on a regular basis until the patient understands and all attempts **must** be recorded on the S132 "Rights Recording Sheet".

There should always be a further date entered onto the s.132 form to record when the next s.132 conversation is scheduled. The next date is at the discretion of the staff member and will be dependent on the needs of the patient.

Responsibility for ensuring that the conversation about the rights is repeated as appropriate for the patient rests with the lead practitioner.

For example, this could be on a weekly basis.

It is clearly not practicable for staff to attempt to provide the informally orally to a patient who is either too ill to understand the information, refuses to listen to staff, or becomes significantly distressed when the attempt is made. If the patient initially fails to understand the information or is too distressed to receive it, staff should make further attempts to provide the information if it is considered that the patient's mental state has improved to the extent that such an attempt would be likely to succeed.

In addition, the process of giving information should be repeated in the following circumstances:

- The patient is considering appealing or becomes eligible again to appeal to either the Tribunal or Hospital Managers.
- Any changes in relation to the patients treatment plan or their consent to that treatment (e.g. because three months have passed since they were first given treatment or have regained capacity to consent to treatment);
- There is to be a Care Programme Approach review (or its equivalent);
- A decision has been taken to renew their detention.

2.3 What Information should be Given?

Patients must be informed of:

<u>The Section</u>

- the provisions of the MHA (i.e. the section) under which they are detained or and the effect of those provisions.
- the maximum length of the current period of detention or that this may be ended at any time if the criteria are no longer met
- the reason for their detention
- the right of the Responsible Clinician and Hospital Managers to discharge the section.

Treatment

- the nature, purpose and likely effects of the planned treatment
- the circumstances (if any) in which they can be treated without their consent – and the circumstances in which they have the right to refuse treatment
- how and when treatment can be given without consent, the role of Second Opinion Appointed Doctors (SOAD) and the circumstances in which they may be involved
- (where relevant) the rules on electro-convulsive therapy (ECT)

Right to Appeal

- the patient's right to have their views about being detained or discharge considered before any decision is made about the renewal of the section or discharge
- the rights (if any) of their Nearest Relative to discharge them
- their right to apply to the Tribunal, the role of the Tribunal and how to apply
- their right to apply to the Hospital Managers for discharge
- that the Hospital Managers must consider discharging them when their detention is renewed
- right to legal representation and how to contact a suitably qualified solicitor
- that free Legal Aid may be available
- how to contact any other organisation who may be able to help them make an application to the Tribunal

Information about the Care Quality Commission & Independent Mental Health Advocate

- the role of the Care Quality Commission (CQC) and the patient's right to meet visiting Commissioners in private
- the right to make a complaint to the CQC and the procedure for doing this
- the right of detained patients to and role of the Independent Mental Health Advocate (IMHA)

Information about withholding of correspondence

- detained patients must be informed that post that is sent by them may be withheld if the person to whom it is addressed requests this

Patients should also be informed when they are discharged from detention and when the authority for their detention expires. They should also be given an explanation of what happens next including any entitlement to section 117 MHA aftercare or other services which are to be provided.

Information leaflets setting out the above information are available from the Site Managers' Office, Emergency Department and MH Liaison, on the ESHT intranet and SPFT public internet, as well as from the local MHA office. Information leaflets must be given to the patient by the staff member providing the rights advice. The MHA office will be able to provide alternative format leaflets if required.

2.4 Who should give the Information?

See the MHA Administration flowcharts for information (Appendix A). Generally it is the responsibility of MH Liaison/CAMHS Liaison to give rights advice to detained patients. The giving of information relating to the consent to treatment provisions may be undertaken by the patient's Responsible Clinician where appropriate.

Where an independent interpreter is needed, consideration should be given to the patient's gender, religion, age, language, dialect and cultural background. Family members must not be used as interpreters and staff members should not be used as interpreters in most situations.

2.5 How should the Information be Given?

The rights advice should:

- be given at a suitable time
- be given somewhere quiet and private
- be given in a friendly and helpful way
- be given in a way that the patient understands
- in an accessible format, including, where appropriate, with the aid of assistive technologies and interpretive and advocacy services
- be given as part of a conversation
- reflect the content of the Information Leaflet for the patient's MHA section

2.6 S132 Rights Recording Form

Each attempt to explain the patient's MHA rights **must** be recorded on the "Section 132 MHA Rights Recording Form" (see Appendix D).

2.7 Information for Nearest Relative

When the patient is advised of their section 132 rights **for the first time following new MHA status** (e.g. when the patient is placed on s. 5(2) MHA holding power, section 2 MHA, section 3 MHA etc.) the staff member providing the **initial** rights advice must seek confirmation that the patient wishes their Nearest Relative to be informed and **immediately let the local MHA office know**. Information will only be sent to the nearest relative by the local MHA office on confirmation from the staff member that the patient does not object.

Unless the patient objects, the MHA Office will send a copy of the relevant Information Leaflet(s) to the patient's Nearest Relative together with a letter advising of the patient's circumstances. This letter will also state the rights of the Nearest Relative regarding their powers of discharge (where appropriate).

Where the patient objects to information being released to the Nearest Relative, the staff member must inform the MHA office immediately.

Sussex Partnership NHS
NHS Foundation Trust

APPENDIX D Section 132 MHA - Rights Recording Form.

S132 – Record of Discussion with a Patient about their Rights under the Mental Health Act

Patient name			**Unit No**		
Ward/Hospital			**Interpreter/Specialist material/other support?**		
Date of discussion			**Location of discussion**		
Section		**Start date/time**		**Expiry date/time**	

Summary of discussion topics (refer to relevant Patient Info. Leaflet):	*Tick as applicable*	***Further discussion to be held on (insert date)***
Section and duration Reasons for detention Implications Consent to Treatment Appeal rights (Mental Health Tribunal & Associate Hospital Managers) Independent Mental Health Advocate role Care Quality Commission PALS/Complaints	☐ The patient understands their rights Or ☐ The patient does not understand their rights	…….. ☐ Date of next discussion entered in ward diary/plan

Nearest Relative – see detention application (not applicable for s5) The nearest relative is: ……..	*Tick as applicable* ☐ The patient AGREES to the hospital sending information to the nearest relative Or ☐ The patient DOES NOT AGREE to the hospital sending information to the nearest relative

Name of staff member: **Job title:**

After completion please ensure this is stored on the patient record

APPENDIX E – SECTION 17 MHA LEAVE OF ABSENCE FORM

Sussex Partnership NHS
NHS Foundation Trust

Mental Health Act 1983 – Section 17 leave of absence

Patient name: …….…… Section: …… Ward / unit: ……

In an emergency, please contact: ……..……..

Leave type: Accompanied ☐ Unaccompanied ☐

Frequency: Daily ☐ Weekly ☐ Other ☐ please specify ……

Accompanied by: Hospital staff ☐ Relative ☐ Other ☐ please specify…..……

Duration: ……. hours ……. minutes

Conditions of leave: ……..……..

……..……..

Leave type: Accompanied ☐ Unaccompanied ☐

Frequency: Daily ☐ Weekly ☐ Other ☐ please specify ……..…..

Accompanied by: Hospital staff ☐ Relative ☐ Other ☐ please specify……..…

Duration: ……. hours ……. minutes

Conditions of leave: ……..……..

……..……..

Overnight leave ☐ from:…… to: ……

Address during leave: ……..……..

Conditions of leave: ……..……..

Escorted s17(3) leave ☐ **(see overleaf for explanation)** from: ..…… to: ..……

Conditions of leave: ……..……..

Escort: Nursing staff ☐ Other ☐ please specify ……..…….

Signed: …….. Name: ……... Date: ..……..…..
On behalf of the Hospital Managers

This leave form is valid for 7 days from the date of signature, unless otherwise stated. Until new form completed or until further review will not be accepted – an end / review date **MUST** be specified if longer than 7 days.

If leave is for 7 consecutive days or more please complete your reasons for not placing this patient under a Supervised Community Treatment Order overleaf

---

Signed: …… Name: …… Date: ……..

Responsible Clinician ☐ Authorised Acting Responsible Clinician ☐

THIS FORM HAS BEEN COPIED TO: Patient ☐ Carer ☐ Other ☐

Signed: …….. Name: ……... Date: ..……..…..

Patient Signature: …… (to confirm patient has received a copy)

Patient name: ……..…… Section: …….....

Ward / unit: …….

My reasons for not placing this patient under a Supervised Community Treatment

Order are as follows: …….

……..

……..

……..

……..

Signed: …….. Date: ……

Responsible Clinician ☐ Authorised Acting Responsible Clinician ☐

s17(3) leave – escorted leave

The Responsible Clinician may direct that the patient must remain in custody during his leave if it is necessary in the interest of the patient or for the protection of other persons. The purpose of this provision is to provide those who are caring for a high-risk patient during a period of leave with an immediate power to restrain the patient should he make an attempt to abscond. "These kinds of arrangement would allow detained patients to have escorted leave for outings, to attend other hospitals for treatment, or to have home visits on compassionate grounds. If a patient is granted leave of absence on condition that he stays in another hospital, he may be kept in the custody of an officer on the staff of the other hospital".

If the patient escapes from such custody he can be re-captured immediately: there is no need to wait for him to fail to return to his "base" hospital or for the leave to be revoked.

APPENDIX F- S.2/3 MHA digital assessment and detention paperwork flowchart (April 21)

AMHP receives referral for MHA assessment. Where the patient is seen by a doctor first the doctor can provide the first recommendation via the platform and will be prompted to phone the referral through to the AMHP Service

↓

AMHP notifies 2 x Doctors via S12 Solutions platform.

↓

Doctors "send" signed medical recommendations to AMHP on S12 Solutions platform.

↓

Doctors log in to S12 Solutions software to accept referral and complete medical recommendation (following patient assessment)

↓

AMHP checks med recs, request amendments on S12 Solutions platform (if needed)

↓

(If needed) Doctor(s) amends form and returns to AMHP on S12 Solutions platform

↓

AMHP completes application on S12 Solutions form on platform. The platform generates email which forwards application and 2 x med recs to AMHP team e-mail.

↓

AMHP speaks to nurse in charge/ Site Manager/MH Liaison lead to confirm secure email address to send MHA papers. AMHP emails application to agreed person and to MHA office email.

↓

Nurse in charge/Site Manager/MH Liaison accesses email and confirms to AMHP when papers received.

↓

Nurse in charge/ Site Manager uses Receipt & Scrutiny checklist.H3 form (electronic or paper forms) to scrutinise contents of electronic MHA medical recommendations and application.

↓

Nurse in charge/ MH Liaison lead saves electronic MHA medical recommendations and applications to Carenotes and scans and uploads the electronic/paper H3 form and checklist to Carenotes.

↓

For patients detained at acute hospital, a printed copy of the MHA forms must be placed on the ward file.
Once electronic forms are uploaded to Care notes, emails are deleted by wards or units.

↓

MHA office:

- To be notified of pending MHA detentions by email - to check outcome.
- Undertake scrutiny on Care notes documents and, if amendment required, request form author to make amendment and return amended, signed form to the MHA office (as current practice)
- Email medical recommendations to independent consultant for medical scrutiny.

APPENDIX G – CONTACT DETAILS (As at AUGUST 2022)

SUSSEX PARTNERSHIP NHS FOUNDATION TRUST MENTAL HEALTH ACT ADMINISTRATION TEAM CONTACT INFORMATION

MHA detentions at Conquest Hospital and Eastbourne DGH

All paperwork to be scanned/emailed to MHA team [redacted]
If any paper MHA paper forms are completed these must be sent to:
MHA office, Department of Psychiatry, District General Hospital, Kings Drive, Eastbourne, East Sussex BN21 2UD

EAST - WEST SUSSEX MENTAL HEALTH ACT SERVICES

[redacted]

MENTAL HEALTH LAW SERVICES

MHA Services Manager: [redacted]

MHA Services Officer: [redacted]

MHA Services Officer: vacancy

Mental Health Law Practice Development Manager: [redacted]

Mental Health Law Practice Development Officer: [redacted]

CONQUEST HOSPITAL - MENTAL HEALTH LIAISON TEAM

Tel: (main office) 01424 757569 Mobile (emergency A&E) [redacted]
Contact hours 24/7

EASTBOURNE DGH - MENTAL HEALTH LIAISON TEAM

Telephone: 01323 435759

Contact hours: 24/7

EAST SUSSEX CAMHS LIAISON TEAM

Telephone: [redacted] 9am-8pm weekdays, 10-6pm weekends & bank holidays
Email (out of hours): [redacted]

East Sussex Healthcare NHS Trust

Equality Impact Assessment Form

1. Cover Sheet

Please refer to the accompanying guidance document when completing this form.

Strategy, policy or service name	Use of the Mental Health Act 1983 (MHA) Policy
Date of completion	December 2021.
Name of the person(s) completing this form	Gail Gowland, Head of Safeguarding
Brief description of the aims of the Strategy/ Policy/ Service	This policy is intended to provide assistance to East Sussex Healthcare NHS Trust ("ESHT") employees when involved with the admission, care and treatment, transfer and discharge of patients who are detained under the Mental Health Act 1983 ("MHA"). .
Which Department owns the strategy/ policy/ function	Corporate Department - Safeguarding
Version number	V 3.0
Pre Equality analysis considerations	None.
Who will be affected by this work? **E.g. staff, patients, service users, partner organisations etc.**	ESHT Staff, Managers, Service Users
Review date	December 2024
If negative impacts have been identified that you need support mitigating please escalate to the appropriate leader in your directorate and contact the EDHR team for further discussion.	To whom has this been escalated? Name: Click here to enter text. Date: Click here to enter a date.
Have you sent the final copy to the EDHR Team?	Yes

2. EIA Analysis

<table>
<tr><td></td><td>☺ 😐 ☹</td><td>Evidence:</td></tr>
<tr><td>Will the proposal impact the safety of patients', carers' visitors and/or staff?

Safe: Protected from abuse and avoidable harm.</td><td>Choose</td><td>Negative.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td>Neutral</td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table>
</td></tr>
<tr><td>Is the proposal of change effective?

Effective: Peoples care, treatment and support achieves good outcomes, That staff are enabled to work in an inclusive environment. That the changes are made on the best available evidence for all involved with due regards across all 9 protected Characteristics</td><td>choose</td><td>Yes</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td>What impact will this have on people receiving a positive experience of care?</td><td>Choose</td><td>The policy is intended to support staff to use the Mental Health Act 1983 (MHA) correctly for the benefit of the patients.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table></td></tr>
<tr><td>Does the proposal impact on the responsiveness to people's needs?</td><td>Choose</td><td>Neutral</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table></td></tr>
<tr><td>What considerations have been put in place to consider the organisations approach on improving equality and diversity in the workforce and leadership?</td><td>Choose</td><td>Neutral.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table></td></tr>
</table>

Access

Could the proposal impact positively or negatively on any of the following:

• Patient Choice	Choose	Neutral
• Access	Choose	Neutral
• Integration	Choose	Neutral
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		<table><tr><th>Race</th><th>Gender</th><th>Sexual orientation</th><th>Age</th><th>Disability & carers</th></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>
Engagement and Involvement How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:	Choose	Neutral
Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)		<table><tr><th>Race</th><th>Gender</th><th>Sexual orientation</th><th>Age</th><th>Disability & carers</th></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>
Duty of Equality Use the space below to provide more detail where you have identified how your proposal of change will impact.	Choose	Neutral

Characteristic	**Rating** ☺ ☹ 😐	**Description**
Race	Choose	Neutral
Age	Choose	Neutral
Disability and Carers	Choose	Neutral

Religion or belief	Choose	Neutral
Sex	Choose	Neutral
Sexual orientation	Choose	Neutral
Gender re-assignment	Choose	Neutral
Pregnancy and maternity	Choose	Neutral
Marriage and civil partnership	Choose	Neutral

Human Rights

Please look at the table below to consider if your proposal of change may potentially conflict with the Human Right Act 1998

Articles		Y/N
A2	Right to life	**N**
A3	Prohibition of torture, inhuman or degrading treatment	**N**
A4	Prohibition of slavery and forced labour	**N**
A5	Right to liberty and security	**N**
A6 &7	Rights to a fair trial; and no punishment without law	**N**
A8	Right to respect for private and family life, home and correspondence	**N**
A9	Freedom of thought, conscience and religion	**N**
A10	Freedom of expression	**N**
A11	Freedom of assembly and association	**N**
A12	Right to marry and found a family	**N**
Protocols		
P1.A1	Protection of property	**N**
P1.A2	Right to education	**N**
P1.A3	Right to free elections	**N**

East Sussex Healthcare NHS Trust

Information Governance and Data Protection Policy

Document ID Number:	1747
Version:	V2
Ratified by:	Policy Ratification Group
Date ratified:	December 2021
Name of author and title:	Ruth Paine, Information Governance Lead
Date originally written:	26 April 2018
Date current version was completed:	December 2021
Name of responsible committee/individual:	Information Governance Steering Group
Date issued:	05 January 2021
Review date:	December 2024
Target audience:	All ESHT staff
Compliance with CQC Fundamental Standard	17 – Good Governance
Compliance with any other external requirements (e.g. Information Governance)	DSPT Requirements: 1.2; 1.3; 1.4; 1.5; 1.6 and; 1.8
Associated Documentation:	Information Security Policy and SOPs Responding to Requests for Access to Health Records SOP Auditing Access to PII SOP Data Protection Officer Role SOP Privacy by Design SOP

Did you print this yourself?

Please be advised the Trust discourages retention of hard copies of the policies and can only guarantee that the policy on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0	April 2018	Ruth Paine	A new IG and DP Policy supersedes the IG Strategy and Policy v1.4 issued December 2017	A new IG and DP Policy to reflect the GDPR and DPA18
V1.1	July 2020	Ruth Paine	add an extra sentence	section 4 on page 7 regarding breach of data protection
V2	Dec 2021	Ruth Paine	Due for review	Section 5.4 and Appendix B updated

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
IGSG	Approving Group	May 2018
IGSG	Lynette Wells	July 2020
IGSG	Damian Reid	December 2021

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

The trust has a legal obligation to comply with all Data Protection and related legislation. It also has a duty to comply with guidance issued by the Department of Health, the NHS, advisory groups to the NHS and guidance issued by professional bodies.

All legislation relevant to an individual's right of confidence and the ways in which that can be achieved and maintained are paramount to the trust. This relates to roles that are reliant upon either/both paper and electronic systems such as: patient administration; purchasing; invoicing and treatment planning. Legislation also regulates the use of manual records relating to patients; staff and others whose information may be held within the trust.

Inspections, monetary penalties and custodial sentences could also be imposed upon the trust, and/or employees for non-compliance with relevant legislation and NHS guidance.

2. Purpose

The aims of this policy are to detail how the trust meets its legal obligations and NHS requirements concerning data protection and confidentiality. The requirements within the policy are primarily based upon the Data Protection legislation which is the key piece of legislation covering confidentiality and security of information.

In developing this Information Governance policy, the Trust recognises and supports:

- The need for an appropriate balance between openness and confidentiality in the management and use of information
- The principles of corporate governance and public accountability and equally places importance on confidentiality of, and the security arrangements to safeguard, both personal information about service users, families, carers, staff and commercially sensitive information
- The need to share service user information with partner organisations (health and social care) and other agencies in a controlled manner consistent with the interests of the service user and, in some circumstances the public interest
- The principle that accurate, timely and relevant information is essential to deliver high quality care and that it is the responsibility of all clinicians and managers to ensure and promote the quality of information and to actively use information in decision making processes

2.1. Rationale

Information Governance is a framework for the way organisations 'process' or use information. It covers personal information, i.e. that relating to patients/service users and employees, and corporate information, e.g. financial and accounting records. Information Governance provides a way for employees to deal consistently with the many different rules about how information is handled.

More details on the principles of the Data Protection Act 2018 and the Caldicott Principles may be found in Appendices A and B

2.2. Principles

Information can be used to:

- Deliver and improve the quality of care;
- Improve health and care outcomes;

- Reduce inequalities; and
- Increase productivity and efficiency

Information Governance provides a framework to ensure that personal information is used in line with legislation, i.e., justifiably and securely.

The Trust will ensure that this IG policy is implemented through supporting standard operating procedures (SOPs) in related areas. Some policies have a considerable amount of information governance within them, but are the responsibility of other departments in the trust, eg, health records, data quality, information security etc.

An assessment of compliance with the data security and protection toolkit (DSPT) assertions will be undertaken each year. Annual reports and proposed action/development plans will be presented to the Information Governance Steering Group (IGSG).

2.3. Scope

This document covers all aspects of information within the trust including (but not limited to):

- Patient/service user information
- Staff information
- Corporate/organisational information

This document covers all aspects of handling information, including (but not limited to):

- Structured record systems – paper and electronic
- Transmission of information – e-mail, bulk electronic upload, post and telephone

This document covers all information systems purchased, developed and managed by or on behalf of the trust and its partners, including any individual directly employed or otherwise by the trust:

- Trust staff and volunteers
- Third party/contracted staff/organisations
- To include staff using trust PII but employed by other organisations

3. Definitions

Caldicott Report/Review
The committee chaired by Dame Fiona Caldicott – which made a number of recommendations for regulating the use and transfer of person identifiable information and should be applied to whenever a disclosure of Person Identifiable Information (PII) is being considered. The Caldicott Principles are listed in Appendix B.

Confidentiality
Ensuring that information is not made available or disclosed to unauthorised individuals, entities or processes.

Data Security and Protection Toolkit (DSPT)
NHS Digital manages the DSPT which is the successor to the Information Governance Toolkit (IGT). This toolkit includes assertions relevant to the new legislation and cyber security requirements. The CQC will include a review of the DSPT as part of their routine regulatory activity.

Person Identifiable Information (PII)
Information about a person which would enable that person's identity to be established. This might be fairly explicit such as an unusual surname or isolated postcode or items of different information which if taken together could allow the person to be identified. All information that relates to an attribute of an individual should be considered as potentially capable of identifying them to a greater or lesser extent.

Subject Access Request (SAR)
Under data protection legislation an individual may request a copy of the information that the trust holds about them; this is called a Subject Access Request. In most instances the trust must comply with these requests and follow a documented process. In ESHT these requests are usually referred to as Requests for Information or RFIs.

4. Accountabilities and Responsibilities

Chief Executive

Has overall responsibility for compliance with legislation and the Information Governance Policy within the trust. The implementation of, and compliance with, this policy is delegated to relevant Directors and senior staff.

Caldicott Guardian

The Caldicott Guardian should be (in order of priority):
- An existing member of the management board or senior management team of the organisation;
- A senior health or social care professional;
- The person with responsibility for promoting clinical governance or equivalent functions within the organisation.

The Medical Director is the designated Caldicott Guardian. In the event of the Caldicott Guardian being unavailable, the Deputy Medical Director (Governance) will act as Deputy Caldicott Guardian. More detail can be found in Appendices B and C.

It is particularly important that the Caldicott Guardian has the seniority and clear authority from the Board/senior management team and Chief Executive to influence policy development and strategic planning, and carry the confidence of his or her colleagues.

The Caldicott Guardian role is:
- Advisory, and accountable for that advice;
- The conscience of the organisation;
- Provides a focal point for patient/service user confidentiality & information sharing issues;
- Concerned with the management of patient/service user information.

Senior Information Risk Owner (SIRO)

The SIRO should be an Executive Director or member of the Senior Management Board with overall responsibility for the organisation's information risk policy. The SIRO will also lead and implement the information governance risk assessment and advise the Board on the effectiveness of risk management across the organisation. The Director of Finance is the designated SIRO and reports direct to the Chief Executive on information risk issues.

The Senior Information Risk Owner role is:
- Accountable for IG processes within their organisation;

- Fosters a culture for protecting and using data;
- Provides a focal point for managing information risks and incidents;
- Concerned with the management of all information assets.

Data Protection Officer (DPO)

This post is a mandatory requirement of the DPA18. The post holder must be able to work independently and report to Director level on IG risks and breaches. The role is combined with the role of the Information Governance Lead role.

Information Governance Lead

This post provides support to the Caldicott Guardian and the SIRO. The IG Lead is a specialist assurance manager whose key duties include: ensuring the trust's DSPT is submitted within time; advising on data protection legislation and information governance best practice; developing processes and governance to support an information governance culture; raising awareness and providing in-house learning materials; maintaining and developing links with related job roles e.g.: information security, data quality, health records, Freedom of Information (FoI) etc.

Clinical Leads and General Managers

The Divisional Director together with the General Manager are responsible for ensuring that all divisional staff are aware of this document and other supporting information governance policies and SOPs. They are also responsible for ensuring that evidence of compliance is provided and leading on investigations of potential breaches of information governance.

Staff

All staff, whether permanent, temporary or contracted, including students, contractors and volunteers are responsible for ensuring they are aware of the information governance requirements and ensuring they comply with these on a day to day basis. In addition to mandatory annual IG training, the Trust has issued staff guidance which is available via the Trust website. Staff are reminded of the following:

You must not access your own, friends or families healthcare or personnel records. This is a serious breach of data protection, information security and confidentiality and may lead to formal disciplinary proceedings.

Information Governance Steering Group (IGSG)

The key roles of this group are to:

- Receive, amend and approve a wide range of policies connected to information governance and data protection
- Oversee the implementation plans for the Data Security and Protection Toolkit (DSPT) for onward ratification by the Policies Group
- Receive details of information governance incidents
- Receive compliance reports on a range of KPIs including: FoI; Requests for Information; Health Records; Data Quality

The IGSG terms of reference can be found at Appendix D.

5. Procedures and Actions to Follow

5.1. Legitimate Processing

The Trust is defined by law as a public body, so to be compliant with the DPA18 and GDPR the Trust must establish 2 lawful bases for processing personal information. For health and social care organisations to process personal data, a condition from Article 6 of the GDPR will be used; for the processing of special categories of personal data, ie, health information a condition from Article 9 of the GDPR will be used. Some processing, eg, research will require different conditions to make the processing legal. The use of consent for processing will only be used when no other condition is suitable. The majority of processing will fall into one of the following categories:

For processing personal data as a public body:
6(1)(e) '… for the performance of a task carried out in the public interest or in the exercise of official authority …'

For processing health information:
9(2)(h) ' medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems …'
The management tasks of a health public body may include: waiting list management; performance against national targets; activity monitoring; local clinical audit and; the production of datasets to submit for commissioning purposes and national collections

For processing personal information for research purposes:
9(2)(j) '… scientific or historical research purposes or statistical purposes … and provide for suitable and specific measures to safeguard the fundamental rights and interests of the data subject …'

For processing personal information for either safeguarding or employment purposes:
9(2)(b) '… is necessary for the purposes of carrying out the obligations and exercising the specific rights of the controller or of the data subject in the field of employment … social protection law in so far as it is authorised by … Member State Law ..'

5.2. Privacy Notices

Individuals have the right to be informed about the collection and use of their personal information. The Trust must explain in plain language the purposes for collecting personal information and what the information is used for.

The Trust fulfils this legal requirement by informing patients and relatives in a variety of ways including: a Privacy Notice webpage; a Patient Information Leaflet; Privacy Notice Poster and; a Statement on patient letters.

5.3. Data Security & Protection Toolkit

NHS Digital host the Data Security & Protection Toolkit (DSPT). This is an online self-assessment tool that measures compliance against the National Data Guardian's 10 data security standards. The 10 standards are:

- Personal Confidential Data
- Staff Responsibilities
- Training
- Managing Data Access
- Process Reviews
- Responding to Incidents

- Continuity Planning
- Unsupported Systems
- IT Protection
- Accountable Suppliers

As the DSPT is a working assessment that changes, please contact Information Governance for a report on the level of current compliance.

All staff are required to comply with requests for evidence of compliance with DSPT requirements, this should be through routine work, eg, documentation audits, reports, training compliance, minutes of meetings etc, but may be enhanced by spot checks and/or site visits.

5.4. Information Governance Incidents

When there has been an actual or suspected IG incident, it must be reported on datix as soon as possible. If there is a belief that the incident is serious, the IG team must be informed at the same time. The trust will use the incident reporting screening tool accessed from the Data Security and Protection Toolkit (DSPT) website which will assess and advise if the incident requires reporting externally to the Information Commissioner's Office (ICO) for investigation or whether the incident can be handled internally.

In line with the David Nicolson letter (Gateway letter 13177 January 2010), the trust will include a report of all IG incidents in the annual report.

5.5. Auditing Access to Person Identifiable Information (PII) SOP

The Information Governance Lead is also the designated Data Protection Officer for the trust. As part of this role the IG Lead will conduct monthly audits on the access to confidential information by staff using their smartcards to access the national spine.

The audit methodology is to run an alert report from the SCR website and validate the access against ESHT attendance data from OASIS. Reports will be prepared and presented to IGSG and any other relevant groups.

The Data Protection Officer is also the first point of contact should a patient or member of staff have reason to believe that their information has been accessed unlawfully. Any allegations of unauthorised access are investigated and the findings reported back to the reporter. If evidence of a breach is found, the information will be passed to Human Resources and the Anti-Crime Team to consider what action should be taken.

5.6. Privacy by Design (including Privacy Impact Assessment and Information Sharing Protocols) SOP

The DPA18 states that privacy by design is a requirement for projects and that privacy and data protection compliance must be present in project from the start. The PbD approach is a process involving the completion of privacy impact assessment (PIA) and, if appropriate, the agreement of an information sharing protocol (ISP). Examples of when it should be used are: when building new IT systems for storing or accessing PII; using data for new purposes.

6. Equality and Human Rights Statement

An equality impact assessment has been carried out in order to establish that this policy does not discriminate or have a detrimental impact upon employees or service users on the

grounds of disability, age, race, gender, sexual orientation, religion or belief. There are no issues to note.

7. Training

All staff are made aware of their information governance responsibilities through generic and specific training programmes and guidance. This is to ensure all staff are appropriately qualified for the roles and responsibilities they hold. Information governance is included in the mandatory trust induction training and must be renewed annually.

8. References

Includes (but not limited to) the following:
Data Protection Act 2018
The General Data Protection Regulation 2016
Human Rights Act 1998
NHS Digital Data Security and Protection Toolkit (DSPT)
DoH *'The Caldicott Guardian Manual'* 2017
Records Management Code of Practice 2021
The National Data Guardian 2021

Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Information Governance Steering Group Terms of Reference	IG Lead	Peer review	Annual	IGSG	IGSG	IGSG
Information Governance training	L&D Compliance	Reports	At least Quarterly	IGSG	IGSG	IGSG
Information Governance incidents	IG Lead	Reports	At least Quarterly	IGSG	IGSG	IGSG

Appendix A - The Six Data Protection Principles (2018)

Summary:

Principle 1: The processing of personal data must be lawful, and fair and transparent.

Principle 2: The purpose for which personal data is collected on any occasion must be specified, explicit and legitimate and personal data so collected must not be processed in a manner that is incompatible with the purpose for which it was collected.

Principle 3: Personal data must be adequate, relevant and not excessive in relation to the purpose for which it is processed.

Principle 4: Personal data undergoing processing must be accurate and, where necessary, kept up to date.

Principle 5: Personal data must be kept for no longer than is necessary for the purpose for which it is processed.

Principle 6: Personal data must be processed in a manner that includes taking appropriate security measures (and, in this principle, “appropriate security” includes protection against unauthorised or unlawful processing and against accidental loss, destruction or damage).

Appendix B - Caldicott Principles

The National Data Guardian expanded the principles in December 2020, adding in an eighth key principle:

Summary of the Principles:

Principle 1. Justify the purpose(s) for using confidential information
Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.
Principle 2. Don't use personal confidential data unless it is absolutely necessary
Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).
Principle 3. Use the minimum necessary personal confidential data
Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.
Principle 4. Access to personal confidential data should be on a strict need-to-know basis
Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.
Principle 5. Everyone with access to personal confidential data should be aware of their responsibilities
Action should be taken to ensure that those handling personal confidential data - both clinical and non-clinical staff - are made fully aware of their responsibilities and obligations to respect patient confidentiality.
Principle 6. Comply with the law
Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.
Principle 7. The duty to share information can be as important as the duty to protect patient confidentiality
Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.
Principle 8. Inform patients and service users about how their confidential information is used
A range of steps should be taken to ensure no surprises for patients and service users, so they can have clear expectations about how and why their confidential information is used, and what choices they have about this. These steps will vary depending on the use: as a minimum, this should include providing accessible, relevant and appropriate information - in some cases, greater engagement will be required.

Appendix C - Key Caldicott Guardian Responsibilities

Strategy & Governance: the Caldicott Guardian should champion confidentiality issues at Board/senior management team level, should sit on an organisation's Information Governance Board/Group and act as both the 'conscience' of the organisation and as an enabler for appropriate information sharing.

Confidentiality & Data Protection expertise: the Caldicott Guardian should develop a knowledge of confidentiality and data protection matters, drawing upon support staff working within an organisation's Caldicott function but also on external sources of advice and guidance where available.

Internal Information Processing: the Caldicott Guardian should ensure that confidentiality issues are appropriately reflected in organisational strategies, policies and working procedures for staff. The key areas of work that need to be addressed by the organisation's Caldicott function are detailed in the Information Governance Toolkit.

Information Sharing: the Caldicott Guardian should oversee all arrangements, protocols and procedures where confidential patient information may be shared with external bodies both within, and outside, the NHS and CSSRs. This includes flows of information to and from partner agencies, sharing through the NHS Care Records Service (NHS CRS) and related new IT systems, disclosure to research interests and disclosure to the police.

Appendix D – Information Governance & Security Group Terms of Reference

INFORMATION GOVERNANCE & SECURITY GROUP

Terms of Reference

1. Constitution
The Audit Committee resolves to establish a sub-group to be known as the Information Governance & Security Group (IGSG).

2. Purpose
To ensure that the Trust has effective policies and management arrangements covering all aspects of Information Governance (IG), in line with current legislation.

3. Objectives
The IGSG will carry out the following duties:

3.1 provide advice on compliance with the Data Protection Act 2018, the Freedom of Information Act 2000, and other relevant IG legislation, including appropriate policies and procedures, eg, Information Governance and Data Protection Policy; Auditing Access to PII; Privacy by Design

3.2 ensure that the Senior Information Risk Officer (SIRO) and Caldicott Guardian are supported

3.3 ensure that the Trust undertakes annual assessments and audits of the Information Governance policies and arrangements including access to confidential information;

3.4 establish, monitor and regularly review the Trust's IG action plans and formally approve the annual Data Security and Protection Toolkit (DSPT)) submission;

3.5 receive and consider reports into breaches of information confidentiality and security and where appropriate undertake or recommend remedial action and the dissemination of lessons learnt;

3.6 ensure that IG checklists and/or privacy impact assessments are carried out for any changes to current systems or procurement of new information systems;

3.7 support the SIRO and IAOs to ensure that the trust's information risk assessment programme is implemented;

3.8 work with Human Resources to ensure that staff have access to appropriate and current guidance on both keeping personal information secure and sharing it when appropriate; respecting patients' rights around the use of their own information;

3.9 work with Learning & Development to ensure that all staff undertake annual mandatory IG training;

3.10 liaise with other Trust committees/groups in order to promote information governance and provide a focal point for the resolution and action of information governance issues.

4. Membership
4.1 Core Membership:

- Director of Finance & SIRO (chair)
- Director of Corporate Affairs (vice chair)
- Associate Director of ESHT Digital
- Head of Legal
- Information Governance Lead & Data Protection Officer
- Information Governance Manager (supports IGSG)
- IT Engagement and Information Security Lead
- Head of Clinical Administration
- Clinical Coding Service Manager

- Learning & Development Manager
- Human Resources Manager
- Library and Information Services Manager
- Head of Compliance

4.2 Ad-hoc members (for specific reports/updates):

- Any Information Asset Owner
- Information Security Facilitator
- Registration Authority Manager
- Finance Representative
- EME/Medical Devices Representative
- Communications Representative

5. Meeting Attendance

5.1 Quorum:

A quorum shall be five members which must include one of the following:

- Director of Finance and SIRO (chair) or Director of Corporate Affairs (vice chair)
- Information Governance Lead
- IT Engagement and Information Security Lead

If a member cannot attend, they must endeavour to send a deputy; deputies will count towards quorum

The SIRO and CG will attend meetings during the year.

5.2 Frequency of Meetings:

The IGSG will meet a minimum of three times per year, or more frequently at the behest of the chair.

6. Accountability

The IGSG is accountable to the Trust's Audit Committee and onward to the Trust's Board.

7. Authority

The IGSG has delegated authority from the Trust Board for taking any necessary action to progress all information governance issues.

8. Reporting

The notes of the IGSG will be formally recorded and submitted to the Trust's Audit Committee for information and held by the Information Governance Manager. Electronic copies of the notes will be held in the IG section of the Trust's shared drive.

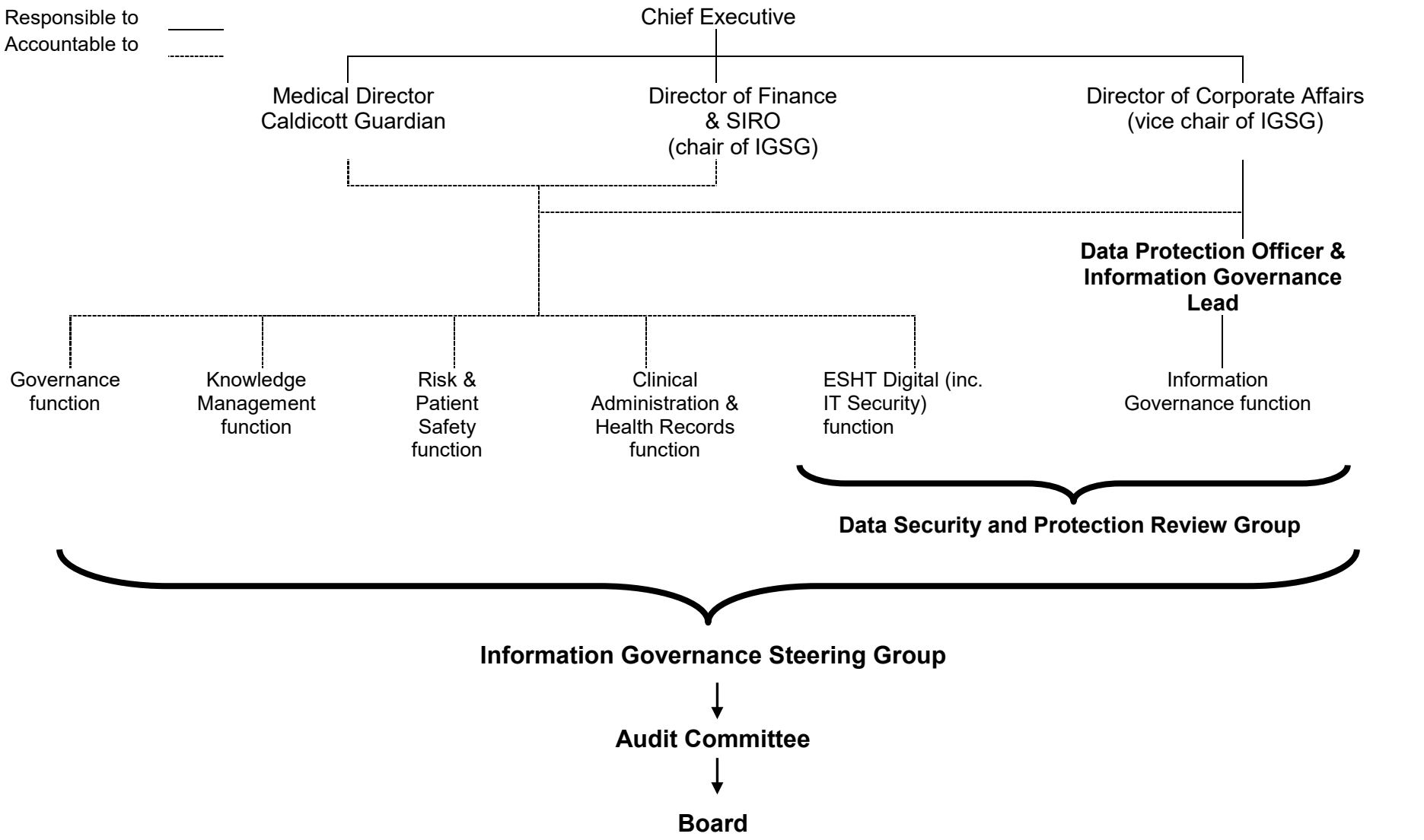
9. Monitoring Effectiveness

The effectiveness of the IGSG will be evidenced through improved compliance with DSPT.

10. Date Reviewed

These ToR will be reviewed annually by members of the IGSG.

Appendix E – IG/Caldicott Guardian/SIRO Function Organisation Chart



Appendix F – Equality Impact Assessment Form

Equality Impact Assessment Form

1. Cover Sheet

Please refer to the accompanying guidance document when completing this form.

Strategy, policy or service name	Information Governance and Data Protection Policy
Date of completion	01/07/2021
Name of the person(s) completing this form	Ruth Paine
Brief description of the aims of the Strategy/ Policy/ Service	To outline the Trust's responsibility regarding compliance with Data Protection legislation.
Which Department owns the strategy/ policy/ function	Information Governance
Version number	V1.1
Pre Equality analysis considerations	None
Who will be affected by this work? E.g. staff, patients, service users, partner organisations etc.	staff, patients, partner organsiations
Review date	01/07/2023
If negative impacts have been identified that you need support mitigating please escalate to the appropriate leader in your directorate and contact the EDHR team for further discussion.	To whom has this been escalated? Name: Click here to enter text. Date: Click here to enter a date.
Have you sent the final copy to the EDHR Team?	No

2. EIA Analysis

<table>
<tr><td></td><td>☺ 😐 ☹</td><td>Evidence:</td></tr>
<tr><td>Will the proposal impact the safety of patients', carers' visitors and/or staff?

Safe: Protected from abuse and avoidable harm.</td><td>Neutral</td><td>Good IG and DP processes will minimise the risk of personal information being disclosed inappropriately</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td>Is the proposal of change effective?

Effective: Peoples care, treatment and support achieves good outcomes, That staff are enabled to work in an inclusive environment. That the changes are made on the best available evidence for all involved with due regards across all 9 protected Characteristics</td><td>Neutral</td><td>IG and DP is applicable to all people equally</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table></td></tr>
<tr><td>What impact will this have on people receiving a positive experience of care?</td><td>Neutral</td><td>Good IG and DP processes will give people confidence that the Trust looks after personal information</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td><table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
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<table>
<tr><td>Does the proposal impact on the responsiveness to people's needs?</td><td>Neutral</td><td>Good IG and DP processes include responding to people’s rights under the legislation.</td></tr>
<tr><td>Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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</td></tr>
<tr><td>What considerations have been put in place to consider the organisations approach on improving equality and diversity in the workforce and leadership?</td><td>Neutral</td><td>Not relevant to this policy</td></tr>
<tr><td>Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
<tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr>
<tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr>
</table>
</td></tr>
<tr><td colspan="3">Access
Could the proposal impact positively or negatively on any of the following:</td></tr>
<tr><td>• Patient Choice</td><td>Neutral</td><td></td></tr>
<tr><td>• Access</td><td>Neutral</td><td></td></tr>
<tr><td>• Integration</td><td>Neutral</td><td></td></tr>
</table>

Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		<table><tr><td>**Race**</td><td>**Gender**</td><td>**Sexual orientation**</td><td>**Age**</td><td>**Disability & carers**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>**Gender reassignment**</td><td>**Marriage & Civil Partnership**</td><td>**Religion and faith**</td><td>**Maternity & Pregnancy**</td><td>**Social economic**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>
Engagement and Involvement How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:	Negative	Not relevant to this policy
Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)		<table><tr><td>**Race**</td><td>**Gender**</td><td>**Sexual orientation**</td><td>**Age**</td><td>**Disability & carers**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>**Gender reassignment**</td><td>**Marriage & Civil Partnership**</td><td>**Religion and faith**</td><td>**Maternity & Pregnancy**</td><td>**Social economic**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>
Duty of Equality Use the space below to provide more detail where you have identified how your proposal of change will impact.	Neutral	Not relevant to this policy
Characteristic	**Rating** ☺☹😐	**Description**
Race	Neutral	
Age	Neutral	
Disability and Carers	Neutral	

Religion or belief	Neutral	
Sex	Neutral	
Sexual orientation	Neutral	
Gender re-assignment	Neutral	
Pregnancy and maternity	Neutral	
Marriage and civil partnership	Neutral	

Human Rights

Please look at the table below to consider if your proposal of change may potentially conflict with the Human Right Act 1998

Articles		Y/N
A2	Right to life	**No**
A3	Prohibition of torture, inhuman or degrading treatment	**No**
A4	Prohibition of slavery and forced labour	**No**
A5	Right to liberty and security	**No**
A6 &7	Rights to a fair trial; and no punishment without law	**No**
A8	Right to respect for private and family life, home and correspondence	**No**
A9	Freedom of thought, conscience and religion	**No**
A10	Freedom of expression	**No**
A11	Freedom of assembly and association	**No**
A12	Right to marry and found a family	**No**
Protocols		
P1.A1	Protection of property	**No**
P1.A2	Right to education	**No**
P1.A3	Right to free elections	**No**

East Sussex Healthcare NHS Trust

Delivering Accessible Information (Policy)

Document ID:	1860
Version:	V1.0
Ratified by:	Policy Ratification Group
Date ratified:	June 2019
Name of author and title:	[redacted] Equality & Human Rights Lead
Date Written:	January 2018
Name of responsible committee/individual:	Lynette Wells, Director of Corporate Affairs
Date issued:	June 2019
Review date:	June 2021
Target audience:	All Staff, patients, carers and service users
Compliance with CQC Fundamental Standard	Good Governance
Compliance with any other external requirements (e.g. Information Governance)	Equality Act 2010, Public sector Equality Duty, Accessible Information Standard, Health & Social Care Act
Associated Documents:	Equality & Human Rights Policy

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0	January 2018	[redacted]	New Document	-

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
WPPG		
Policy Group		
ESHT Digital		Nov 2018
Clinical Admin		Nov 2018
Information Governance		Oct 2018
BSL Link-4 Communication		Jan 19
DeafCOG		Mar 19

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

Understandable information and effective communication are vital components of patient centred Care. Many people who access healthcare have difficulty understanding the information provided about their care. This may be because they are blind, d/Deaf, have a learning disability, or because they have limited or no English. It may be because they need support in terms of reading (limited literacy) or they have a condition which limits their ability to communicate (for example following a brain injury or a stroke). Children and young people have specific communication requirements too. People with Learning disabilities may also have specific communication needs.

It is important, therefore, that information is presented in an accessible way, and where appropriate in a range of languages and formats that are easily used and understood by the intended user or audience.

The Accessible Information Standard (AIS) directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss.

The AIS (Health & Social Care Act 2009) requires all NHS Organisations to comply with the 5 steps of the standard:

1) **Identify** – by asking people if they have any information or communication needs, and find out how to meet their needs.
2) **Record** - those needs in a set way
3) **Highlight** - a person's file, so it is clear that they have information or communication needs, and clearly explain how those needs should be met.
4) **Share** - information about a person's needs with other NHS and adult social care providers, when they have consent or permission to do so.
5) **Meet** – those needs by making sure that people get information in an accessible way and communication support if they need it

2. Rationale

The Trust believes providing accessible information will help to improve access to its services, promote social inclusion and enable people to make more informed choices about their care. The provision of accessible information will aid communication with service users, support effective engagement activities, and support choice, personalisation and empowerment. It will also promote the effective and efficient use of Trust resources.

The provision of accessible information can reduce inequalities and barriers to good health. The implementation of this policy will demonstrate the Trust is meeting its legal duties to reduce inequalities between patients in access to health services and in the outcomes achieved.

This policy seeks to ensure that East Sussex Healthcare NHS Trust has a clear, consistent, transparent and fair approach to the provision of accessible, inclusive information and communication support to patients, service users, their carers and or parents (where the patient or service user is a child). It specifically aims to improve the quality and safety of care received by individuals with information and communication needs, and their ability to be involved in autonomous decision-making about their health, care and wellbeing.

3. Scope

Good communication and The Accessible Information Standard in particular, applies to all NHS service providers and the adult social care system.

All of the healthcare professional frameworks contain commitments to good communication, including making arrangements to ensure patients' language and communication needs are met (inc General Medical Council, Nursing and Midwifery Council).

The Standard does not necessarily require the provision of information in a patient, service user, carer or parent's 'preferred' format. It is the 'needs' of the patient, service user, carer or parent's information which must be met, which may differ from their preferences.

Individuals' preferences for being communicated with in a particular way, which do not relate to disability, impairment or sensory loss, and as such would not be considered a 'need' or 'requirement' (for example a preference for communication via email, but an ability to read and understand a standard print letter) are excluded from the AIS and are not included in the scope of this policy.

Commissioners of NHS and publicly-funded adult social care must also have regard to this Standard, in so much as they must ensure that contracts, frameworks and performance-management arrangements with provider bodies enable and promote the Standard's requirements.

The Accessible Information Standard includes, within its scope, the needs of a patient or service user's main carer, as well as other important or regular informal (unpaid) carers. A carer is a person who is either providing or intending to provide a substantial amount of care on a regular basis for someone who is disabled, ill or frail. A carer is usually a family member, friend or neighbour and does not include care workers. (Carers (Recognition and Services) Act 1995.)".

The policy covers all information and communication relating to patient care, Trust corporate business (where applicable), including both internal and external communication with all people, and should be followed by all staff.

4. Definitions

A full list of definitions is included in appendix B

5. Accountabilities

The Chief Executive has overall responsibility for the strategic direction and operational management of the Trust and takes overall responsibility for this policy and procedure document.

The Equality & Human Rights Lead has the responsibility to ensure this policy is communicated to all staff and provide training where necessary to ensure staff are able to use and adhere to the policy.

All Managers have the responsibility to ensure documents they are developing, services they are delivering, changing and or managing, are within the context of this policy and to ensure this policy is communicated to all their staff / teams.

Clinical Staff have a duty to ensure they meet every patients' communication need and the context of this policy should not limit any need for further reasonable adjustments. Clinical

staff have a responsibility to ensure this policy is communicated to all their staff / teams and implemented within their service.

All Staff have the responsibility to ensure patients, their carers and or their parents are not denied or delayed access to healthcare and information about their healthcare and that services are safe and meet the needs of those requiring communication support / reasonable adjustments.

All staff are responsible for ensuring that they are communicating with colleagues, patients, carers and the public in a way which is effective and ensures information is clear and understood by the person receiving the information. It is therefore the responsibility of all staff to ensure that they are aware of the relevant translation, interpretation and accessible information services available and how to access them. Information on how to access interpretation services can be found in appendix C.

6. Process

A short guide for staff on the process to follow when accessing interpreting services is provided in appendix C.

Accessible information requires the provision of information in a format that the individual can read or otherwise access and understand. The 'judgement' or 'assessment' about whether this requirement has been fulfilled lies with the individual patient, service user, carer or parent themselves, i.e. can they read, access and understand the information? Can they 'use' the information as it was intended? If they can, then the organisation has met this aspect of its obligations under the Standard.

The AIS aims to support individuals' rights to autonomy and, specifically, their ability to access health and social care services independently. British Sign Language (BSL) interpretation and other communication support should be provided when accessing services by an appropriately qualified and registered professional and not by an individual's family members, friends or carers. However, if a person chooses to use their own interpreter, family member or friend etc, the parameters in which the individual's family member / friend / carer is to be used, MUST be confirmed using an appropriately qualified and registered professional interpreter and clearly recorded in their notes each time they access Trust services. It must be made clear to the patient that

- the Trust cannot guarantee the accuracy of any translated information or confidentiality of the person interpreting.
- The Trust cannot be held responsible for any inaccurately translated information or any confidential information shared by a patient's own interpreter.

This preference and consent MUST also be regularly reviewed and MUST be reviewed whenever a new course of treatment / episode of care is started or proposed or significant decision or choice is to be made.

In all instances, the individual patient, service user, carer or parent MUST be offered professional communication support where they have an identified need for communication using BSL, deafblind manual or other alternative communication system.

6.1. Identifying Communication Support Needs

Communication and / or information needs MUST be identified at registration / upon first contact with the service or as soon as is practicable thereafter. This initial question may be asked over the telephone, face-to-face at a reception desk, as part of a registration or admission form or through an alternative process.

There are four key areas (four subsets) of communication and / or information needs which MUST be identified proactively and opportunistically (eg the next time an existing patient / service user makes contact with the Trust / is seen by the service).

- Communication delivery method (e.g. BSL, deafblind manual)
- Communication tools used (e.g. a talking mat, hearing aids)
- Information format (e.g. braille, easy read, plain English)
- Information delivery method (e.g. email, telephone)

Suggested questions which may be used to identify if an individual has any information and / or communication support needs, and the nature of these needs include:

• Do you have any communication needs?
• Do you need information in a format other than standard print?
• Do you have any specific communication requirements?
• How do you prefer to be contacted?
• What is your usual method of communication?
• How would you like us to communicate with you?
• Can you explain what support would be helpful?
• What communication support should we provide for you?
• What is the best way to send you information?

Relevant prompt or follow-up questions when communicating may encourage individuals to provide further information about their needs.

• Do you have difficulty hearing, or need/wear hearing aids, or need to lip-read what people say?
• Do you have difficulty with memory or ability to concentrate, learn or understand?
• Do you have difficulty speaking or using English language to communicate or make yourself understood?

The above questions, and other advice contained within the Mental Health and Learning Disabilities Data Set (MHLDDS) provide guidance with regard to identification of disability and are based on the document *'Have you got a learning disability? Asking the question and recording the answer for NHS healthcare providers'* by Improving Health and Lives: The Learning Disabilities Observatory.

6.2. Recording Communication Support Needs

Patients', service users', carers' and parents' needs must be recorded in such a way that the data recorded enables actions to be taken to meet those needs, by any member of staff – including someone who has had no previous contact with the individual. Recording individuals' communication needs must clearly identify the support / intervention required to enable effective communication. Recording that a person is 'deaf', for example, does not explain whether they are able to read written English, if they use British Sign Language (BSL) or are a lipreader and / or hearing aid user. Ensure all of the person's needs – and how to meet them – are captured on the Patient Administration Systems (eg PAS, SystmOne etc).

Assumptions about communication support or alternative formats required, or any recording of needs, must not be made without consultation with the individual themselves and / or, where appropriate, their carer or parent.

For some patients, service users, carers and / or parents, accessing healthcare and information about it may not require any equipment, tools or adjustments but may require staff to modify their behaviour or make environmental adjustments such as ensuring the light is adequate for visual or hearing impairment; or ensuring the patient, service user, carer and / or parent can clearly see the staff members face when talking; or directing conversation towards a particular side of the patient, service user, carer and / or parent in the case of unilateral hearing loss. Even where physical adjustments or equipment / tools are not required, environmental adjustments must still be recorded in the same way.

Communication support needs must be recorded electronically on the Patient Administration Systems. Systems will vary depending on the setting eg. community – Systmone; maternity – EuroKing; acute – PAS etc. All systems are equipped to record patient communication needs.

Where the provision to record communication needs electronically is not available / provided (ie health visitors visiting a patient at home), this must recorded in the notes and be added electronically as soon as is reasonably practicable.

When recording additional information about patients, service users, carers and parents, staff should be mindful of their duties under the GDPR 2018, including ensuring that information is 'relevant' and 'not excessive' (to the purpose of recording it).

6.3. Flagging Communication Support Needs

A record of communication and / or information needs MUST be flagged or otherwise highlighted / made 'highly visible' to relevant staff when the individual has subsequent interaction or contact with the Trust (to enable appropriate actions to be taken to meet those needs).

'Highly visible' is defined in the Specification as follows:

"A recording of an individual's information or communication support needs must be 'highly visible' to relevant staff and professionals. In the context of this Standard 'highly visible' means:

- Obvious and overtly apparent; and
- Visible on the cover, title and / or 'front page' of a document, file or electronic record; and / or
- Visible on every page of an electronic record (for example as an alert, flag or banner); and / or
- Highlighted in some way on a paper record so as to draw attention to the information as being of particular importance, for example in a larger or bold font, and / or a different colour." (DCB1605 Accessible Information 2017: Implementation Guidance, V1.1.).

ESHT recommends a coloured sticker is placed on the folder to prompt the reader to view the information about communication needs contained on the patient information sheet. This will ensure confidential patient information remains confidential and complies with the GDPR 2018.

Once recorded, that record of an individual's information and / or communication support needs MUST be 'highly visible' and any action to be taken to meet those needs, are clear to the next person providing care to that patient.

Where paper records are used, a clear process MUST be established. This may include drawing attention to the fact that an individual has an information or communication support need by using a larger print, highlighter, coloured sticker or other mechanism on the front cover and / or front page of a patient or service user's notes, file or record (as appropriate and complying with GDPR 2018). If a patient or service user's notes, file or record has multiple volumes, information or communication support needs should be visible on the front cover and / or front page of each volume.

Where electronic record or administration systems are used, a record of information or communication support needs MUST be flagged (or linked to an alert) to ensure that, once recorded, staff are prompted to respond to individuals' information and / or communication support needs and / or automatic processes are triggered in order that those needs can be met, for example auto-generation of correspondence in an alternative format.

6.4. Sharing Communication Support Needs

Having first obtained the relevant consent or other authority to share a patients' communication and/or information needs, staff MUST ensure that information about individuals' information and / or communication support needs are included as part of existing data-sharing processes, and as a routine part of referral, discharge and handover.

Information and / or communication needs should be included as part of referrals both within and between organisations, including (but not limited to) referrals from primary into secondary care, transfers and handovers between wards or units, and discharge from an inpatient setting into the community.

All of the data items associated with the four subsets have been included in the 'inclusion dataset' for Summary Care Records with additional information. This means that, if the patient's information and / or communication needs are recorded in their GP patient record using the identified codes, and the patient has consented for 'additional information' in their Summary Care Record (SCR), then details of their information and / or communication needs will automatically be available to anyone viewing their SCR.

Note that this data-sharing is to support direct patient / service user care (not for reporting or analysis). Information governance protocols and processes for the obtaining and recording of patient / service user consent must be followed. Remember that consent cannot be assumed.

6.5. Meeting Communication Support Needs

Services MUST provide one or more communication or contact methods which are accessible to and useable by the patient, service user, carer or parent. The method(s) MUST enable the individual to contact the service, and staff MUST use this method to contact the individual. Examples of accessible communication / contact methods include email, text message, telephone and text relay. See appendix C for available alternative communication methods.

An email (esh-tr.accessibleinformation@nhs.net) is available to patients to communicate with the Trust as an alternative method of contact. This email address can be provided to patients to confirm, cancel and amend interpreter bookings or to request patient information in alternative formats. Emails regarding care will be forwarded to relevant departments for response/action. Patients, service users, carers or parents can also provide details of their communication support needs using this email. Information provided will then be added to electronic systems or forwarded to the relevant department for action.

All public organisations including NHS organisations have a legal 'duty to make reasonable adjustments' under The Equality Act 2010. Providing communication support and / or information in alternative formats, that reflect the needs of a patient, service user, carer and / or parent is considered a reasonable adjustment. See appendix E for 'advice about translated or transcribed information'.

Where needed, appropriate, professional communication support MUST be arranged or provided to enable individuals to effectively access / receive health or adult social care, to facilitate effective / accurate dialogue, and to enable participation in decisions about their health, care or treatment. This support may be provided through a telephone interpreter (foreign spoken community languages), Video interpreting (not all languages are available. British and American Sign Language is available), a face to face interpreter (for BSL and where a need is identified for a person requiring foreign spoken community languages), lip speakers, advocates and bilingual advocates see appendix B for guidance on when and how to access interpreters. For guidance on how to work with and communicate using interpreters see appendix F. Where interpreting is required to support communication at an appointment, a longer appointment is likely to be needed.

For some patients, service users, carers and / or parents, accessing healthcare and information about it may require staff to modify their behaviour or make environmental adjustments such as ensuring the light is adequate for visual impairment; or ensuring the patient, service user, carer and / or parent can clearly see the staff members face when talking; or directing conversation towards a particular side of the patient, service user, carer and / or parent in the case of unilateral hearing loss. See appendix D for 'Tips for clear face-to-face communication'.

Further guidance on available communication support and equipment can be found in the appendices or on the extranet along with top tips for effective communication and guidance on communicating using interpreters.

7. Reviewing Communication and Information needs

The purpose of reviewing a person's communication and information needs is to identify if the individual's needs have changed (for example due to a change in their level of sensory loss) and to identify if the most appropriate methods of meeting those needs for example; a person with some visual loss may initially request information in large print, but due to visual deterioration information via email in an audio format better meets their

communication / information needs. This will also support the Trust in meeting its legal obligations under the Public Sector Equality Duties.

8. Special Considerations

Care should be taken to ensure to follow relevant existing legal duties, including those set out in the Data Protection Act (GDPR 2018) and Mental Capacity Act 2005 around the handling and processing of data.

8.1. The scope of the Accessible Information Standard does not consider those whose only communication barrier is language. However patients and their carers/parents who use a foreign spoken community language as their method of communication should be provided with access to interpretation services when accessing trust services.

9. References

1. Mental Health and Learning Disabilities Data Set (MHLDDS)
2. Have you got a learning disability? Asking the question and recording the answer for NHS healthcare providers' by Improving Health and Lives: The Learning Disabilities Observatory
3. Access all Areas? (Action on Hearing Loss, 2013)
4. Action Plan on Hearing Loss (NHS England, 2015)
5. Equality Delivery System 2 (NHS England, 2013)
6. Final report of the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) (University of Bristol CIPOLD Team, 2013)
7. NHS Five Year Forward View (NHS England, 2014)
8. Patients First and Foremost: The Initial Government Response to the Report of Mid Staffordshire NHS Foundation Trust Public Inquiry (Department of Health, 2013)
9. 'Sick of It' (SignHealth, 2014)
10. The Care Act 2014
11. The Equality Act 2010
12. The Accessible Information Standard (2016)
13. The NHS Constitution (Department of Health, 2013)
14. The Power of Information (Department of Health, 2012)
15. Transforming care: A national response to Winterbourne View Hospital, Department of Health Review: Final Report (Department of Health, 2012)
16. Valuing People: A New Strategy for Learning Disability for the 21st Century (Department of Health, 2001)
17. Valuing People Now: A New Three-Year Strategy for People with Learning Disabilities (Department of Health, 2009)
18. Your rights to equality from healthcare and social care services (Equality Act 2010 Guidance for service users, Volume 4 of 7) (Equality and Human Rights Commission, 2014)

10. Competencies and Training Requirements

There are no defined competencies. Training on accessible communication including the use of interpreters is included in the induction program and mandatory Equality & Diversity training. Additional/ad-hoc training can be provided upon request.

11. Monitoring arrangements

Requests for written translations, face to face interpreters and advocates will be monitored daily. Any requests for interpreters that cannot be provided will be recorded and actioned using the Trust's incident reporting system (Datix).

Telephone interpreting will be monitored quarterly and reported annually. Any requests for telephone interpreters that cannot be provided will be recorded and actioned using the Trust's incident reporting system (Datix).

Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Interpreter requests	Kim Novis	Booking system	Daily & Annually	[redacted]	E&D/Clinical Admin	Q&S
Written translation requests	Kim Novis	Booking system	Daily & Annually	[redacted]	E&D/Clinical Admin	Q&S

12. Equality and Human Rights Statement

See Appendix A.

Appendix B

Definitions

Advocate - A person who supports someone who may otherwise find it difficult to communicate or to express their point of view. Advocates can support people to make choices, ask questions and to say what they think.

Accessible information - Information which is able to be read or received and understood by the individual or group for which it is intended.

Alternative format - Information provided in an alternative to standard printed or handwritten English, for example large print, braille or email.

Braille - A tactile reading format used by people who are blind, deafblind or who have some visual loss. Readers use their fingers to 'read' or identify raised dots representing letters and numbers. Although originally intended (and still used) for the purpose of information being documented on paper, braille can now be used as a digital aid to conversation, with some smartphones offering braille displays. Refreshable braille displays for computers also enable braille users to read emails and documents.

British Sign Language (BSL) - is a visual-gestural language that is the first or preferred language of many d/Deaf people and some deafblind people; it has its own grammar and principles, which differ from English.

BSL interpreter - A person skilled in interpreting between BSL and English. A type of communication support which may be needed by a person who is d/Deaf or deafblind.

Communication support - Support which is needed to enable effective, accurate dialogue between a professional and a service user to take place.

Communication tool / communication aid - A tool, device or document used to support effective communication with a disabled person. They may be generic or specific / bespoke to an individual. They often use symbols and / or pictures. They range from a simple paper chart to complex computer-aided or electronic devices.

d/Deaf - A person who identifies as being deaf with a lowercase d is indicating that they have a significant hearing impairment. Many deaf people have lost their hearing later in life and as such may be able to speak and / or read English to the same extent as a hearing person. A person who identifies as being Deaf with an uppercase D is indicating that they are culturally Deaf and belong to the Deaf community. Most Deaf people are sign language users who have been deaf all of their lives. For most Deaf people, English is a second language and as such they may have a limited ability to read, write or speak English.

Deafblind - The Policy guidance Care and Support for Deafblind Children and Adults (Department of Health, 2014) states that, "The generally accepted definition of Deafblindness is that persons are regarded as Deafblind "if their combined sight and hearing impairment causes difficulties with communication, access to information and mobility. This includes people with a progressive sight and hearing loss" (Think Dual Sensory, Department of Health, 1995)."

Disability - The Equality Act 2010 defines disability as follows, "A person (P) has a disability if — (a) P has a physical or mental impairment, and (b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities." This term also has an existing Data Dictionary definition.

Disabled people - Article 1 of the United Nations Convention on the Rights of Persons with Disabilities has the following definition, “Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

Easy read - Written information in an ‘easy read’ format in which straightforward words and phrases are used supported by pictures, diagrams, symbols and / or photographs to aid understanding and to illustrate the text.

Impairment - The Equality and Human Rights Commission defines impairment as, “A functional limitation which may lead to a person being defined as disabled...”

Interpreter - person able to transfer meaning from one spoken or signed language into another signed or spoken language.

Large print - Printed information enlarged or otherwise reformatted to be provided in a larger font size. A form of accessible information or alternative format which may be needed by a person who is blind or has some visual loss. Different font sizes are needed by different people. Note it is the font or word size which needs to be larger and not the paper size.

Learning disability - This term has an existing Data Dictionary definition and is also defined by the Department of Health in Valuing People (2001). People with learning disabilities have life-long development needs and have difficulty with certain cognitive skills, although this varies greatly among different individuals. Societal barriers continue to hinder the full and effective participation of people with learning disabilities on an equal basis with others.

Lipreading - A way of understanding or supporting understanding of speech by visually interpreting the lip and facial movements of the speaker. Lipreading is used by some people who are d/Deaf or have some hearing loss and by some deafblind people.

Notetaker - In the context of accessible information, a notetaker produces a set of notes for people who are able to read English but need communication support, for example because they are d/Deaf. Manual notetakers take handwritten notes and electronic notetakers type a summary of what is being said onto a laptop computer, which can then be read on screen.

Patient Administration System (PAS) - Mainly used in hospital settings, and especially by NHS Trusts and Foundation Trusts, Patient Administration Systems are IT systems used to record patients’ contact / personal details and manage their interactions with the hospital, for example referrals and appointments.

Read Codes - A coded thesaurus of clinical terms representing the clinical terminology system used in general practice. Read Codes have two versions: version 2 (v2) and version 3 (CTV3 or v3), which are the basic means by which clinicians record patient findings and procedures.

Speech-to-text-reporter (STTR) - A STTR types a verbatim (word for word) account of what is being said and the information appears on screen in real time for users to read. A transcript may be available and typed text can also be presented in alternative formats. This is a type of communication support which may be needed by a person who is d/Deaf and able to read English.

SNOMED CT (Systematised Nomenclature of Medicine Clinical Terms) - Classification of medical terms and phrases, providing codes, terms, synonyms and definitions. SNOMED

CT is managed and maintained internationally by the International Health Terminology Standards Development Organisation (IHTSDO) and in the UK by the UK Terminology Centre (UKTC). SNOMED CT has been adopted as the standard clinical terminology for the NHS in England.

Text Relay - Text Relay enables people with hearing loss or speech impairment to access the telephone network. A relay assistant acts as an intermediary to convert speech to text and vice versa. British Telecom (BT)'s 'Next Generation Text' (NGT) service extends access to the Text Relay service from a wider range of devices including via smartphone, laptop, tablet or computer, as well as through the traditional textphone.

Translator - A person able to translate the written word into a different signed, spoken or written language. For example a sign language translator is able to translate written documents into sign language.

Appendix C

Interpreting Services Guide for Staff

Telephone interpreting:
This is the preferred method of interpreting for most people who do not speak English accessing short appointments and A&E attendances. Telephone should be used in the first instance. If during the conversation you discover/query any of the following you should raise a request for a face to face interpreter and continue using telephone until the interpreter arrives:

- Patient lacks capacity / query capacity / has learning disability
- There are safeguarding concerns
- There is bad news to be given
- The patient is deaf, blind or deaf and blind
- The nature of the appointment is very complex
- Conversations will last longer than 30 minutes
- Patient requires a general anaesthetic or sedation for surgery/procedure

To access on demand telephone interpreting: call **0800 587 0963,** provide your departments PIN and state language. The interpreter will ask if you would like to place an outgoing call to interpret or interpret with person present.

Patient present: Place the call on loudspeaker or pass the patient the 2nd handset. Introduce yourself and the nature of the appointment. Direct your conversation, questions etc at the patient and not the interpreter (eg. “how are you feeling today”? NOT “Can you ask him/her how they’re feeling today”?)

Patient not present: Provide the interpreter with patient phone number and when connected direct your conversation to the patient not the interpreter. If there is no answer you may leave a message in accordance to the patient’s wishes/consent etc.

Pre-booked telephone interpreters: Pre-booking telephone interpreters can be booked with a minimum of 2 hour’s notice. This can be done by completing the online booking form on the Trust extranet (see below). If you require a booking within 24 hours please also call or email the accessible information team (below) to ensure this is prioritised.

Video Interpreting
The interpreter on wheels is kept with switchboard. The device must be signed out and back in when returned to switchboard. To comply with infection control you must also sign to say that it has been wiped down prior to being returned to switchboard.

NOT pre-booked - When retrieving the device from switchboard during normal working hours a note must be made of any pre-booked requests and the device must be cleaned and returned in time for this booking. If there are no pre-booked requests or it is out of hours, the device must still be cleaned and returned to switchboard immediately after use.

Pre- booked – Ensure you collect the device no more than 5 minutes prior to the booked slot and it must cleaned and returned to switchboard immediately after use.

Face to Face interpreting (including bilingual advocates, BSL and LS):
To book an interpreter, please use the following link:

http://nww.esht.nhs.uk/corporate/equality-and-diversity/interpreter-request/ and complete the online booking form

(For **British Sign Language (BSL)/ Lip speaking (LS) during Out of Hours** (5:00PM to 8:00am Weekdays or any Bank Holidays and Weekends) email office@bsl-link4comm.co.uk and/or text **07794 405794**. You must also complete a booking form on the Trust extranet.)

Translation of documents (inc Braille): email your document to **esh-tr.AccessibleInformation@nhs.net** we aim to complete requests with 48 hours but can take 7-10 days depending on the size, complexity and type of document. Braille documents must be posted therefore may take slightly longer.

Contacts for communication and interpreting services:

The Accessible Information Team Tel: 01424 755255

East Sussex Healthcare NHS Trust Email: esh-tr.Accessibleinformation@nhs.net

Website (external):
https://www.esht.nhs.uk/about-the-trust/departments/equality-and-humanrights/accessible-information/

To book or cancel interpreter requests http://nww.esht.nhs.uk/corporate/equality-and-diversity/interpreter-request/

For further communication resources including translated documents, leaflets and appointment letters please visit the extranet http://nww.esht.nhs.uk/corporate/equality-and-diversity/

Appendix D – Tips for clear face-to-face communication

- Make sure you have the person's attention before trying to communicate with them. If they do not hear you, try waving or tapping them lightly on the shoulder.
- Identify yourself clearly. Say who you are and what you do – it may be more relevant to explain your reason for seeing the person rather than your job title.
- Check that you are in the best position to communicate, usually this will be facing the person, but consider whether seated or standing is more appropriate. Communication at eye level is usually easiest so if you are speaking to a wheelchair user consider sitting down if possible.
- Find a suitable place to talk, with good lighting and away from noise and distractions.
- Speak clearly and a little slower than you would do usually, but do not shout.
- Keep your face and lips visible – do not cover your mouth with clothing, a hand or your hair. If a member of staff is concerned about religious expression they should discuss this with their manager in advance.
- Use gestures and facial expressions to support what you are saying.
- If necessary, repeat phrases, re-phrase the sentence or use simpler words or phrases.
- Use plain, direct language and avoid using figures of speech such as 'it's raining cats and dogs' or euphemisms such as 'expecting the patter of tiny feet'.
- Check if the person has understood what you are saying. Look for visual clues as well as asking if they have understood.
- Encourage people to ask questions or request further information. Ask if they would like anything in writing as a reminder or reference.
- Try different ways of getting your point across. For example writing things down, drawing or using symbols or objects to support your point.

Appendix E – Advice about translated or transcribed information

- Prior to submitting any information for translation, it must be spell-checked, the accuracy of all content, including any contact details verified, and assurance must be given that the content is up to date and without errors.

- The variant or dialect of a language for translation must be established. If in any doubt this should be confirmed with the individual requiring the translated information.

- Care should be taken before translating any document which is known or likely to be superseded, for example draft versions. In some circumstances it may be more appropriate to delay provision of translated information where a final version is known to be available imminently.

- Consideration should be given to the layout and length of the translated information, for example whether it is appropriate for double-sided printing, and whether the use of headings or images needs to be amended. A plain text document may be more suitable to use for translation.

- Be clear to consider and stipulate:

    - The format the translation is to be provided in, for example, paper copy and / or electronic file;
    - The delivery method for the translation, for example email, internet, post (consider file size limits for documents shared via email);
    - The delivery deadline / urgency of the translation;
    - The delivery location for the translation, for example directly to the individual or via the clinical/non-clinical unit
    - The ownership of the document, content and copyright remains with the Trust
    - Whether the translator is expected to proof-read the translated version.

Documents to translated should be emailed to esh-tr.accessibleinformation@nhs.net

Appendix G - Working with BSL Interpreters

Interpreting requires a great deal of concentration. The recommended optimum time for an interpreter to work is around 20 minutes. After this time, the interpreter will need a break, if they are working alone. For meetings and events longer than two hours, two interpreters are necessary so they can co-work with each other and take turns to interpret.

•For a BSL user, watching an interpreter for a long period of time can also be very tiring. If a Deaf person stops watching the interpreter to rest, they may miss vital information. This means that Deaf people may appreciate breaks during long presentations.

•In BSL interpreting it is the meaning of the message that is interpreted, not each individual word. It is difficult for the interpreter to deal with information they do not fully understand, so any preparatory information you can give the interpreter in advance will be most useful. Copies of scripts, handouts, presentations etc. are useful, as is a glossary of any particularly difficult terminology. This information should, ideally, be available well in advance, depending on the quantity and nature of the content. The interpreter may also want to ask some questions about the meeting or conversation before it starts to get a clear idea of the topic and any jargon.

•If you are showing videos, ideally the interpreter should view the video beforehand. The interpreter will need to stand next to the screen to enable Deaf people to see the interpreter and the screen at the same time. Don't switch the lights off unless the interpreter can be lit in a different way. This is also true of overhead projection and PowerPoint presentations. You will need to show the slide, talk and then give the audience another chance to look at the slide. During the meeting or conversation, the interpreter may need to interrupt the person speaking or signing and ask them to repeat the message or explain in more detail, to make sure the message is interpreted correctly.

•There may be a slight delay in the conversation as it takes time for the interpreter to process the message before interpreting it into the other language.

•When asking questions of a group, you may need to pause to allow the Deaf person time to respond.

•Only one message can be interpreted at a time, so it is important that only one person speaks/signs at a time.

•If you have planned the chance for Deaf and hearing people to socialise during a break, consider that an interpreter may be needed but remember that interpreters also need time to rest.

•The interpreter and Deaf participants must be very easily seen so they should always be placed in good light. Interpreters should never be placed in front of a window, or with light coming from behind as this will cast shadows on their face, masking their expressions.

•The background behind the interpreter should be plain. Vivid patterns or a harsh white background can be distracting or painful to the eye.

•When giving presentations, speak at a normal pace. Speak clearly and naturally in full sentences. In a one-to-one situation always address the Deaf person, not the interpreter, even though the Deaf person will not always be able to look at you. The interpreter is saying exactly what each person is saying, so will say/sign 'I' and 'my'

•In a mixed setting of Deaf and hearing people, address the audience in general. Don't ask the interpreter any questions or make comments to them; their job is not to get involved, just to pass the message on.

Appendix F Working with Foreign Spoken Community Language Interpreters

1 – Whether using face to face interpreters or telephone interpreters, conversations should be with the patient, information and questions should be given/asked directly to the patient. Eg. *'How are you feeling today'?* **Not** *'Can you ask her how she is feeling today'?*

2 – Hold a brief introductory discussion with the interpreter if possible to agree on basic interpreting protocols. Let the interpreter brief the patient on the interpreters role and assurance of confidentiality.

3 – Allow enough time for the appointments. An interpreted conversation requires more time. What can be said in a few words in one language may require a lengthy paraphrase in another.

4 – Speak in a normal voice, clearly and not too fast or too loudly. It is usually easier for the interpreter to understand speech produced at normal speed and with normal rhythms, than artificially slow speech.

5 – Avoid acronyms, jargon and technical terms that might be difficult to translate, including cultural references. Some concepts may be easy for the interpreter to understand but extremely difficult to translate.

6- Face the patient and talk to the patient directly. Remember it is the patient you are communicating with through the interpreter. You can continue to read body language in this way. Look for signs of comprehension, confusion, agreement or disagreement.

7 – Pause after a full thought for the interpretation to be accurate and complete. If you speak too long, the interpreter may not remember everything and miss a piece of the narrative.

7 – Don't ask or say anything you to do not want the patient to hear. Expect everything you say to be interpreted, and everything the patient and their family says.

8 – Be patient and avoid interrupting during the appointment. Allow the interpreter as much time as necessary to ask questions, for repeats and for clarification. Be prepared to repeat yourself in different words if your message was not understood. Professional interpreters do not translate word for word but rather concept by concept.

9 – Do not expect the length of your speech to directly match the interpreters. Depending on the target language the English version may need to be relayed into complex grammar and a different communication pattern.

10 – Be sensitive to appropriate communication standards. Different cultures have different protocols to discuss sensitive topics and to address physicians. Many ideas taken for granted in the UK do not exist in cultures and may need detailed explanation in another language. Interpreters are also there to assist with cultural awareness.

East Sussex Healthcare NHS
NHS Trust

Patient consent for email communication

I understand that I choose to make use of the email communication service with East Sussex Healthcare NHS Trust

I confirm that I have had explained to me by …… (staff name & Job title), how email communication works and the type of communication that can take place via email. I also confirm that I have read and will comply with the requirements outlined in the patient information leaflet.

I would like to communicate with the Trust via the Accessible Information team at East Sussex Healthcare NHS Trust by email because I have a sensory impairment. I understand that internet email is not a secure medium. I understand that there is a possibility that my emails and the responses could be intercepted and read by someone else. I will bear this in mind in deciding how much information to seek and how much information to disclose by email. I understand that if I require urgent clinical advice or attention I should contact my GP and not email the Accessible information team. The Accessible Information email is operated Mon-Fri 8am – 4pm exc bank holidays.

My email address for communication is: ……

☐ This is my email address

☐ This is the email address of a nominated person

Name of nominated person (if applicable): …….
Relationship to patient (if applicable): ……..
Patient's name: …… Date: _ _ / _ _ / _ _ _ _
Patient's signature: …….

Staff member obtaining consent (Consent is only valid when the below is completed by a member ESHT staff)

Name: _____ Date: _____
Position: _____ Signature: _____

This form must be sent to:
The Accessible Information Team
Level 4, Management Corridor
Conquest Hospital
The Ridge
St Leonards
East Sussex
TN37 7RD

Or email to: esh-tr.accessibleinformation@nhs.net

East Sussex Healthcare NHS
NHS Trust

The Accessible Information Standard (SCCI 1605 (Accessible Information))

As a Healthcare provider we have new duties to support those accessing our services who have information or communication needs because of a disability or sensory impairment. We must:

1. **Identify** your communication and information needs;
2. **Record** your communication and information needs that you have identified;
3. Have a **flagging** system so that if a member of staff opens your record, it is immediately brought to their attention you have a communication or information need;
4. **Share** the identified information and communication needs you have identified with other services/people involved in your care;
5. **Meet** the communication and information needs you have identified identified.

For more information visit: www.england.nhs.uk/accessibleinfo

East Sussex Healthcare NHS
NHS Trust

Name:
DOB:
Address:
NHS number:

Please complete the information below as formal notification of information and communication preferences. We have dedicated Communication Support Champions available if you require help completing this form or would like further information and advice.

I communicate using (e.g. BSL, deafblind manual):

To help me communicate I use (e.g. a talking mat, hearing aids):

I need information in (e.g. braille, easy read, plain English):

The best way to contact me is (e.g. email, telephone):

(For Hospital / Staff use only)
Alert created on OASIS by (Insert name): Date:

East Sussex Healthcare NHS Trust

Visiting Policy (Supporting patients and families to safely communicate)

Document ID Number	2049
Version:	V2
Ratified by	Clinical Documentation and Policy Ratification Group
Date ratified:	08 August 2023
Name of author and title:	Angela Colosi Deputy Chief Nurse
Date originally written:	April 2020
Date current version was completed:	June 2023
Name of responsible group/individual:	Clinical Advisory Group
Date issued:	07 September 2023
Review date:	June 2026
Target audience:	All Clinical & Support Staff in hospitals
Compliance with CQC Fundamental Standard	Person-centred care Dignity and respect Need for Consent Safe Care and Treatment Safeguarding service users form abuse and improper treatment
Compliance with any other external requirements (e.g., Information Governance):	Visiting in care homes, hospitals and hospices - GOV.UK (www.gov.uk) Coronavirus » Living with COVID-19: Visiting healthcare inpatient settings principles (england.nhs.uk) Regulations for service providers and managers - Care Quality Commission (cqc.org.uk)
Associated Documents:	End of Life Care Policy

Acknowledgement to Surrey and Sussex Healthcare NHS Trust

Did you print this yourself?
Please be advised the Trust discourages retention of hard copies of this document and can only guarantee that the version on the Trust Extranet is the most up to date version.

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0	April 2020	Jayne Winter	NA	New guidance
V1.1	May 2020	Jayne Winter	Some additions to the document and removal of a paragraph.	Removed a paragraph from 5.4, Addition 5.7, 5.1. Slight change to 7.1
V1.2	June 2020	Jayne Winter	Changes to virtual visiting guidance	Changes to virtual visiting guidance
V1.3	March 2021	Angela Colosi	New National Guidance: C1112 & government roadmap	Addition of Visitor leaflet, minor amendments to virtual visiting. Face coverings.
V1.4	June 2021	Tina Lloyd	Differing interpretation by ward staff and complaints from patients and visitors	Specific reference to permitting one person per day to visit chosen by the patient – does not have to be the same person every day
V1.5	December 2021	Hazel Tonge/Angela Colosi	Escalating COVID cases and new Omicron variant	Rewrite of policy with more emphasis on visiting, IPC and mask wearing
V1.6	January 2022	Angela Colosi	Addition to Section 8.9	8.9 Managing Conflict addition to this section.
V2	June 2023	Angela Colosi	Review post pandemic	A total review post pandemic and in line with legislative DOHSC consultation document

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Ward Matrons/Community Team Leads	Fortnightly Matrons meeting	19th June 2023
ADNs and HoNs		13th July 2023
Jayne Winter	Supportive and Palliative Care Team	13th July 2023
[redacted]	Lead Chaplain	13th July 2023
Joy Jones	Bereavement and Chaplaincy	13th July 2023
[redacted]	Trust Security Advisor	26th July 2023
CAG	Clinical Advisory Group	26th July 2023

Table of Contents

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

1. Introduction

1.1. Since the COVID-19 pandemic began, visiting has not been possible except in exceptional circumstances and more recently under controlled conditions. ESHT have needed to adapt to find new ways of supporting both the person and those closest to them.

1.2 Government guidance was last issued on the 7th June 2022[1] and on the 21st June[2] publication of an open consultation document which proposes a change in legislation to ensure that visitors are able to visit loved ones in hospital, care homes and hospices.

1.3 CQC assesses health and care providers against the fundamental standards and other requirements set out in CQC regulations. Providers are required to comply with certain fundamental standards of care which implicitly cover visiting. These include the following:

- regulation 9 (1) - person-centred care: the care and treatment of service users must a) be appropriate, b) meet their needs, and c) reflect their preferences
- regulation 9 (3)(a) - person-centred care: the things which a registered person must do to comply with regulation 9 (1) include carrying out, collaboratively with the service user, an assessment of the needs and preferences for care and treatment of the service user
- regulation 10 (2) - dignity and respect: a registered person is required to comply with a) ensuring the privacy of the service user, b) supporting the autonomy, independence and involvement in the community or the service user and c) having due regard to any relevant protected characteristics of the service user.

1.4 CQC carries out assurance regarding visiting as part of their regulation of health and care settings. Although visiting is not explicitly mentioned in the current CQC regulations, it is considered best practice that visiting is not normally restricted, and that any restrictions should be reasonable, proportionate and time limited.

2. Purpose

2.1 **Rationale**

Visiting plays a crucial role in maintaining good health and wellbeing for both people living in care homes and patients attending hospitals, including mental health settings and hospices. The government are clear that visiting should be encouraged, supported and made as straightforward as possible to allow visitors to patients in hospital settings to maintain a meaningful connection with others and spend quality time with the people who are special in their lives.

2.2 **Principles**

The government recognises the contribution that visiting makes to the wellbeing and care of patients attending hospitals as well as the emotional wellbeing of their families. No patient should have to attend hospital on their own unless they choose to. References in this policy to hospital visitors therefore cover not only inpatient care but also the enabling of patients attending hospital for outpatient, emergency department and diagnostic services to be accompanied by someone if they need or wish to be.

2.3 **Scope**

This procedural document covers all those patients in ESHT in-patient settings and their families. It does not specifically cover Maternity and Children's services in depth, but the principles of the document are applicable and should be applied to these areas.

[1] Coronavirus » Living with COVID-19: Visiting healthcare inpatient settings principles (england.nhs.uk)
[2] Visiting in care homes, hospitals and hospices - GOV.UK (www.gov.uk)

3. Definitions

3.1 **Family**
This term is used in this document and can refer to relatives, next of kin or loved ones. Predominately it means those people most important to the patient.

3.2 **Virtual Visiting**
Virtual visiting is used where it is not possible to physically visit and utilises electronic devices to facilitate contact between a patient and their family.

4. Accountabilities and Responsibilities

4.1 **Chief Nurse and Director of Infection, Prevention and Control**
The Chief Nurse has the overarching responsibility for staff and family safety when visiting patients or attending ESHT premises.

4.2 **Chief of Staff**
The Chief of Staff has the overarching responsibility for patient experience.

4.3 **Divisional Assistant Directors of Nursing, Heads of Nursing and Ward Matrons/Operational Managers (Senior Nursing Team)**
This staff group are responsible for ensuring that the systems and processes in place are complied with correctly by ward/team staff and that visiting is available as per national guidance and legislation.

4.4 **Document Author**
The document author will:

- Ensure that the procedural document is approved, and the ratifying committee/group has evidence that the document has been developed in compliance with national guidance and with consultation of relevant staff group and feedback from our local population.
- Co-ordinate the development and review of the document
- Handover all associated documentation to any successor.

5. Procedures and Actions to Follow

5.1 **General Principles**

These are based on current guidance but will need to be reviewed following revised legislation.

- Local arrangements for visiting, including an advice leaflet for visitors, should be clearly communicated, e.g., on organisation websites and through social media.
- Anyone showing any symptoms of COVID-19 should not visit. This is essential for infection prevention and control.
- Anyone feeling unwell, should not visit.
- Where a face-to-face visit is not practical then virtual visits (see Appendix A for examples) should be supported and facilitated.
- Number of visitors at the bedside: Two visitors
- Visiting hours – 14.00 – 20.00 (this will vary for some high acuity areas e.g., Critical Care)
- No visitors are permitted for the first 24 hours post surgery unless agreed as an exception.
- Patients may be accompanied where appropriate and necessary to assist their communication and/or to meet their health, care, emotional, religious, or spiritual care needs.
- Booking appointments will no longer be needed.

5.2 **Face coverings:**
Visitors, parents, guardians, siblings may be asked to wear a mask/face covering following a local risk assessment, if prevalence of infection is high in the local population and in ESHT premises. In areas where infection is actively present and it is a high risk area, visitors, parents, guardians, siblings may be asked to wear a surgical facemask.

5.3 **Visiting hours**
Visiting hours will now primarily run from 2pm-8pm daily with an individualised approach where required.

5.4 **Areas for Consideration**

5.4.1 ***Carers of adult patients*** – When supporting an adult with cognitive impairment or additional vulnerabilities, where not being present would cause the patient to be distressed, visiting and caring support will be decided on a patient by patient basis.

5.4.2 ***End of life care*** – at ESHT, compassionate visiting is supported for those receiving end of life care. Extended or open visiting will be decided on a case by case basis by the Nurse in Charge.

5.4.3 ***Paediatrics*** - In the SSPAU at EDGH, an accompanying adult should be with the child at all times. On Kipling in-patient area there is no restriction on numbers or duration of visiting but overnight only one parent/carer is permitted.

5.4.4 ***Outpatients*** – Patients may be accompanied by a family member or friend.

5.4.5 *SCBU* - Visiting is permitted 24hrs a day for the parents/carers. Grand parents and siblings of the baby, from 8 am till 1pm and 3pm to 8pm, 2 at a time at the cot side. During busy periods visitors are booked with time slots to avoid overcrowding.

5.4.6 ***Safeguarding*** – Staff to be mindful of the privacy and dignity of all patients and to be vigilant to the possibility of visitors or patients using cameras/smart phones and advise accordingly.

5.4.7 ***Following surgery*** - No visitors unless agreed in exceptional circumstances for the first 24 hours post surgery. No more than 2 visitors (which includes young people under 16).

5.4.8 ***Critical Care*** – 13.00-19.00, 2 visitors at any time. Another set of 2 can visit later the same day.

6. Risk Assessments

6.1 Risk assessments are no longer required except in the event of an infection outbreak or any other unforeseen circumstances e.g., building works.

7. Virtual Visiting

Virtual visits are a mechanism during the pandemic that allowed patients to contact their families and vice versa when it was not possible to have a physical visit.

Families may also not be able to see the patient if they live far away and so you may be requested, or think it would be beneficial, to arrange a virtual visit.

Virtual visiting can take place using a number of different devices/options:

- Using a patient's own device to make calls/video calls

- Using patient bedside entertainment system TV/phone units to make calls to families.

7.1 **Patients' own Devices**
If the patient has their own device, then this can be used independently to contact their friends and family. If the patient cannot manage their own device and cannot enter their own details, then it is preferable for a Trust device to be used. With the Trust device a staff member can help and support where it is required to enable the virtual visit.

7.2 **Patient Bedside Entertainment System**
If the options above are not possible and the patient is in a bed with access to a patient bedside entertainment system unit, this can be used to make phone calls (unfortunately video calls are not possible on these units). Patients can make free outbound calls from the bedside terminal to all landline numbers starting with 01/02/03 and free mobile calls that are capped at 2 minutes but unrestricted to the number of times used. Any calls into these units are chargeable to the person making the call.

7.3 **Process for Setting up the Device**
It is not possible to use FaceTime, Skype or WhatsApp for virtual visits on a Trust device, only Zoom. The family have to set up the call as it is not possible for Trust staff to do this. If a Trust device is available, then instructions for set up can be found in Appendix A.

7.4 **Family Information**
An information leaflet has been developed to support families when their loved one is at the end of life. This will be available on the Trust extranet alongside a general patient information leaflet (Appendix B).

7.5 **End of Life Care**
Generally, when a patient is critically ill or dying, families tend to spend as much time as possible with their person, many holding a vigil until the person dies; needing the ability to say their goodbyes and let the person know they are loved/being thought of. Face to face visiting is therefore extremely important and should be facilitated. ESHT deliver end of life care in a variety of settings including the patient's own home.

8. Reasonable explanations and specific exceptions (in consultation by the Government) – *For information and consideration.*

8.1 The Department of Health and Social Care (DHSC) are consulting on introducing a legal requirement that a provider does not restrict visiting without a reasonable explanation, with the onus being on the provider to explain why the decision is reasonable, if asked by the CQC[3].

Alternatively, DHSC could introduce a legal requirement which states that providers can only restrict visiting if a specific exception applies, and regulations would set out what those exceptions might be. These exceptions would help to ensure that residents, staff and visitors remain safe, and to account for some practical considerations.

Health and care providers must follow public health guidance and advice on how to keep residents and staff safe and protected from anything that could cause them harm. Certain situations may arise where the protection against risks will outweigh other harms such as those caused by visiting restrictions. We would expect that, as a rule, end of life visiting would always be accommodated by providers, and therefore these exceptions may not apply.

[3] Visiting in care homes, hospitals and hospices - GOV.UK (www.gov.uk)

If an exception-based approach is applied, exceptions to the requirement that a provider does not restrict visiting (including accompanying those attending hospital) unless an exception applies could include the following situations as suggested by the consultation. They are provided in this policy as a guide until it is confirmed that the guidance will become legislated.

8.2 **If the resident or patient does not wish to receive a visitor**
A patient may not wish to receive a visitor due to feeling unwell or through personal choice, or if the patient lacks the mental capacity to determine if they should receive a visitor, a best interests decision not to receive a visitor may be made on their behalf. It is up to health and care providers to ensure that the person's wishes are respected by staff and potential visitors. If a person lacks capacity to make a decision about receiving a visitor, visits should still be enabled unless this is not in the person's best interests. In this situation, a best interests decision should be made and recorded in line with the best interest checklist in section 4 of the Mental Capacity Act 2005 Mental Capacity Act MCA. They would do this by considering all relevant circumstances, including the person's wishes and feelings, beliefs and values, the views of their family, and what the person would have wanted if they had the capacity to make the decision themselves.

8.3 **If a visitor is confirmed to have an infectious disease or is confirmed to be a contact of someone who has an infectious disease**
Visitors may be suffering from or carrying an infectious disease that would pose a threat to individuals in hospital. This is because some people receiving care are likely to have a higher risk of developing a severe illness from infectious diseases, and these settings tend to be enclosed settings where infection may spread quickly. A visitor may be denied access to hospital if they pose a known and immediate risk of spreading an infection which would pose a risk to the health and safety of individuals within the care setting or hospital.

8.4 **If the person being visited has an infectious disease or there is an outbreak in the hospital**
If a hospital patient has an infectious disease where there is a risk of transmission, this may put those who visit them at risk of contracting that disease, as well as spreading it to the wider community. If this would pose a significant public health risk, there may be circumstances where the hospital may wish to consider some limited restrictions on visiting. In this situation they should be able to explain the reasons for any visiting restrictions, ensuring that these are proportionate to the risks and that they have considered ways to maintain visiting, such as ensuring that a minimum of one visitor is still allowed.

8.5 **If a visitor is a risk to the physical and/or mental health and wellbeing of residents, patients and/or staff**
Examples of this could include a visitor who:

- has been physically or verbally abusive to staff or patients in the hospital setting
- has stolen or damaged property or been financially abusive to a patient
- is behaving erratically or is under the influence of alcohol or drugs
- is supplying a resident or patient with drugs
- is a visitor refusing to follow infection prevention and control processes put in place by the health or care setting such as practicing hand hygiene or wearing appropriate PPE

8.6 Providers must have robust procedures to prevent people using the service from being abused by staff or other people, including visitors, and to protect the health and wellbeing of service users, staff and other visitors. Where an individual lacks the capacity to decide if they should have contact with a named individual a best interests decision should be made and recorded in line with the best interest checklist in section 4 of the Mental Capacity Act by considering all relevant circumstances, including the person's wishes and feelings,

beliefs and values, the views of their family, and what the person would have wanted if they had the capacity to make the decision themselves. As laid out in the Mental Capacity Act code of practice, it may be appropriate to seek a decision from the Court of Protection if it is suspected that a person who lacks capacity to make decisions to protect themselves is at risk of harm or abuse from a named individual.

8.7 **If a patient's treatment plan does not include visiting, in order to aid their recovery**
In some circumstances a patient's treatment plan may include not having visitors for a short amount of time, for example in a rehabilitation facility as visitors may put their recovery at risk. In this situation the restrictions should be proportionate to the risk posed to the patient by receiving visitors. *In ESHT visitors are not permitted until after a 24 hour period for patients who have had surgery.*

8.8 **If a visitor is requesting to visit at a time outside standard, reasonable, visiting hours (such as late at night or early in the morning)**
An individual may wish to visit someone at a time which does not fit standard, reasonable, visiting hours. This may be disruptive to the person receiving the visit, or to other residents or patients. The length of a visit may also be taken into consideration as it may not be appropriate for a provider to accommodate a visitor for long periods of time such as a whole day. Providers would need to be able to demonstrate what made a certain time unacceptable, for example if it interfered with their ability to provide necessary care or was disruptive to other residents or patients. If this exception was included, we would expect that providers would offer alternative visiting times that are convenient, where visitors cannot make normal visiting hours (if applicable) and that consideration would be given to how far relatives may have to travel to visit if, for example, someone has been placed 'out of area'. It is worth noting that what constitutes 'reasonable visiting hours' will differ across health and care settings and would need to be established based on the setting.

8.9 **If there is an unforeseen emergency occurring in the hospital and visiting cannot be safely accommodated**
There may be times where it is unsuitable for anyone, including visitors, to go to certain parts of a hospital or an unforeseen circumstance or emergency requires closure of a care setting or hospital. These could include, but are not limited to, a fire being identified and dealt with, an ongoing medical emergency, a resident or patient behaving violently or police involvement.

8.10 **If the hospital does not have the capacity to receive a large number of visitors**
If the hospital only has capacity for a certain number of people to be in the building or available space, then by default, the setting would be unable to accommodate a large number of people, including visitors. For example, if it would be impractical for a single patient to receive a large number of friends or family at one time.

9. Equality and Human Rights Statement

9.1 This policy aims to treat people equally in terms of access to communication whilst maintaining an individualised and personalised approach, patient privacy and dignity. It is ESHT's aim to eliminate unlawful discrimination, harassment and victimisation. People must be treated the same whether they share a protected characteristic or not. Patients must be treated with fairness, respect, equality, dignity and autonomy. This policy has considered and identified a negative impact and inequality on people who have suspected or confirmed COVID19 infection. Equal opportunity for effective communication methods will be given to all but within the confines of this policy to ensure, as much as possible, the emotional wellbeing of all patients and their families (Appendix C).

10. Monitoring Compliance with the Document

Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Outbreaks	Lisa Redmond	Operational Monitoring of outbreaks	As they occur	Trust Infection, Prevention and Control Group	Relevant Division/WPSS	Divisional Clinical Governance Groups

Appendix A: Setting Up Zoom Account for Sharing with Families

ESHT has identified Zoom as the safest way to undertake video calls as part of our virtual visiting scheme, as it ensures the devices used within the Trust do not hold any patient or family identifiable information.

Before requesting a 'virtual visit' ensure you have a Zoom account set up. If you do not have a Zoom account, it's free and easy to set up, either on a computer or a mobile device. There is an app available in both apple store and google play.

Once you have a Zoom account then arrange a time for the visit and send either the patient or the palliative care team (esht.palliativecare@nhs.net) your meeting ID and password. Please note virtual visits are for all patients, just being facilitated through the palliative care team as a central point of contact.

On a computer:

1. Go to zoom.us
2. Click on the 'sign up, it's free box'
3. Add a date of birth (the information is not stored)
4. Add your email address, they will send you a link to confirm your email
5. Once this has been confirmed, you will be asked to set up your account
6. You might be asked if you are signing up on behalf of a school, click no
7. Then complete your details, including setting a password for your account
8. Skip inviting others
9. Click on I'm not a robot and if any pop up, follow instructions
10. You should then be taken to your profile; on here you will see your personal meeting ID
11. To arrange a meeting, contact the Supportive and Palliative care team to arrange a suitable time for the meeting.
12. At the arranged time, log into Zoom, click on 'Meetings' and then 'Personal Meeting Room', you can then click on 'start meeting'.
13. The meeting box will then open; anyone joining the meeting will automatically go into the 'waiting room', you will get a message telling you 'virtual visiting tablet' has entered the meeting room – click on 'admit'.
14. If there is no video from people joining your meeting, click on the … in the corner of the participant screen and click ask to start video
15. At the end of the meeting, click 'End' and then 'end meeting for all'.

How to Join a Scheduled Zoom call

1. Ensure family requesting visit have sent you or the patient their meeting ID and password
2. Open the Zoom app
3. Click on Join a Meeting
4. Add meeting password
5. Click on 'join meeting'
6. Add meeting password
7. A new box will open telling you that you are in the hosts personal meeting room, waiting for the host to start the meeting
8. Touch the top of the screen for Zoom controls, click on 'start video'
9. At the end of the meeting, click on End.

Appendix B: Family Information Leaflet

Care at the End of Life – A leaflet for families and friends

Please be aware that this is updated advice during the COVID-19 outbreak

Introduction

This leaflet is for the family and for close friends of someone who is nearing the end of their life in hospital. It includes information on how the person who is dying will be cared for and how you, their family and friends will be supported.

All our staff are committed to providing the best possible care to the person who is dying, respecting their privacy, dignity, choices and confidentiality.

Visiting

At East Sussex Healthcare NHS Trust we have always tried to support patients nearing end of life to be with their family or friends, if this is their wish. We know that this is precious time. However we are currently living in exceptional circumstances. We will continue to support visiting where possible for patients nearing end of life, but ask that this is now reduced to one family member (or friend) each day. We ask that you confirm visiting arrangements with the relevant Ward Matron.

There may be times when visiting will need to be suspended for safety reasons. We know that this will be so hard for so many families. We know that this decision brings great responsibility, but our staff will care for your loved one with compassion and respect at all times. Our staff will be with your loved one for you. We will share your messages and we will do our very best to support you to communicate and be with your loved one through virtual visiting on mobile devices.

Sometimes a person can deteriorate unexpectantly. The ward staff will do their best to contact you, day or night, if that is your wish.

The Last Days of Life

When a person is dying it is important that we focus our care on their comfort and dignity. The doctors and nurses will assess the individual needs of the dying person and identify the main priorities for their care, ensuring they are supported and kept comfortable. It is difficult to predict exactly what will happen or how fast a person will deteriorate, but the needs of the dying person will be reviewed regularly.

In the last days the dying person is likely to become weaker, sleep more and require extra care from nursing staff. Their need for food and fluids can reduce. Fluids given in a drip may no longer be appropriate as this may increase symptoms. Moistening lips and regular mouth care can maintain comfort for the dying person.

What should I do before I come into hospital?

Where will the procedure take place?
The person who is dying may no longer be able to take their tablets. If they require medication to keep them comfortable, then it can be given by injection or through a small pump known as a syringe driver.

Sometimes a person's breathing changes as their condition deteriorates. Occasionally their breathing can become noisy. This is usually not distressing to the person who is dying, but changing their position or giving medication might help.

For most people, the final moments of life are peaceful, with a gradual slowing and irregularity of breathing before it ceases.

What Can you do to Help?

Please do let the nursing staff know what is important to your loved one. If possible share a special picture or verse or words of comfort with the staff.

You can send a personal message using a dedicated email: esht.patientmailbox@nhs.net

If your loved one has a smart phone please ensure they have the charger and let the ward team know so that they can support you with keeping in touch. We will also try to support you with keeping in touch with 'virtual visiting', using an IPad to make a video call. Please ask the ward team for more information.

When a Person Dies

If you have not been able to visit due to visiting restrictions or because you are in self isolation, the doctor or nurse will contact you by telephone. If you do not wish to be contacted in the night, please do let the ward team know this. After a short while a member of the hospital team will verify that the person has died. The nursing staff will then attend to the personal needs of the person who has died, before they are transferred to the hospital mortuary.

Unfortunately during this COVID-19 outbreak it will not be possible to support a visit to see your loved one after they have died, through the Bereavement Office. Please check with your Funeral Director if a visit will be possible, but please be aware that guidance from Public Health England may change. You will be asked to ring the Bereavement Office after 10am on the first working day following the death, when a Bereavement Officer will give you advice and support about the next practical steps to be taken regarding registration and funeral arrangements.

Funeral Directors can be contacted immediately following a death, who will support and advise you of their own procedural arrangements during this time. During this COVID-19 outbreak the death registration procedure has changed to keep everyone safe. The Bereavement Office will electronically send the Medical Certificate completed by the doctor to the East Sussex Registration Service.

After you have been advised to do so by a Bereavement Officer, ring the central Registry Office number on 0345 6080198 to make an appointment to register the death. You will not be attending in person but a Registrar will call you to complete this by phone and the

Death Certificates will be posted to you. When you ring for the appointment the Registrar will guide you through this process in more detail. Unfortunately during this COVID-19 outbreak families are not being invited in to the hospital to see a Bereavement Officer; however they will help and support you in any way they can on the phone following the death of your loved one.

This is an extremely difficult and anxious time so please do not hesitate to contact the service with any questions or concerns you may have. If we are unable to answer anything, the correct information or person will be found for you whenever possible.

Helpful contacts

- The ward team Tel: 0300 131 4500 hospital switchboard and then ask for the relevant ward
- Hospital Chaplaincy Team
  Tel: 0300 131 4500 hospital switchboard and ask for the Duty Chaplain
- Supportive and Palliative Care Team:
  Tel: EDGH[redacted]
  Tel: Conquest[redacted]
- Bereavement Office:
  Tel: 0300 131 4500 hospital switchboard and ask for the office at the relevant hospital.

Your comments

We are always interested to hear your views about our leaflets. If you have any comments, please contact the Patient Experience Team – Tel: 0300 131 4784 or by email at: esh-tr.patientexperience@nhs.net

Hand hygiene

The Trust is committed to maintaining a clean, safe environment. Hand hygiene is very important in controlling infection. Alcohol gel is widely available at the patient bedside for staff use and at the entrance of each clinical area for visitors to clean their hands before and after entering.

Other formats

If you require any of the Trust leaflets in alternative formats, such as large print or alternative languages, please contact the Equality and Human Rights Department.

Tel: 0300 131 4434 Email: esh-tr.AccessibleInformation@nhs.net

After reading this information are there any questions you would like to ask? Please list below and ask your nurse or doctor.

_____

_____

_____

_____

Reference

The following clinicians have been consulted and agreed this patient information:
Jayne Winter (Macmillan Lead Nurse Supportive and Palliative Care Team)

The directorate group that have agreed this patient information leaflet:

Macmillan Lead Nurse Supportive and Palliative Care Team

Next review date:	October 2024
Responsible clinician/author:	Jayne Winter (Macmillan Lead Nurse Supportive and Palliative Care Team)

Appendix C: EIA Form

Equality Impact Assessment Form

1. Cover Sheet

Please refer to the accompanying guidance document when completing this form.

Strategy, policy or service name	Visiting Policy (Supporting patients and families to safely communicate)
Date of completion	July2023
Name of the person(s) completing this form	Lisa Forward
Brief description of the aims of the Strategy/ Policy/ Service	Describes policy and procedures for staff to follow to facilitate visitors
Which Department owns the strategy/ policy/ function	Clinical Advisory Group
Version number	2
Pre Equality analysis considerations	Ensuring there are no visitors affected without rationale
Who will be affected by this work? **E.g. staff, patients, service users, partner organisations etc.**	Staff, patients, families, carers
Review date	June 2026
If negative impacts have been identified that you need support mitigating please escalate to the appropriate leader in your directorate and contact the EDHR team for further discussion.	N/A
Have you sent the final copy to the EDHR Team?	Choose an item.

2. EIA Analysis

<table>
<tr><td></td><td>☺ 😐 ☹</td><td>Evidence:</td></tr>
<tr><td>Will the proposal impact the safety of patients', carers' visitors and/or staff?

Safe: Protected from abuse and avoidable harm.</td><td>Choose:
Positive</td><td>This policy ensures the safety of all visitors where situations occurs that may put them at risk e.g. during infection outbreaks.</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td>Choose:
Neutral</td><td><table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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</table></td></tr>
<tr><td>Is the proposal of change effective?

Effective: Peoples care, treatment and support achieves good outcomes, That staff are enabled to work in an inclusive environment. That the changes are made on the best available evidence for all involved with due regards across all 9 protected Characteristics</td><td></td><td>The policy provide guidance to support staff in knowing in what situations visiting may be restricted and also in what situations there may need to be flexible solutions e.g. EoLC or virtual visiting.</td></tr>
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</table>
</td></tr>
<tr><td>What impact will this have on people receiving a positive experience of care?</td><td>Choose:
Positive</td><td>The is flexibility within the policy to support patients and staff in particular situations e.g. patients with disabilities, particular needs, EoLC.</td></tr>
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</table>
</td></tr>
<tr><td>Does the proposal impact on the responsiveness to people's needs?</td><td>Choose:
Positive</td><td>Where necessary, responses on individual needs requirements can be arranged to support patients e.g. virtual visiting or the ability for patients to refuse visitors.</td></tr>
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<table>
<tr><td>What considerations have been put in place to consider the organisations approach on improving equality and diversity in the workforce and leadership?</td><td>Choose:
Positive
Neutral
Negative</td><td>This policy does not have a focus on workforce or leadership.</td></tr>
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</td></tr>
<tr><td colspan="3">Access
Could the proposal impact positively or negatively on any of the following:</td></tr>
<tr><td>• Patient Choice</td><td>Choose:
Positive</td><td>This policy provides guidance to staff on how to support patients with any preferences they may have. Patients can also use their own mobile devices or patients can use hospital equipment.</td></tr>
<tr><td>• Access</td><td>Choose:
Positive</td><td>Generally there is a long period of time each day for visiting. If this is impacted upon, there are alternatives or flexibility to allow patients to access their families or carers.</td></tr>
<tr><td>• Integration</td><td>Choose:
Positive
Neutral
Negative</td><td>N/A</td></tr>
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Engagement and Involvement How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:	Choose: Neutral	
Equality Consideration *Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)*		<table><tr><td>**Race**</td><td>**Gender**</td><td>**Sexual orientation**</td><td>**Age**</td><td>**Disability & carers**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>**Gender reassignment**</td><td>**Marriage & Civil Partnership**</td><td>**Religion and faith**</td><td>**Maternity & Pregnancy**</td><td>**Social economic**</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>
Duty of Equality Use the space below to provide more detail where you have identified how your proposal of change will impact.	Choose: Positive	There is an information leaflet to support visiting and this is also available in alternative formats e.g. different languages, larger print.
Characteristic	**Rating** ☺ ☹ 😐	**Description**
Race	Choose: Neutral	Policy applies to all patients and visitors regardless of any characteristic.
Age	Choose: Neutral	Policy applies to all patients and visitors regardless of any characteristic.
Disability and Carers	Choose: Neutral	Policy applies to all patients and visitors regardless of any characteristic.
Religion or belief	Choose: Neutral	Policy applies to all patients and visitors regardless of any characteristic.

Sex	Choose: Neutral	Policy applies to all patients and visitors regardless of any characteristic.
Sexual orientation	Choose: Neutral	Policy applies to all patients and visitors regardless of any characteristic.
Gender re-assignment	Choose: Neutral	Policy applies to all patients and visitors regardless of any characteristic.
Pregnancy and maternity	Choose: Neutral	Visiting for Maternity areas in not described in detail but the principles apply. These areas may have more information and be specific to individuals situation.
Marriage and civil partnership	Choose: Neutral	Policy applies to all patients and visitors regardless of any characteristic.

Human Rights

Please look at the table below to consider if your proposal of change may potentially conflict with the Human Right Act 1998

Articles		Y/N
A2	Right to life	**No**
A3	Prohibition of torture, inhuman or degrading treatment	**No**
A4	Prohibition of slavery and forced labour	**No**
A5	Right to liberty and security	**N**
A6 &7	Rights to a fair trial; and no punishment without law	**N**
A8	Right to respect for private and family life, home and correspondence	**N**
A9	Freedom of thought, conscience and religion	**N**
A10	Freedom of expression	**N**
A11	Freedom of assembly and association	**N**
A12	Right to marry and found a family	**N**
Protocols		
P1.A1	Protection of property	**N**
P1.A2	Right to education	**N**
P1.A3	Right to free elections	**N**

A Due Regard, Equality and Human Rights Analysis form must be completed for all procedural documents used by East Sussex Healthcare NHS Trust. Guidance for the form can be found on the Equality and Diversity Extranet page.