Royal Devon University Healthcare
NHS Foundation Trust

Trust Policies

Reference Number: RDF2204-24
Date of Response: 05/03/24

Further to your Freedom of Information Act request, please find the Trust's response(s) below:

Please can you send me the following:

1. *Discharge Policy (with reference to Care Plans)*
2. *Violence and Aggression Policy*
3. *Safeguarding Policy*
4. *Complaints Policy*
5. *Data Protection Policy (with reference to challenging/amending information held in patient records)*
6. *Documentation about the authorisation process for funding of patient aftercare reablement*

   Answer: Please see documents attached with email.

   Staff names and contact details have been redacted as disclosure would contravene the Data Protection Act 2018 and the Trust therefore applies an exemption under Section 40 (2) - Personal Information of the Freedom of Information Act 2000 and Section 10 of the Data Protection Act 2018.

7. *Please include any related documents referred to in any requested policies.*

   Answer: The Trust has considered your request, however to obtain, check, gain release approval and provide you with the 80+ documents requested would exceed the appropriate cost limit as set out in Section 12 (1) of the Freedom of Information Act 2000 and is therefore exempt.

   Under the Freedom of Information Act 2000 Section 12 (1) and defined in the Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulations 2004, a public authority is not obliged to comply with a request for information if it estimates that the cost of complying would exceed the appropriate limit. The limit of £450 represents the estimated cost of one person spending two and a half days in determining whether the Trust holds the information, locating, retrieving and extracting that information.

   a. *and the sign off (adoption) dates and who signed the documents.*

      Answer: Please see table overleaf:

8. *Please can you also tell me how to make a limited data protection subject access request.*

   Answer: Please click link below:

   https://www.royaldevon.nhs.uk/about-us/information-governance/access-your-personal-data-health-records/

Policy	Doc attached	Adoption Date	Sign off
1. Discharge Policy (with reference to Care Plans)	Discharge-and-transfer-policy-v.5.3.pdf	October 2007	Safety and Risk Committee
2. Violence and Aggression Policy	Violence-Aggression-Policy-v5.0-FINAL - Northern Services.pdf Violence-Prevention-and-Reduction-Policy-v8 - Eastern Services.pdf	April 2015 July 2004	Health and Safety Group Health and Safety Group
3. Safeguarding Policy	Safeguarding-Adults-Policy-v1.2.pdf	January 2024	Safeguarding Committee
4. Complaints Policy	Complaints-policy-27.07.pdf	March 2023	Patient Experience Operational Group
5. Data Protection Policy (with reference to challenging/amending information held in patient records)	Data-protection-policy-v.1.0.pdf	May 2019	Information Governance Steering Group
6. Documentation about the authorisation process for funding of patient aftercare reablement	* Please see *below:	N/A	N/A

*The Trust can confirm that it holds information that you have requested. This information is exempt under Section 21 of the Freedom of Information Act because it is reasonably accessible to you. The information you requested can be accessed via the following link: https://www.nhs.uk/conditions/social-care-and-support-guide/care-after-a-hospital-stay/care-after-illness-or-hospital-discharge-reablement/#:~:text=Reablement%20is%20a%20type%20of,able%20to%20cope%20at%20home.

Discharge and Transfer Policy

Post holder responsible for Procedural Document	Divisional Director of Operations
Author of Policy	[redacted] Discharge Lead
Division/ Department responsible for Procedural Document	Operations Support Unit
Contact details	Ext [redacted]
Date of original document	October 2007
Impact Assessment performed	**Yes**/ No
Ratifying body and date ratified	Safety and Risk Committee: 25 October 2019
Review date	April 2024 (every 5 years)
Expiry date	October 2024
Date document becomes live	28 October 2019 (v5.3-8 June 2021)

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience		Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute services	
CQC Fundamental Standards - Regulation:		Infection Control	
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		Status: Final	
Version	Date	Author	Reason
1.0	October 2007		New Policy
2.0	January 2010		Routine Revision
3.0	June 2014	Head of Access & Patient Flow	Revised Policy (replacing December 2013 Version)
4.0	June 2016	Discharge Lead	Revised Policy (replacing June 2014 version)
5.0	October 2019	Discharge Lead	Revised Policy (replacing June 2016 version)
5.1	August 2020	Assistant Director of Nursing	Addition of Self Discharge Against Medical Advice appendix 5. Addition of 20.5
5.2	August 2020	Operations Admin	Amended page numbers, removed old self discharge form and updated contents page
5.3	May 2021	Discharge Lead	Hyperlinks updated and added for Safeguarding Adults Policy and the Domestic Abuse Affecting Patients Policy

Associated Trust Policies/ Procedural documents:	Medicines Management Policy Patient Transfer System SOP SPOA Referrals & Information Safeguarding Adults Policy Infection Prevention & Control Policy Incident Reporting, Analysing, Investigating and Learning Policy and Procedures Patient Transport Booking System Moving and Handling (including Bariatric / Plus Size patients) Policy Assessing Mental Capacity Policy Domestic Abuse Affecting Patients Policy
Key Words	Simple Discharge; Discharge Planning; Leaving Hospital; Going Home Policy; Patient discharge; Interagency relations; Patient transport services; Pharmacy; Occupational therapy; Physiotherapy; MDT; community care teams; Integrated Services; Social services; Medically safe discharge
In consultation with and date: Governance Managers (circulated by email) – August 2019 Assistant Directors of Nursing – August 2019 Senior Nurses (circulated by email) – August 2019 Cluster Managers (circulated by email) – August 2019 General Managers (circulated by email) – August 2019 Quality Assurance – 15/10/19 Safety and Risk Committee – TBC	

Contact for Review:	Trust Discharge Lead
Executive Lead Signature: *(Applicable only to Trust Strategies & Policies)*	[redacted] Chief Executive

CONTENTS

KEY POINTS OF THIS POLICY

- The purpose of this policy is to ensure co-ordinated safe and timely discharge to all adult in-patients from the Trust to other healthcare organisations, home or community care.

- To facilitate a smooth discharge from care in hospital to care in the community, a discharge plan must be well defined, prepared and agreed with each individual patient.

- Prompt and efficient discharge of patients from acute hospital beds to the next level of care plays a vital part in ensuring capacity is available for patients needing to access acute care beds.

- To allow sufficient time for suitable and safe arrangements to be made, discharge planning should begin on admission, or at pre-admission clinics, with a predicted date of discharge being identified within 24 hours of admission and communicated to patients and, if appropriate, their carers/relatives.

- The purpose of discharge planning is to ensure that patients are discharged in a timely fashion to clinically appropriate and agreed environments. Multi-disciplinary assessment of individual patient needs is the key factor in planning and co-ordinating discharge care.

- Reducing both individuals' length of stay in hospital and delays in discharge results in improved health related outcomes and quality of care. Such improvements requires a close working partnership with other organisations, including primary care, hospital services, adult social care, voluntary services and the private sector.

1. INTRODUCTION

1.1 The Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust) recognises that to facilitate a smooth discharge from care in hospital to care in the community, a discharge plan must be well defined, prepared and agreed with each individual patient. To allow sufficient time for suitable and safe arrangements to be made, discharge planning should begin on admission, or at pre-admission clinics, with a predicted date of discharge being identified within 24 hours of admission and communicated to patients and, if appropriate, their carers/relatives.

The planning of discharge care is endorsed by the Government and NICE and outlined in a series of publications (Ready to Go DoH, 2010) (Refer to Discharge Directory).
Prompt and efficient discharge of patients from acute hospital beds to the next level of care plays a vital part in ensuring capacity is available for patients needing to access acute care beds.

1.2 The purpose of discharge planning is to ensure that patients are discharged in a timely fashion to clinically appropriate and agreed environments. Multi-disciplinary assessment of individual patient needs is the key factor in planning and co-ordinating discharge care.

1.3 This document defines the aims of co-ordinated, safe and timely discharge, the rationale for achieving this, the scope of the policy, the responsibilities of individuals and teams, and the operational procedures, systems and documentation involved.

1.4 This policy has been produced to provide a clear process for offering choice within reasonable parameters such that individuals do not remain in an acute hospital bed for inappropriate lengths of time whilst they are fit for discharge, at the detriment to themselves and other individuals needing hospital beds.

1.5 Health and social care communities work together to ensure appropriate care is available to avoid unnecessary admissions and provide for timely discharge or transfer. There is a framework for integrated multidisciplinary and multi-agency team working to ensure a co-ordinated management of patient discharge and transfer planning processes.

1.6 **Failure to comply with this policy could result in disciplinary action.**

2. PURPOSE

2.1 The purpose of this policy is to ensure co-ordinated safe and timely discharge to all adult in-patients from the Trust to other healthcare organisations, home or community care.

2.2 Reducing both individuals' length of stay in hospital and delays in discharge results in improved health related outcomes and quality of care. Such improvements requires a close working partnership with other organisations, including primary care, hospital services, adult social care, voluntary services and the private sector.

2.3 The purpose of a properly planned discharge from an acute hospital bed is to ensure that an individual can function as independently as possible in a safe and supported environment with no or minimal deterioration in quality of life.

2.4 To ensure that patients are discharged safely to an appropriate destination that meets the needs of the patient, paying particular attention to patients deemed vulnerable who may be less able than others to voice their wishes and any concerns. These groups include people with learning disabilities, mental health problems or dementia,

victims of neglect or of sexual or domestic violence, and those people who are particularly frail or nearing the end of their life.

2.5 To achieve effective discharge through good communication between professionals, whether verbal or written.

2.6 To ensure that multidisciplinary discussions are timely and robust.

2.7 To ensure that all risks relating to the discharge of a patient are identified and discussed so that appropriate management plans can be put into place.

2.8 To ensure that appropriate documentation is completed throughout the discharge process.

2.9 To set out the process requirements and staff responsibilities to support well-organised, safe and timely discharge for all patients.

2.10 To fully involve patients and their carers/relatives in the discharge process and ensure that patients receive appropriate assessment, planning and information about their discharge and after care.

2.11 This policy applies to all adult in-patients being discharged / transferred from services provided by the Trust. This includes internal transfers as well as external transfers to other care providers.

2.12 The policy does not apply to children's services or maternity services.

3. DEFINITIONS

3.1 **Discharge**

The process whereby a person is discharged from an NHS trust providing acute, community or mental health & learning disability services or independent sector providers of NHS care. Hospital discharge should be viewed as a process rather than an event.

3.2 **Simple Discharge**

Patients with simple discharge needs make up at least 80% of all discharges (DoH, 2010) NHS Choices 2013. They are defined as patients who:

- Return to their usual place of residence.
- Do not require a significant change in support offered to the patient or their carer in the community.
- Where on-going care/support needs or discharge destination are not in dispute.

Time in hospital does not determine whether a patient has simple discharge needs. The key criterion is the level of on-going care required.

3.3 **Complex Discharge**

The remaining patients in hospital who have more complex needs (approximately 20%) require referral for assessment by other members of the Multi-Disciplinary Team (MDT).

Complex discharges relate to patients:

- Who will be discharged home or to a carers home, or to intermediate care, or to a nursing or residential home, and
- Who have complex on-going health and/or social care needs which require detailed assessment, planning, and delivery by the multi-disciplinary team and multi-agency working, and whose length of stay is more difficult to predict.

- Where a discharge deviates from the normal discharge pathway and requires complex co-ordination of services to enable safe discharge.

3.4 **Predicted Date of Discharge (PDD)**
A target discharge date by which time it is expected/predicted that the individual should be fit/stable, ready and safe to be discharged. All agencies will apply the discharge process simultaneously to ensure the discharge occurs on the target date.

3.5 **Medically optimised for Discharge**
The patient no longer has the capacity to benefit from on-going acute hospital-based inpatient services within an acute setting and where:

- On-going care needs have been agreed and can be met in another setting, home or through primary, community, intermediate care or adult social care.
- On-going care needs can be met more appropriately in a secondary or community care setting closer to the patient's home.
- Additional tests and interventions can be carried out in an outpatient or ambulatory setting.

3.6 **Self – Discharge**
Where an individual discharges themselves against medical advice (see Self-Discharge Form).

3.7 **Transfer**
The process whereby a person is moved between clinical areas/departments on a temporary or permanent basis within the organisation; or as a result of the decision to transfer the responsibility for care and support to another organisation.

3.8 **Internal Transfers**
These are formal general ward and department transfers where a new base ward or department will be established and care will be handed over from one clinical team to another (this does not include transfers to community hospitals but does include the Mardon Neuro-Rehabilitation Centre).

3.9 **External Transfers**
These are formal care provider to care provider transfers of care and include community hospitals and care homes.

3.10 **Patient Transfer System (PTS)**
This is a web based electronic database application and is the principle tool for the maintenance and monitoring of the SPoA/Patient Transfer waiting list, that Ward Whiteboard SPoA referrals are sent to and monitored from.

3.11 **'To Take Out' Medicines (TTOs)**
Prescribed medicines which the patient takes home with them when they leave hospital.

3.12 **Urgent Community Response (UCR)**
A joint health and social care service providing support to people in their own homes in times of crisis, to avoid unnecessary admissions to hospital and facilitate discharges home from hospital.

3.13 **Social Care Reablement (SCR)**
Provides short term support to people who have recently had a period of illness or injury to help them regain confidence and learn, or relearn skills such as washing, dressing and meal preparation and regain a level of independence.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 The **Chief Nurse** has overall executive responsibility for patient discharge.

4.2 The **Named Consultant** in charge of a patient's care who has overall responsibility to ensure the patient is stable and safe for discharge and ensuring the Discharge Summary is written.

4.3 The **Assistant Director of Nursing (ADN)** has overall responsibility for monitoring compliance with the Discharge Policy within their division.

4.4 The **Senior Nurse** has overall responsibility for monitoring the discharge process within their areas of speciality.

4.5 The **Lead Nurse/ Head of Patient Flow** has overall responsibility for ensuring adherence to this policy and for escalation of any capacity pressures to the appropriate specialty or clinical division.

4.6 The **Discharge Lead** has overall responsibility for:

- Overseeing safe and effective discharge planning throughout the Trust.
- Ensuring patients are discharged from the Trust safely and as far as possible, in line with their predicted discharge date (PDD).
- Monitoring discharges, providing advice and training to the organization in regard to discharge systems and processes.
- Providing specialist advice, supporting staff acting as an expert for patient transfers for MDT and ward staff, including signposting to other specialist services.
- Acting as a point of contact for colleagues within community hospitals, primary care, social services and voluntary agencies in relation to any concerns related to the hospitals discharge procedure and process.

4.7 The **Operations System Manager** has overall responsibility for:

- Monitoring, reporting and recording on the transference of patients from the Trust to community hospitals, intermediate care facilities, other onward care settings, or discharge home with packages of care.
- Ensuring that information regarding the Patient Transfer System waiting lists, transfers and delays, are accurately recorded, monitored and reported on.
- Managing the collation, and submission of national Delayed Transfers of Care (DTOC) submissions.
- Leading development of the Patient Transfer System.

4.8 The **Medical Team** has overall responsibility for:

- Providing a PDD to patient/family/carer post ward round. Any change to this date is agreed with the Consultant or senior member of their team.
- Working with the Multi-Disciplinary Team to agree and manage a discharge plan for the patient.
- Prescribing TTOs within 24 hours prior to the anticipated discharge date.
- Documenting the PDD in the medical notes.
- Documenting that the patient is 'medically fit for discharge' or 'no longer requires an acute hospital bed'.
- Ensuring that the Discharge Summary is completed prior to discharge.

4.9 The **Matron** has overall responsibility for:

- Ensuring that all patients have a PDD detailed on the Ward Whiteboard, recorded in patient notes, and that this date has been communicated to the patient, relatives/carer, as appropriate.

- Ensuring that systems are in place so that patient discharge is co-ordinated and progresses according to plan.
- Ensuring that information required to plan and manage patient discharges is gathered, and recorded accurately, especially in respect of conversations with the patient, their family and/or carers: including the date and times of those conversations.
- Continuously monitoring the discharge progress of all patients and, if necessary, ensuring positive action is taken to expedite discharges for those who are medically fit and have exceeded their PDD.
- Reviewing and escalating any delays to patient progress.

4.10 The **Registered Nurse** has overall responsibility for:

- Ensuring discharge planning commences within 24 hours of admission and that progress is appropriate to achieve the PDD.
- Ensuring that patient and relatives / carers are fully involved in the discharge planning process, their needs and wishes are taken into account and they have at least 24 hours notices of the discharge date, whenever possible.
- Ensuring that, for patients with complex needs, a referral to the Single Point of Access (SPoA) is made as early as possible. (SPoA Referral)
- Ensuring the discharge checklist is utilised in conjunction with discharge planning and that prompt referrals are made to relevant agencies using the appropriate referral criteria and documentation (Refer to Discharge Checklist).
- Ordering patient's medication 24 hours before the discharge.
- Organising transport via the Patient Transport Booking System for those who meet the entitlement for transport.
- Ensuring that transport arrangements are made with any pertinent information regarding the patient's condition given to the ambulance service transporting patients. (e.g. Treatment Escalation Plan (TEP) status, infections, issues regarding transferring, manual handling).
- Ensuring that the discharge address is confirmed and checked as correct, including post code, and that the patient can access their destination address e.g. they have a key.
- Contacting the receiving hospital, care home or social care facility (or community nurse team. If the patient is returning home to complete a Community Nursing Services Referrals) prior to discharge from the ward, notifying of any known infection and any current infection control practices in place e.g. antibiotic therapy, dressing regime, barrier nursing.
- Ensuring the patient has the necessary medication, dressings and relevant information about post discharge care.
- Ensuring all arrangements and referrals in relation to discharge planning are clearly documented, signed and dated within the discharge planning/checklist documentation.

4.11 The **Multi- Disciplinary Team (MDT)** has overall responsibility for:

(MDT includes all professions relevant to an individual patient to include clinicians, nurses, allied health professionals, specialist nurses/services, social care workers and voluntary workers.)

- Timely and appropriate discharge planning;
- Referrals to other professionals, taking into account the estimated date of discharge, and recognising relevant legislation.
- Planning and instigation of diagnostic tests and other interventions to avoid delays in treatment and discharge.
- Reviewing the patient's response to treatment and their condition daily.
- Ensuring that any equipment required to support the patient following discharge has been assessed for suitability. Where this is not practicable, a robust plan is in place to ensure such assessments are undertaken on arrival at the discharge destination.

- Ensuring that informal carers (e.g. family members who are providing care) have sufficient information and are safe to undertake the care.
- Initiating the timely completion the discharge checklist/plan.
- Ensuring that, where there is a change to the patients moving and handling needs, a community moving and handling plan is handed over to the team that will be continuing the patient's care. Where this has not been possible, the patient's most recent hospital moving and handling plan should be sent instead.

4.12 The **Pharmacists/Pharmacy Technicians** have overall responsibility for:

- Medication management both as a source of medicines information and practical guidance for staff, patients and their relative/carer(s) in the preparation for discharge.
- Pro-actively planning medication on discharge from the point of admission. Confirming the medication history/ associated adherence, documenting this information and ensuring that the TTO is completed as far ahead of the expected date and time of discharge as is clinically appropriate.

4.13 The **Single Point of Access (SPoA)** has overall responsibility for:

- Providing specialist advice and support to wards and MDTs on complex hospital discharges.
- Acting as a point of contact for colleagues within community hospitals, primary care, social services and voluntary agencies in relation to people with complex discharge packages or concerns related to the hospitals discharge procedure and process.
- Assisting ward staff in the identification of patients with on-going care needs.
- Supporting ward staff in assessment of patient discharge needs and assisting ward staff in making alternative discharge plans, as appropriate.
- Advising ward staff about suitability for and availability of Community Hospital beds or intermediate care settings.

4.14 The **Supportive and Palliative Care Team** has overall responsibility for:

- Providing ward staff with specialist support and advice for patients in the last year of life. This may include advice for patients with complex symptoms or supportive needs.
- Co-ordination of rapid discharge for patients in the last few days of life . In these instances the team will complete the fast track assessment and liaise with the necessary community teams.

5. STANDARDS OF DISCHARGE AND TRANSFER PLANNING

5.1 It is never appropriate for a patient to remain in an acute hospital setting after they are declared medically stable/safe, ready for transfer and no longer requiring hospital treatment.

In order to facilitate the best use of hospital capacity and improve patient flow throughout the system, the Trust's Discharge & Transfer Policy advocates the following key principles:

- Discharge planning starts at the point of admission (unscheduled) and at the pre-assessment stage for scheduled admissions.
- A working diagnosis is established as quickly as possible, ideally within 24-48 hours.
- Board/ward rounds will be scheduled daily to allow senior review of all patients.
- Patient discharge needs assessed as either simple or complex and the discharge plan managed accordingly/

- The PDD will be proactively managed against the treatment plan on a daily basis and formally reviewed at each MDT meeting and changes communicated to the patient and their family/carer.
- Elective patients will be informed of their predicted length of stay at pre-assessment - this will be confirmed on admission.
- The PDD for non-elective patients will be established within 48 hours maximum on arrival at base ward by the MDT. This will be documented on the Patient Flow Board, in the patient's medical/nursing notes and inputted onto the electronic Ward Whiteboard (See Discharge Directory).
- Patients and their family/carer will be given clear information on the PDD early on in their care pathway.
- A discharge assessment and care plan should be completed for all patients, including consideration of home circumstances, within 24 hours of admission to a base ward.
- For internal transfers, good communication between wards is vital to ensure the patient experiences consistent continuity and quality of care. All internal transfers require a clinician to clinician patient handover.
- The discharge planning process is owned by the ward team, the Consultant is clinically accountable for the discharge and transfer of care decision and the ward Matron/Sister/Nurse in Charge is responsible for its delivery.
- For patients with complex care needs the MDT is critical to the planning and delivery of the transfer of care pathway and responsible for the timely escalation of constraints.
- Board/ward rounds will occur daily to allow a senior review of all patients.
- Patients will be medically safe at the point of discharge with appropriate on-going care arrangements in place.
- Discharges/transfers should be planned to occur before 12 noon on any day of the week including weekends.
- A copy of the patient's medical Discharge Summary will accompany the patient on discharge and one sent to the patient's General Practitioner (GP).
- Medications should be ordered 24 hours in advance of the planned discharge or transfer wherever possible, following the guidance for ordering and safe storage of medication as set out in the Medicines Management Policy.
- Medications must be explained to the patient including any relevant changes by the discharging nurse.
- The discharge of patients from a base ward after 21:00 and before 08:00 should be avoided unless it is clinically and socially safe to do so and in the best interests of the patient and that receiving destination and/or family, carers are informed.
- All patients should be encouraged to use their own transport home where possible. If the patient fits the criteria for transport, the ward must submit an electronic transport request form via the electronic white board ensuring the discharge destination is confirmed and checked as correct.
- The discharging nurse must ensure the patient is fully clothed before discharge. The patient must not be discharged in night clothes unless the patient declines the offer of clothes, or alternative clothing is not available.
- If a TEP form has been discussed with the patient, the original should accompany the patient on discharge. A copy should be kept in the patient's medical records.
- Communication with the patient's GP, locality/community teams is essential ensuring that their knowledge and views are taken into consideration.
- Timely completion and actioning of the discharge checklist to include TTOs and transfer of care management arrangements.

6. SIMPLE / NON-COMPLEX DISCHARGE

6.1 For the majority of hospital admissions they will be a planned or a simple discharge. The length of stay and the discharge plan will have been agreed prior to the admission or as soon after admission as possible. (See Appendix 1.)

6.2 All discharges should be planned to take place before midday.

6.3 The consultant and the ward Matrons must ensure robust arrangements are in place for PDDs to be reviewed and updated on a daily basis.

6.4 The patient and/or carers should agree with the discharge plan. This must be documented in the discharge plan. The discharge plan could include, for example, care provision by relatives, or restart of care package or return to usual care home (pending assessment by the home to check that they can still provide care).

6.5 Where care has already been in place, the MDT is responsible for nominating a member of staff to contact Care Direct Plus (CDP), or the care agency or care home directly, to arrange for care to be reinstated. Where there is an assessed need for a long term package of care and the patient is not complex but needs care, contact CDP on 01392 381206 (professional).

6.6 Social Care reablement (SCR) are able to offer support to people who have recently had a period of illness or injury to help them regain confidence and learn, or relearn skills such as washing, dressing and meal preparation and regain a level of independence. For patients who meet this criteria a referral should be made to SPoA. (SPoA referral)

6.7 If a patient requires support to settle home after a period in hospital, such as provision of groceries, turning heating on, collection of medication or other practical support, a referral should be made to Neighbourhood Friends on 01392 823690. (Refer to Discharge Directory).

6.8 If a patient requires a referral to Community Nursing Service, or Community Therapy Service, an electronic referral can be completed on the Ward Whiteboard in hours.. Out of hours, contact Devon Doctors 0845 504 8997. (Refer to Discharge Directory).

6.9 A sick certificate / Statement of Fitness to Work should be issued to all patients who require them by the medical team looking after the patient.

6.10 Likely equipment needs must be identified early utilising the MDT.

6.11 Medical staff must be timely in prescribing discharge medication and completing the discharge summary.

6.12 The discharging nurse from the ward must complete and sign the discharge checklist/plan.
N.B In times of heightened escalation and extreme bed pressures later discharges may be necessary and should be discussed and agreed with patients, carers, families and receiving care facility.

6.13 Medical staff must be timely in prescribing discharge medication and completing the discharge summary.

7. ELECTIVE ADMISSIONS

7.1 Discharge planning commences at pre-assessment clinic.

7.2 The following areas will be discussed with the patient:

- Predicted Date of Discharge given.
- Any equipment required following admission.
- Discharge Care Plan commenced.
- Discharge booklet to be given to patient where applicable.

8. COMPLEX DISCHARGES OR TRANSFERS

8.1 Once a patient has been identified as having complex needs (Appendix 2) they should be referred, as soon as possible, to the Single Point of Access (SPoA). If the patient has complex moving and handling needs, then a referral to the Moving and Handling Team, for advice and support, can be made.

8.2 The majority of the referrals to SPoA will be older person with complex needs, physical, social and mental. There may also be issues around housing and finance.

8.3 Complex discharges may also include patients deemed vulnerable who may be less able than others to voice their wishes and any concerns. These groups include people with learning disabilities, mental health problems or dementia, victims of neglect or of sexual or domestic violence, and those people who are particularly frail or nearing the end of their life. (See Safeguarding Vulnerable Adults Policy.)

8.4 Appendix 2 demonstrates the patient discharge process for complex discharges.

9. SINGLE POINT OF ACCESS (SPoA)

9.1 Patients with complex care needs may already be known to the Community Health & Social Care Teams (CHSCT) who will instigate a community led discharge 'PULL' process supporting early discharge. (Refer to Discharge Directory).

9.2 Patients identified as needing support to leave hospital can be referred to the SPoA via the electronic Ward Whiteboard referral form by a member of the MDT or contacting the team direct on 01392 406172. (Refer to Discharge Directory).

9.3 The SPoA will be responsible for accepting the patient as being suitable for their service and determining which service/onward care setting is the most appropriate.

9.4 The active patient transfer list will be reviewed daily (Monday to Friday) by the SPoA, Discharge Lead and Operations Systems Manager through use of the Patient Transfer System (PTS).

9.5 It is the responsibility of the base ward of the SPoA referral to ensure the medically fit status of the patient (denoted by the ambulance icon transfer symbol on the Ward Whiteboard) is accurate at all times, and the SPoA are verbally and electronically informed of any changes in status or update to the referral. (Refer to Discharge Directory)

10. COMMUNITY HOPSITAL TRANSFER

10.1 The use of East Devon community hospitals is managed through the SPoA who will agree if this is the most appropriate onward care destination.

10.2 The use of all 'other' and 'out of area' community hospitals are managed by the Trust's Discharge Lead and Operations Systems Manager.

10.3 Once a decision has been made that a community hospital bed is appropriate, the Lead Nurse will identify bed availability with the SPoA daily for those patients who are "green to go" and identify the patient.

10.4 Where there is an empty bed and there are no patients identified, then SPoA is responsible for identifying another patient who will be asked to transfer to a community hospital bed when the organisation is in escalation status.

10.5 If the patient refuses to go, the Discharge Lead will be informed and discuss with the relevant patient/ carer and if they still decline this will be escalated to the Lead Nurse / Head of Patient Flow or the On-Call Manager.

10.6 To request transport, complete the Patient Transport Booking System request from the electronic Ward Whiteboard. The discharging address must be confirmed as correct as this may be different to the one the patient came in from.

10.7 A nursing referral form for transfer and discharge of patients must be completed in addition to a verbal handover; with a copy to be retained in the patient's notes.

10.8 A telephone call should be made by the discharging ward to the admitting community hospital when the patient leaves the ward.

10.9 Patients should not be discharged from inpatient ward areas after 9pm at night unless a later discharge has been discussed and agreed with the receiving community hospital, patient, family or carers where appropriate.

10.10 Discharges/transfers of care to community hospitals should take place as early in the day as possible. Later discharges after 8pm need to be discussed and agreed with the receiving ward.
N.B In times of heightened escalation and extreme bed pressures later discharges may be necessary and should be discussed and agreed with patients, carers, families and receiving care facility

11. HOSPITAL TO HOSPITAL TRANSFER

11.1 For transfers to another acute hospital, or to an out of area community hospital, the patient must have been accepted by an appropriate consultant or senior clinician to accept the patient's care.

11.2 The name of the accepting clinician for the receiving hospital must be clearly documented in the medical notes by the RD&E consultant/medic.

11.3 When the accepting hospital has notified the ward they are able to receive the patient, there must be a registered nurse to registered nurse verbal handover using the Situation – Background – Assessment – Recommendation (SBAR) model.

11.4 A handover using either a handwritten nursing referral form or an electronic transfer referral form available on the patient transfer system should go with the patient.

11.5 On the day of transfer, the registered nurse must confirm with the receiving hospital whether they require the patient's actual notes or photocopies, along with a current TEP form which must be an original copy and NOT a photocopy.

11.6 All medication/property/clothing and any other items belonging to the patient must be clearly documented as having been sent with the patient on the day of transfer.

12. MANAGING COMPLEX DISCHARGE

12.1 Communication is central to the process of managing hospital discharge, commencing as early as possible, throughout a patients stay and following discharge.

12.2 The acute hospital environment is not designed to meet the needs of people who are medically fit and safe for transfer. Some of the risks included, but are not limited to:

- Greater functional decline
- Less likelihood of returning home
- Greater likelihood of needing formal support
- Greater likelihood of hospital readmission
- Greater mortality
- Institutionalisation
- Social isolation.
- Greater likelihood of hospital-acquired infection.
- Poor patient experience
- Increased whole system pressure as individuals are unable to access the appropriate environment of care in as timely a manner as possible.

12.3 Decisions to accept care or support at home or to live in nursing or residential care are major, and often made during a time of considerable change in personal circumstances including adjustment to disability, increasing dependence and the potential erosion of social networks.

12.4 Individuals and/or their representatives may find it difficult to choose a short term discharge destination or care provider for many reasons including but not limited to perceptions of:

- Inconvenient location.
- Uncertain timescale.
- Uncertainty about the quality or cost of care.
- Strong and sometimes unrealistic expectations of their ability to manage without support.
- Time needed to come to terms with change of circumstances.
- Mental capacity issues.
- Ethnic or religious beliefs that limits providing a certain type of service.

12.5 The MDT will interact with patients and/or their family/carers to offer support with any concerns, whilst reinforcing the message that everyone will work towards the patients timely discharge from hospital.

12.6 When a patient is clinically ready for discharge/transfer of care they need to understand that they cannot continue to occupy an inpatient bed. If their preferred location or care provider is not available they will be made aware that they must accept an available alternative, whilst they await availability of their preferred choice.

12.7 For patients who are funding their own care ("self-funding") they will be provided with the same advice, guidance and assistance on choice as those fully or partly funded by their Local Authority (LA)/Clinical Commissioning Group (CCG).

12.8 Any decision made on the individuals behalf by the MDT or a legal representative must be made in the patient's best interest, in line with the Mental Capacity Act 2005.

13. AVAILABLITY AND INTERIM CARE

13.1 A discharge plan should include choice where possible and recognise a patient's autonomy to choose from available options.

13.2 It is important that the MDT is aware of a patient's housing/home situation well ahead of the proposed discharge date in order to inform this choice.

13.3 If more than one appropriate option is available when a patient is ready for transfer or discharge from hospital, the MDT will offer support to the patient, family/carer to choose.

13.4 If only one identified home or hospital can meet the individuals care needs, the process of searching for alternative options should not delay discharge. A plan for transfer to the available option will be made, and if necessary the patient transferred on an interim basis and the search continued once the patient has been transferred.

13.5 There may be occasions when a patient needs support from housing services in order to be discharged from hospital. Early identification of any issues that may delay discharge is key, so that there is maximum opportunity to put in place any support required. This can include support from local authority housing services or other local community services (Bay 6).

13.6 When a patient requires transfer to another hospital, including a community hospital, but the preferred hospital has no vacancies, patients do not have the right to remain in the current hospital longer than required because they do not wish to accept treatment/rehabilitation at an available, more suitable alternative. If they choose to decline the offered transfer, discussions should start regarding discharge from NHS care.

13.7 When a patient needs care at home or a move to a care home, and the preferred care provider or location is not available (including that the patient's own home might not be ready to support the discharge or the preferred care provider might have no vacancies), patients do not have the right to remain in hospital longer than required because they or their family/carer have refused or not reviewed available options.

13.8 The MDT/SPoA will provide information should a patient require a domiciliary care package, care home placement, intermediate care or 'step down' care. Refusal to make a choice about available options or refusal to accept a single available temporary option must not lead to a patient remaining in the hospital indefinitely.

14. THE DISCHARGE PROCESS

14.1 The discharge process comprises six stages (Appendix 3). The discharge process audit trail template to accompany this is designed to evidence a patient's journey through the discharge process. (Refer to Discharge Directory).

14.2 Stages 1 to 3 apply to every patient in order to provide support and prevent the need for further escalation:

- Stage 1 – Information provided on admission
- Stage 2 – Assess likely care needs on discharge
- Stage 3 – Offering options and preparing for discharge

14.3 Stages 4 to 6 represent the formal escalation process:

- Stage 4 – Available care declined
- Stage 5 – Formal meeting and formal letter
- Stage 6 – Legal process and formal letter

14.4 The final stage constitutes eviction from the Trust.

14.5 STAGE 1- Give standard information on admission

14.5.1 The discharge planning process will be led at ward level by the MDT responsible for the individual's care, with one named member taking overall responsibility for each individual – hereafter referred to as the responsible MDT member. This may be SPoA, case manager or another health or social care professional as appropriate. The responsible MDT member supports the individual and/or representative in liaison with all those involved in the patient's care. They will ensure that those who need to be involved after discharge are contacted at the earliest opportunity to discuss the patient's needs.

14.5.2 All parties will record plans, communication with the patient and/or representatives, referrals and actions in the medical records.

14.5.3 A discharge-planning information leaflet has been agreed locally (i.e. at the hospital), a member of the MDT will give this to the patient and/or their representatives as soon as possible after admission, and discuss the content with them. (See Discharge Directory.)

14.5.4 Staff on the ward should take note of relevant information about the patient's housing and home circumstances as soon as possible after admission, and record this information in the medical records/care plan. This will enable early identification of any issues that may have contributed to admission and any issues that need to be rectified in order to facilitate return home.

14.5.5 If the patient is identified as homeless, please refer to Bay 6 for guidance and further information.

14.5.6 A patients mental capacity to choose their discharge destination in accordance with the Mental Capacity Act 2005 should be established as early as possible after their admission which may include establishing if anyone is able to make a decision on the patients behalf, for example under a Lasting Power of Attorney.

14.5.7 If there are safeguarding concerns that may impede discharge, these should also be flagged to the appropriate team early on in line with organisational policies on safeguarding. The responsible MDT member should ensure that the patient and/or representative are aware of the Discharge and Transfer Policy and process, and of the circumstances in which a move to alternative or interim accommodation or care might be necessary. All communications should reinforce the expectation that patients will leave the hospital as soon as their need for inpatient treatment ends.

14.5.8 The discharge plan should include an indication of the Predicted Date of Discharge.

14.6 STAGE 2 – Assess likely care needs on discharge

14.6.1 As soon as the patient's needs on discharge can be appropriately gauged and are stable, a baseline assessment should be undertaken to determine whether the individual or carer is likely to need new or different services on discharge and the appropriate notifications, assessments and referrals to other services made.

14.6.2 The responsible MDT member should discuss expectations with the patient and/or their representative, and use Template Letter 1 (see Discharge Directory) to reinforce this.

14.6.3 If no new needs are anticipated then it should be possible for previously arranged care (if any) to be restarted in the patient's usual place of residence (home or care/nursing home) without the need for further assessments.

14.6.4 If the patient requires support from housing services to enable discharge from hospital, relevant information on services available should be provided. In the event support from housing services takes some time to arrange, an alternative short term offer will be made and it is expected the individual will accept this offer.

14.6.5 All relevant assessments should be completed by the MDT and appropriate arrangements put in place for discharge as soon as possible, and before the PDD.

14.6.6 A patients mental capacity to choose their discharge destination in accord with the Mental Capacity Act 2005 should be established as early as possible after their admission which may include establishing if anyone is able to make a decision on the patients behalf, for example under a Lasting Power of Attorney.

14.6.7 If there are safeguarding concerns that may impede discharge, these should also be flagged to the appropriate team early on in line with organisational policies on safeguarding. The responsible MDT member should ensure that the patient and/or representative are aware of the Discharge and Transfer Policy and process, and of the circumstances in which a move to alternative or interim accommodation or care might be necessary. All communications should reinforce the expectation that patients will leave the hospital as soon as their need for inpatient treatment ends.

14.6.8 In certain circumstances, a third party may choose to "top-up" social care funding to pay for a more expensive care option. This can be discussed with the adult social care services representative.

14.6.9 In line with the Mental Capacity Act 2005, a person with Power of Attorney, or who is a court appointed guardian, can choose to self-fund their preferred option on behalf of the individual but this decision would need to be in the patient's best interest. Support from the Complex Hospital Discharge Team (CHDT) is offered to relatives or friends making decisions of this nature, which may be life-changing for the patient.

14.7 STAGE 3- Offering options and preparing for discharge

14.7.1 The SPoA, social care or delegated service and a member of the MDT will jointly advise the patient and/or their representative about currently available care providers that can meet their needs (which might be only one option at that time) and any potential cost or contribution at the earliest appropriate stage. The patient and/or their representative should be advised on likely availability and waiting times, costs, and on their right to seek inspection reports from the CQC.

14.7.2 If it is identified that the patient will 'self-fund' their care, the social care professional will inform the responsible MDT member whether or not the individual has care arranged. If not, they will offer to help the patient and/or representative find available option/s.

14.7.3 A lack of vacancies can result in long waiting lists for some of the more popular care homes. If there is at least one available option, the patient cannot remain in hospital to wait for further choices and must either accept one that is available or make alternative interim arrangements.

14.7.4 If the patient has been referred for inpatient rehabilitation they and/or their representative will be made aware that a bed might not be available at the community hospital closest to their home. The MDT will explain that transfer to an alternative

hospital will enable the individual to receive required services in an appropriate setting and maximise their chance of swift recovery.

14.7.5 The responsible MDT member should clarify expectations and may use template letter 2 (see Discharge Directory), if appropriate, to minimise confusion later on.

14.7.6 If post-hospital options are severely restricted or the patient is on a waiting list for a specific location, the patient and/or representative must either accept transfer to somewhere that is not their first preference on a short-term basis, or make alternative interim arrangements. They will not have the option of remaining in hospital to wait for their preferred option to be available.

14.7.7 In cases where the patient requires a package of care, they and /or their representative will be advised of available care options that can temporarily meet their care needs while they wait for their favoured option.

14.7.8 When a patient transfers temporarily to a care arrangement that is not their preferred choice, a representative from the relevant organisation will continue to discuss permanent options with the individual and/or representative.

14.7.9 In cases where available options are declining to accept the patient into their care, this is outside the remit of this policy – in these cases there may be no options to choose from and so alternative means of meeting the individual's needs should be discussed with the CCG and social care and sought outside of this policy.

14.7.10 Discharge arrangements should be put in place to coincide with the individual's PDD.

14.8 STAGE 4 – Available care declined

14.8.1 In all cases, if the patient is assessed as having capacity and does not agree with the recommended level of on-going care and support they require, their wishes must be respected and discharge home arranged.

14.8.2 If a patient and/or their representative is not happy with the proposed arrangements for discharge, MDT members will explain clearly that refusal to choose an available care provider or location will not prevent the discharge process proceeding.

14.8.3 At this stage, the responsible MDT member should encourage resolution of any potential barrier to discharge and seek support from MDT members involved. The patient and/or representative is provided details by the ward or directed to the patient advice and liaison service (PALS) for advice and information regarding advocacy if required.

14.8.4 The hospital and MDT, in consultation with the patient and/or representative, should agree what the patient needs on discharge and what constitutes a suitable and appropriate option. At this stage the MDT must ensure:

- That the patient (and/or their representative) has had clear explanation verbally and in writing of discharge and on-going care arrangements.
- All relevant information is available to enable an informed decision to be made.
- Assistance to find alternative places of safety has been offered.

14.8.5 At this stage it would be appropriate to conduct a review of the Discharge Process Audit Trail Document, or start one if it has not already been completed.

14.8.6 If discharge arrangements are not agreed in time for the PDD, the responsible MDT member should escalate to the ward matron/senior nurse for support. The matron will consult any specialist staff involved and notify the appropriate operations

manager. All parties should continue to encourage patients and/ or their representatives to make their own choices throughout this process.

14.8.7 The Matron will start the formal process and arrange a meeting to discuss discharge within 5 working days of the PDD, documenting this and discussions with the patient and/ or their representatives in the medical notes.

14.8.8 The following people should be invited to the meeting:

- Patient and / or representatives
- Ward Matron/Senior Nurse/ appropriate representative
- SPoA/CHDT/Senior Discharge Officer
- Relevant Manager from agency leading discharge
- The patients consultant may also wish to attend the meeting.

14.8.9 The local process to escalate delayed transfers of care (DTOC) should be followed throughout the process.

14.9 STAGE 5 – Formal Meeting and Formal Letter

14.9.1 At the point of arranging a formal meeting, it would be appropriate to notify any Trust / Local Authority / Legal Advisors and provide a summary of the situation to date. The purpose of this is to ensure that, should it be necessary to use stage 6 of the policy, that there is minimal delay in progressing this final stage.

14.9.2 Consideration should be given to having an appropriate note taker present to record the key decisions made and actions agreed during the meeting. Copies of this record should be placed within the patients notes.

14.9.3 If the patient and/ or their representative/s do not engage with discharge planning or are unable to attend a reasonable request for a formal meeting this should go ahead without them and a follow-up letter should be sent afterwards summarising discussion and plans.

14.9.4 The formal meeting enables all parties to discuss transfer to the most appropriate available care provider at least as an interim option. The matron/senior nurse will consult specialist staff / operational managers involved for guidance and, if it appears that there will be further delay, escalate as required. A plan for discharge within 5 working days must be made at this meeting.

14.9.5 If an MDT decision is made at this point that the patient or their representatives are not acting in the individual's best interests, a referral to the Court of Protection may be made.

14.9.6 The ward matron or deputy should give or send template letter 3 (see Discharge Directory), which should be adapted as required, within 24 hours of the meeting. The letter should be copied to all parties present at the meeting and a copy placed in the individual healthcare records.

14.9.7 SPoA, adult social care and ward staff should continue to support the patient and/or representative where possible to finalise plans for discharge. If required the SPoA, adult social care or relevant professional continues to search for available care options.

14.9.8 The MDT will continue to work with the patient and/or representative to arrange an appropriate means of meeting the individual's care needs at the point of discharge. The allocated SPoA, adult social care or relevant professional should lead the process of making arrangements for a patient to transfer to an identified care provider or location on the agreed date.

14.10 STAGE 6 – Legal process and formal letter

14.10.1 If no agreement has been reached about discharge arrangements after stages 1 – 5, and subsequent transfer arrangements are challenged or not adhered to by the patient and/or representative, the matron should escalate to the senior nurse who should also inform the ADN, lead consultant (if there is one) and Trust senior operational manager.

14.10.2 This group should contact the appropriate senior manager from the agency leading the discharge to urgently meet and discuss plans for transfer to an interim location or alternative care provider.

14.10.3 The group should ensure a summary is prepared of any outstanding issues yet to be resolved, and consult Trust advisors regarding any legal proceedings concerned.

14.10.4 In straightforward situations, the matron will then use template letter 4 (see Discharge Directory) to notify the patient and / or representative of their planned transfer / discharge arrangements, and should these be refused that legal advice will be sought and discharge instigated to the named interim option.

14.11 Compulsory discharge from the Trust

14.11.1 If the final stage of the escalation process does not result in discharge from the Trust, the most senior clinician in the Trust will be informed by the senior operational manager without delay. The senior clinician and senior operational manager will discuss compulsory discharge from the Trust with the Trust solicitors, and a plan made to enact this.

15. PROBLEMATIC DISCHARGE / TRANSFER

15.1 If concerns are raised by other health/social care professionals relating to the discharge or transfer of a patient to other healthcare organisations or a community destination, this should be escalated in the first instance to the Discharge Lead/Lead Nurse / Head of Patient Flow for the Trust.

15.2 The matron or clinical lead for the ward will be asked to commence an investigation into the issues raised and complete an action plan if appropriate.

15.3 The outcome of the investigation and any relevant actions taken/put in place will be sent to individual/individuals raising initial concern.

15.4 Any trend noted about a specific area will be escalated to heads of nursing.

16. TRANSFER OF PATIENTS IN AN EMERGENCY SITUATION

16.1 In the case of patients needing transfer to another acute setting due to critical illness or urgent need, guidance and transfer forms are available in the following areas and should be completed in line with Nursing Midwifery Council guidance on good record keeping (Nursing and Midwifery Council, 2015).

16.2 **ITU transfers**
Complete Southwest Critical Care Transfer form available in ITU.

16.3 **Cardiac transfers**
Consult the Surgical Patients Transfer criteria (available in Cardiology) and, if necessary, contact the Pathway Co-ordinator on bleep 808.

16.4 **ED transfers**

Complete Southwest Critical Care Transfer form available from ITU and attach copy of ED admission form.

17. INTERNAL TRANSFERS

17.1 Assessment for the need of a nurse escort must be conducted by the registered nurse in charge and documented in the patient's notes.

17.2 Any incidents or accidents should be accurately recorded using the Trust's Datix system. Any incident that is reported involving equipment failure must be followed by the immediate removal of that piece of equipment from service.

17.3 The registered nurse caring for the patient must have full knowledge about the patient when they handover care to the receiving ward.

17.4 The registered nurse should ensure that no actions or omissions on his/her part cause any detriment to the condition or safety of patients/clients during transfer.

17.5 The registered nurse escorting the patient during the transfer is responsible for maintaining careful observations to ensure patient safety, to care for any infusions and drainage, and to provide an appropriate response to any observed deterioration in condition. In order to accomplish accurate observations, the registered nurse should stand in a position where close patient observations can be monitored throughout i.e. have a good view of the patient's face.

17.6 In emergency situations, good communication between clinical areas is essential to ensure appropriate equipment is on hand to provide a safe transfer of the patient.

17.7 Communication between all parties should be maintained to ensure the transfer is conducted in a timely manner, both verbal and written (if required), including next of kin.

17.8 Patients must be wearing a patient ID band and details checked to confirm correct identity.

17.9 The patient must be informed as to why the transfer is going to take place (dependent upon patient's condition and level of consciousness).

17.10 Any unnecessary equipment must be removed prior to transfer to reduce risk to patients and possible damage/loss of equipment.

17.11 Staff must be trained and have attended annual updates in Moving and Handling techniques to prevent injury to the patient, themselves and other persons involved, in accordance with Manual Handling Operations Regulation 1992.

17.12 Appropriate moving and handling must be identified to ensure the patient is transferred safely and with dignity.

17.13 Bed rails must be used where appropriate and linked to the Use of Bedrails Clinical Guideline.

17.14 If an emergency situation occurs in transit, e.g. cardiac arrest, or a patient's condition deteriorates, the patient should be taken to whichever clinical area is closest. An emergency call should be place via the nearest telephone point (call 2222) to initiate a response from the Resuscitation Team. It is the responsibility of the team leader to decide where the patient is taken to, whether this is back to the transferring ward/department, Emergency Department (ED) or another Critical Care area.

17.15 Patients with dementia should only be moved for reasons relating to their care and treatment. Any moves for these patients should, where possible, take place during day light hours. Relatives and carers should be kept informed of any move and when this will take place.

17.16 Student Nurses undergoing placements must not escort patients unsupervised. Students are to remain supernumerary to escorts and not be left unaccompanied with patients at any time.

17.17 Porters and/or support workers must follow any instructions given to them by the nurse in charge of the patient in relation to the transfer of a patient.

18. INTERNAL TRANSFERS TO BASE WARDS

18.1 For all types of transfer referred to in this policy, a clear and accurate handover using the **SBAR** form must be written by the registered nurse from the transferring area to the registered nurse in the receiving area. This will ensure the receiving area has the information to enable them to give appropriate and timely management of the patient when they arrive. This should include an up to date assessment of current problem under investigation and likely diagnosis, any physical or mental health risks, last recorded observations and a treatment management plan. Continuity of information is vital to the safety of our patients

18.2 The SBAR handover sheet is an integrated document that requires engagement with both medical and nursing teams and should be completed by both the doctor and nurse prior to transfer. The SBAR form should be started as part of the admission process and remain on the front of the nursing notes for ease when arranging the transfer. The form will be provided in pink to ensure it is easily recognisable on transfer. The SBAR will form part of the patient records and as so must be filed accordingly in the patient's notes. No phone call to the receiving ward is needed, however the site must confirm an available empty bed.

18.3 The registered nurse and doctor must use their clinical judgement to make an appropriate assessment of the patient's clinical condition to determine if an escort is required and to ensure the escort is able to care for the patient during transfer.

18.4 For the discharge or transfers of all patients with an infection control alert please consult the Infection Prevention and Control Policy, in particular, the sections on isolation, Methicillin-Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile. If in any doubt, please ring the Infection Control Team on (01392) 402355.

19. WEATHER

19.1 Discharge of patients in severe weather

In the event of severe weather, wards will ensure that patients being discharged are returning to a suitable and warm environment. Other agencies, such as the voluntary sector, can be contacted to assist if required. (Refer to Discharge Directory).

19. 2 Patients Identified to be nearing the end of their life

19.2.2 Referrals made to the Supportive and Palliative Care team should be for specialist advice and support for patients who have complex symptom or supportive needs.

19.3 The definition of a patient with complex palliative care needs is a patient that is experiencing any single or combination of the following needs:

1. High level of social care needs, equipment needs and/or complex social situation directly linked to their palliative diagnosis.

a. High level of nursing needs including medication administration, pressure care, wound care, feeding/diet management.
- Uncontrolled symptoms and/or complex psychological issues directly linked to their palliative diagnosis.
- Emotional/spiritual distress as a result of their palliative diagnosis.

19.4 Specific Requirements

19.4.1 If a patient has rapid deterioration and is diagnosed as being in their last few days of life, a conversation about their preferred place of care should be held.

19.4.2 If the patient wishes to be cared for at home the Supportive and Palliative Care team should be contacted to support a rapid discharge for end of life care. This should only apply if the patient is in the last few days of life. In all other circumstances the MDT should refer to the SPoA.

20. SELF-DISCHARGE

20.1 It must be established whether the patient has mental capacity. If there is any doubt about this, a mental capacity assessment must be carried out under the Mental Capacity Act 2005.

20.2 The relevant doctor should be contacted to explain to the patient the importance of staying in hospital and the possible risks of a self-discharge. Medication that can be safely prescribed should be and follow up arrangements should be made unless the patient does not want this.

20.3 Ward staff should ensure, where possible, that a self-discharge form is completed and filed in patient's medical notes. These forms are held on wards. (Appendix 5).

20.4 If the patient refuses to sign a self-discharge declaration, a full and accurate documentation of events and conversations with the patient should be documented in the medical file by the ward nurse.

20.5 The GP and other relevant services should be informed.

21. REPORTING AND REDUCTION OF DELAYS

21.1 A delayed transfer of care from acute or non-acute care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready for transfer when:

a. A clinical decision has been made that patient is ready for transfer AND
b. A multi-disciplinary team decision has been made that patient is ready for transfer AND
c. The patient is safe to discharge/transfer.

21.2 Delayed Transfers of Care Reporting

21.2.1 The Patient Transfer System will provide the information for the Delayed Transfers of Care (DToC) Unify monthly submission and will be jointly processed by SPoA & Operations Systems Manager.

21.2.2 The monthly submission obtained from Patient Transfer System is processed in line with the Delayed Transfers of Care Monthly SitReps Definitions & Guidance (NHS England, 2013) (v1.07) from NHS England.

21.3 Management and Reduction of Delays

21.3.1 Operational reports are routinely disseminated to highlight specific areas of delay occurrence. Weekly meetings are held and attended by senior managers from health

and social care, SPoA, and the Operations Support Unit to discuss and agree discharge plans for each patient. The purpose of this is for formal monitoring of delays within the Trust and to highlight and resolve potential internal delays to discharge.

22. TRAINING AND EDUCATION

22.1 All new clinical staff will be expected to attend as part of the local induction education and training, an introduction to the discharge process. Training and education resource and documentation can be found in the discharge directory. (Refer to Discharge Directory).

22.2 All relevant clinical staff that are involved with the discharge process can access opportunities to attend refresher sessions.

22.3 The electronic Discharge Directory available on HUB will be regularly updated with information and resources relevant to the discharge process.

22.4 Nursing staff and other relevant clinical staff are expected to be fully competent and ensure they remain up to date with any changes to the discharge process.

23. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

24. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

24.1 To evidence compliance with this policy, the following elements will be monitored:

What areas need to be monitored?	How will this be evidenced?	Where will this be reported and by whom?
Audit of Discharge Planning documentation completed by ward staff in individual patient records.	Ward Matron/Senior Nurse Safety Thermometer	CQUAT – Senior Nurses
Number of recorded incidents/complaints relating to discharge/transfer	Audit – Discharge Lead	Operations Support Unit – Discharge Lead
Inappropriate out of hours discharge/transfers	Audit – Operational Systems Manager	Operations Support Unit – Discharge Lead

24.2 **Undertaken by**
Trust Discharge Lead with support from Lead Nurse / Head of Patient Flow, ADN's and Matrons.

24.3 Any changes in practice needed will be highlighted to Trust staff via the Governance Managers' cascade system.

25. REFERENCES

NHS Choices (2013). Leaving Hospital - Being Discharged from Hospital. Avaialble at: https://www.nhs.uk/using-the-nhs/nhs-services/hospitals/being-discharged-from-hospital/

Nursing and Midwifery Council (2015). Record keeping: Guidance for nurses and midwives. London: NMC. Available at: https://www.nmc.org.uk/standards/code/record-keeping/

NHS England (2016) Quick Guide: Improving Hospital Discharge into The Care Sector: Available at: https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Improving-hospital-discharge-into-the-care-sector.pdf

Timely Discharge from Hospital, Lees L M&K Publishing 2012.

Shepperd S, Lannin NA, Clemson LM, McCluskey A, Cameron ID, Barras SL. Discharge planning from hospital to home. Cochrane Database of Systematic Reviews 2013, Issue 1. Art. No.: CD000313. DOI: 10.1002/14651858.CD000313.pub4

NICE guidelines – Transition between inpatient hospital settings and community or care home settings for adults with social care needs/ Available at: https://www.nice.org.uk/guidance/ng27

APPENDIX 1: PATIENT DISCHARGE PROCESS FOR SIMPLE / NON-COMPLEX PATIENT DISCHARGES

Action required	Rationale	By Whom
Commence discharge plan with expected discharge date	To ensure plan in place and to identify any potential issues requiring referral to other services	Multi-disciplinary team (MDT) overseen my ward Matron
Facilitate on-going involvement of patient/carer/relatives in the discharge planning process	To ensure effective and timely communication with patient/carers/family regarding all aspects of discharge including estimated discharge date	MDT
Assess patients for safe discharge and advise MDT of potential risks around management of discharge	Effective communication within MDT and ensure safe discharge	Occupational Therapist Physiotherapist
All arrangements in relation to discharge planning should be clearly documented, signed and dated within the clinical notes	To maintain accurate and timely documentation and ensure effective communication	Medical team / Registered Nurse / Therapy staff and other Health Professionals where appropriate
To work together with partner agencies to ensure all pre-existing services are in place prior to discharge	To ensure safe discharge to home or usual place of residence	Registered Nurse
Assessment of medication needs made and discharge prescription completed	To ensure patients medication needs are met in full and all medicines required are provided in a safe, accurate and timely fashion. This should include a review of their own medicine brought in to hospital and those they may have at home	Prescriber / Pharmacist / Registered Nurse
Discharge summary to be completed prior to discharge	To ensure accurate data recorded and sent to GP	Medical team / Registered Nurse / Pharmacist
Ensure relevant information related to specific speciality/discharge is given to the patient and discussed with the patient/carer/family as required	To ensure patients understand of any follow up arrangements	Registered Nurse
If care home is usual place of residence, prior to discharge contact the nurse/manager to provide a verbal handover of the patient including infection status and document in clinical records	Effective communication to ensure continuity of care on discharge	Registered Nurse
Ensure patients medication to take home is correct as prescribed, discussed with the patient/carer/family and is given to patient prior to discharge	To ensure patient/carer/family understand medication doses and treatment	Registered Nurse
Ensure patient/carer/family are fully informed and advised of danger signals to look out for and provide sign posting as appropriate	To ensure patient/carer/family are aware of danger signals related to diagnosis/prognosis	Registered Nurse
Any event e.g. fall during a hospital stay must be communicated to carers/family or professional colleagues within other care setting	Effective communication to ensure continuity of care on discharge	Registered Nurse
Any patient with a pressure ulcer (inherited or hospital acquired) must have full skin map regarding ulcer using measurement documentation clearly in health records and electronic discharge summary immediately prior to discharge	To ensure carers/family and other professional are aware of pressure ulcer. Ensure accurate details of presence of pressure ulcer are recorded in medical notes and discharge summary	Registered Nurse
Ensure carers/family are asked to provide patients own clothing/outdoor wear prior to discharge	Maintain dignity and ensure patients are appropriately dressed for discharge from hospital	Registered Nurse / Healthcare Assistant
Pack or assist the patient to pack their belongings and ensure patient property form is completed	To prevent loss of patients property	Registered Nurse / Healthcare Assistant
Inform patient/carer/family and partner agencies of time of discharge	To provide communication regarding patients expected time of arrival	Registered nurse / Healthcare Assistant / Ward clerk
Arrange transport where appropriate	To ensure arrangements complete	Registered nurse / Healthcare Assistant / Ward clerk

APPENDIX 2: PATIENT DISCHARGE PROCESS FOR COMPLEX PATIENT DISCHARGES

Action required	Rationale	By Whom
Commence discharge planning at pre-admission clinic for planned admissions or as soon after admission as poss ble for non-elective admissions	To identify any potential issues requiring referral to other services	Registered nurse
Refer to appropriate discipline for prompt assessment of patients' needs by member of MDT	Prompt intervention by Therapy staff / Specialist Nurse	Registered Nurse
Assess patients' needs and respond appropriately carrying out interventions as required by members of the MDT	Effective communication within MDT and ensure safe discharge following intervention/treatment	Occupational Therapist / Physiotherapist.
Refer to Single Point of Access (SPOA) for further assessment for on-going needs	To help patients and their carer/family to facilitate a safe discharge from hospital	Registered Nurse / SPOA Clinician
Assessment by Social Work (if appropriate)	Need identified to support patient/carer/family either in their own home or change of circumstances requiring placement	SPOA Clinician / Complex Hospital Discharge Team (CHDT) or Community Led Discharge Team Cluster
Arrange follow up services including the loan of essential equipment and domiciliary treatment	To help patients and their carer/family to facilitate a safe discharge from hospital	Registered Nurse / SPOA Clinician
Assessment of medication needs made and discharge prescription completed	To ensure patients medication needs are met in full and all medicines required are provided in a safe, accurate and timely fashion. This should include a review of their own medicine brought into hospital and those they have at home	Prescriber / Pharmacist
Electronic Discharge Summary is to be completed prior to discharge	To ensure accurate data recorded and sent to GP	Medical Team / Registered Nurse / Pharmacist
If discharge to placement has been arranged, prior to discharge contact the nurse/manager to provide verbal handover of the patient including infection status and document in clinical notes. If discharge to community hospital, provide verbal handover to receiving hospital with written transfer referral form, patients notes and original TEP form	Effective communication to ensure continuity of care on discharge	Registered nurse / Social Worker / SPOA Clinician
Ensure carer/family are asked to provide patients own clothing/outdoor wear prior to discharge	Maintain dignity and ensure patients are appropriately dressed for discharge from hospital	Registere Nurse / Healthhcare Assistant
Ensure all relevant patient information if required for specific speciality or discharge is discussed with patient/carer/family and is given to patient prior to discharge	To ensure patient/carer/family understanding of any follow up arrangements	Registered Nurse
Ensure patient medication to take home is correct as prescribed, discussed with patient/carer/family and is given to patient prior to discharge	To ensure patient/care/family understanding of medication doses	Registered Nurse
Ensure all patients/carer/family are fully informed and advised of danger signals to look out for to provide sign posting as appropriate	To ensure patient/carer/family are aware of danger signals related to diagnosis/prognosis	Registered nurse
Any event e.g. fall during a hospital stay must be communicated to carers/family or professional colleagues within other care setting	Effective communication to ensure continuity of care on discharge	Registered Nurse
Any patient with a pressure ulcer (inherited or hospital acquired) must have full skin map regarding ulcer using measurement documentation clearly in health records and electronic discharge summary immediately prior to discharge	To ensure carers/family and other professional are aware of pressure ulcer. Ensure accurate details of presence of pressure ulcer are recorded in medical notes and discharge summary	Registered Nurse
Pack or assist the patient to pack their belongings and ensure patient property form is completed	To prevent loss of patients property	Registered Nurse / Healthcare Assistant
Inform patient/care/family and partner agencies of estimated time of discharge at least 24-48hrs prior to discharge	To provide communication regarding patients expected time of arrival	Registered Nurse / Healthcare Assistant / Ward Clerk
Confirm transport arrangements where appropriate	To ensure arrangements complete	Registered nurse / Ward Clerk.

APPENDIX 3: SUMMARY OF THE 6 STAGE MANAGING COMPLEX DISCHARGE PROCESS

Royal Devon and Exeter NHS
NHS Foundation Trust

Stage 1: Start discharge-planning discussions and give standard information on admission. Ensure patient is provided with discharge information leaflet. Discuss discharge planning with individual and/or representative before or shortly after admission. Identify MDT member responsible for co-ordinating discharge (named health or social care professional to contact about plans). Print and complete policy audit tool appendix 18	Stage 1 On admission to ward
Stage 2: Refer to service/s required to support discharge (template letter 1 to be given). Refer individual to required services, e.g. another hospital, adult social care, community mental health team (CMHT) when patient is ready to have needs assessed for discharge if available.	Stage 2 As soon as possible after admission
Stage 3: Offer available discharge service/s (template letter 2 to be given). Discuss discharge plans with individual and/or representative regularly. Ensure assessments of care needs are complete. Explain to individual and/or representative that they must accept an available discharge option. Ward representative or social care professional jointly offer patient and/or representative at least one option.	Stage 3 Before PDD
Stage 4: Start the formal process if available service declined and arrange formal meeting. If individual and/or representative are reluctant to accept option/s offered, ward representative or social care professional discuss concerns and encourage them to reconsider. Clarify rationale for transfer to alternative option if their preferred option is not available. Escalate to Ward Leader to agree urgent date for formal meeting if discharge plan still not agreed or concerns remain.	Stage 4 Within 5 working days of PDD
Stage 5: Hold formal meeting to minimise delay and send (template letter 3.) Notify Trust Advisors of current situation. Individual and/or representative invited to formal meeting, which is held even if they do not attend. Give information and encouragement to access support. Send letter describing what was discussed, follow-up arrangements made, any agreements and the rationale for transfer to alternative care.	Stage 5 Within 24 hours of formalmeeting above
Stage 6: Establish viable option and send template letter 4 before instigating discharge. If transfer arrangements are disputed, escalate to Matron and lead consultant, and Senior Operational Manager. They will meet the relevant Senior Manager from the agency leading discharge, and consult Trust/Local Authority legal advisors regarding any legal proceedings concerned. Send final letter to explain that discharge to the identified temporary alternative option will go ahead in line with the policy	Stage 6 At 5 working days after the formal meeting
Compulsory Discharge : Senior Trust Clinician(s) consult with Trust Solicitors to enact compulsory discharge. If final discharge arrangements are not adhered to, Matron and Lead Nurse / Head of Patient Flow will escalated to Senior Clinicians and formal legal proceedings will commence.	Compulsory Discharge As soon as possible after stage 6

APPENDIX 4: DISCHARGE PATHWAY (AUDIT TRAIL)

Royal Devon and Exeter NHS
NHS Foundation Trust

Individuals Name……...Hospital No……..
MDT Representative/s……

Action	Date	Signed
STAGE 1 – INFORMATION PROVIDED ON ADMISSION Discharge planning patient info leaflet given. Patient informed of PDD and told when it is revised. Patient/representative informed of named responsible MDT member Discharge Care Plan/Discharge Checklist started		
STAGE 2 – ASSESS LIKELY CARE NEEDS ON DISCHARGE Patient referred to community services if required. Template Letter 1 given to patient/representative if wished. Expectation managed regarding availability of preferred option.		
STAGE 3 – OFFERING OPTIONS & PREPARING FOR DISCHARGE Template letter 2 given to patient/representative if wished.		
STAGE 4 – AVAILABLE CARE DECLINED. Care declined by (name, relationship): Date: Reason given:		
STAGE 5 – FORMAL MEETING AND FORMAL LETTER Date: Invited attendees: Individual / representative attendees: Template letter 3 given by ward Matron		
STAGE 6 – LEGAL PROCESS AND FORMAL LETTER Alternative discharge location sourced: Template letter 4 given to patient/representative from matron		
Legal advice sourced:		
END: Reason process terminated (start new form if process re-started):		

File in Patients notes and copy to appropriate teams if requested

APPENDIX 5: SELF DISCHARGE FORM

SELF DISCHARGE FORM

Royal Devon and Exeter NHS
NHS Foundation Trust

Royal Devon and Exeter NHS Foundation Trust
Barrack Road, Exeter EX2 5DW

THIS IS TO CERTIFY that I leave this Hospital at my own request, and entirely against the advice of my Medical Officer.

I understand the consequences of self-discharge.

Signed: _____

Date: _____

APPENDIX 6: WARD TRANSFER – NURSE HANDOVER FORM

NHS
Royal Devon and Exeter
NHS Foundation Trust

Ward Transfer – Nurse Handover Form

Patient Name: .....
NHS no: ... *Please affix patient ID label within this box* .....
Hospital no: .....
DOB: .....

Shelford score: 0 1a 1b 2 3	NEWS2 score (**immediately** before transfer): Time taken: HH:MM	Medical handover complete for patient with NEWS score 5 or above:
Transfer Date: DD/MM/YYYY Time: HH:MM	From:	To:
Consultant:	TEP form: ☐	DNAR: ☐
Significant events in last 24 hours e.g. MET calls, high NEWS2 scores, cardiac arrest, rapid tranquilisation		
Working Diagnosis	Relevant PMH	
Infection Control issues	Patient Requirements: Side Room ☐ Monitor ☐	
Mobility Concerns e.g. falls risk, hoist required etc.		
Violence / Aggression / Capacity Concerns/ Learning Disability/ DOLS / Confusion Concerns (please detail any issues)		
Treatment plan, critical actions, outstanding jobs, investigations requiring follow up		
Has the patient received a meal (for those moved shortly before, during or after mealtimes)	Dietary Requirement (e.g. NBM, pureed diet, low calorie etc.)	
Discharge plans & anticipated discharge issues:		
Name of Nurse completing form:		
Name of Nurse receiving the patient:	Time: HH:MM	

Ward Transfer – Nurse Handover Form
Approved by Medicine Governance Group: 27/07/2019
Review date: 12/2020

APPENDIX 7: COMMUNICATION PLAN

Royal Devon and Exeter NHS Foundation Trust

Communication Plan

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the policy	All Staff
The key changes if a revised policy	Hyperlinks updated and added for Safeguarding Adults Policy and the Domestic Abuse Affecting Patients Policy
The key objectives	The purpose of this policy is to ensure co-ordinated safe and timely discharge to all adult in-patients from 'The Trust' to other healthcare organisations, home or community
How new staff will be made aware of the policy and manager action	Cascade by email, preceptorship, induction and Trust Intranet - HUB
Specific Issues to be raised with staff	All staff should be made aware of their duties and responsibility they have in patient discharge and transfers via this policy. Particular attention should be drawn to timeliness, planning and communication.
Training available to staff	Support available from Discharge Lead, Operational Development Manager, Practice Education Team and Intranet HUB
Any other requirements	
Issues following Equality Impact Assessment (if any)	No negative impacts.
Location of hard / electronic copy of the document etc.	Trust intranet

APPENDIX 8: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Discharge & Transfer Policy
Division/Directorate and service area	Operation Support Unit – Site Management
Name, job title and contact details of person completing the assessment	[redacted] – Discharge Lead E221 [redacted]

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

The purpose of this policy is to ensure coordinated, safe and timely discharge, the rationale for achieving this, the responsibilities of individuals and teams, and the operational procedures, systems and documentation involved.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☒ Staff ☒ Patients ☒ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	☒	☐
Disability	☒	☐
Sex - *including: Transgender, and Pregnancy / Maternity*	☐	☒
Race	☐	☒
Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… eg (those affected by homelessness, bariatric patients, end of life patients, those with carers etc)?

5. Do you think the document meets our human rights obligations? ☒

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
• ***Fairness*** *– how have you made sure it treats everyone justly?* • ***Respect*** *– how have you made sure it respects everyone as a person?* • ***Equality*** *– how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity*** *– have you made sure it treats everyone with dignity?* • ***Autonomy*** *– Does it enable people to make decisions for themselves?*

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

This policy clarifies a consistent approach to managing discharge and transfers. The policy is relevant to age and disability, both of which have been dealt with in Section 12.

7. If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact.

Please note this below and how this will be monitored/addressed.

"Protected characteristic":	
Issue:	
How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	

Document Control

Title	**Violence & Aggression Policy**		
Author [redacted]		**Author's job title** Health and Safety Manager and Local Security Management Specialist	
Directorate		**Department** Compliance Team	

Version	Date Issued	Status	Comment / Changes / Approval
2.2	Apr 2015	Revision	Three year revision:
3.0	Sep 15	Final	Approved at CSEC and Published on Bob
4.0	Dec 17	Final	Roles & Responsibilities amended. Training information updated. Reference to NHS Protect removed. Reference to NICE guideline NG10 added. 24/7 Security officer arrangements at NDDH added. Occupational Health responsibilities added. For approval at Health and Safety Committee. Issued Jan 2018.
4.1	July 2021	Revision	Policy harmonised and aligned to mirror RD&E policy, presented to July 2021 H&S Group meeting.
5.0	Sept 2021	Final	Final version, minor amends following consultation & feedback. Approved at H&S Group meeting 09.09.21

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Lead Director
Director of Nursing Quality and Workforce

Superseded Documents
NDHT Managing Violence & Aggression policy (v4.0 Dec 2017)

Issue Date	Review Date	Review Cycle
Sept 2021	Sept 2024	Three years

Consulted with the following stakeholders:

- Clinical Matron Unscheduled Care
- Community Nurse Team Manager
- Consultant Emergency Medicine
- Deputy Director of Nursing and Head of Professional Practice
- Divisional Nurse Planned Care
- Divisional Nurse Unscheduled Care
- Emergency Preparedness, Resilience & Response Officer
- Head of Clinical Site Services
- Head of Therapy Services, Trust Falls Lead
- Health and Safety Group Members
- Health and Social Care Cluster Manager

- Modern Matron
- Outpatients Service Manager
- Occupational Health Department
- Quality Improvement Facilitator (Patient Safety)
- Rapid Intervention, Urgent Care Nursing & Care Home Team Manager
- Safeguarding Adult Lead
- Safeguarding Children's Lead
- Security Management Director

Approval and Review Process

- Health and Safety Group

Local Archive Reference

G:\Corporate Governance

Local Path

\Compliance Team\Health and Safety\Violence and Aggression Policy

Filename

Violence & Aggression Policy V5.0 September 2021

Policy categories for Trust's internal website (Bob)	**Tags for Trust's internal website (Bob)**
Security, Health and Safety	Violent, harassment, assault, violence, aggression, violence and aggression, violence & aggression, v&a, v & a, physical assault, non-physical assault, non-physical assault, abuse, intimidation

CONTENTS

1. Introduction

1.1 This policy is concerned with violence, aggressive and challenging behaviour, both physical and verbal, towards employees of the Northern Devon Healthcare NHS Trust (NDHT) from patients, relatives, visitors or other members of the public. Working in an atmosphere of continuing threat is profoundly damaging to the confidence and morale of staff. There are also costs to the Trust in terms of reduced efficiency, sickness or absence.

1.2 The Trust recognises that as an employer, it has a duty of care towards its staff and that reasonable steps should be taken to ensure their health and safety at all times.
.

1.3 The Trust does not tolerate intentional violence and aggression towards its staff. This will be publicised in public notices displayed in Trust premises (**Appendix B: Violence and Aggression Poster**).

1.4 The Trust recognises enforcing zero tolerance towards individuals for acts of violence and aggression is not achievable due to the occasions when there will be violent and abusive incidents when the person exhibiting challenging behaviour is unable to control their actions due to medical factors.

1.5 This policy will provide guidance to the Trust to pro-actively manage intentional violent and aggressive behaviour and challenging behaviour due to medical factors on the most effective interventions required to minimise risk to staff, patients and visitors.

1.6 The Trust reserves the right to implement a range of sanctions against persons using intentional violence and aggression including the right to exclude any person who in the considered opinion of the Trust threatens the safety and or security of the Trust employees, patients, visitors or property. For further information and guidance refer to **Section 12 Sanctions Management** and **Appendix G**.

1.7 The Trust also acknowledges the need for staff to be skilled in the de-escalation of aggressive and violent behaviour. Additionally identified staff should be trained in a range of restrictive practices refer to **Section 13: Training.**

2. Purpose

2.1 This policy will provide guidance and advice for all employees of the Trust and persons providing services on the management of intentional violence and aggression and challenging behaviour due to medical factors.

2.2 It is important that staff feel safe in their working environment. Violent behaviour not only affects staff personally but it also has a negative impact on the standard of services and the delivery of patient care. In terms of tackling violence against staff, this policy provides information and guidance on a range of measures introduced to make the NHS a safer place to work

3. Regulatory Framework

3.1 The provision of a safe working environment is embedded in the Care Quality Commission's Fundamental Standards (CQC, 2015) Regulation 13: Safeguarding service users from abuse and improper treatment and Regulation 15: Premises and

equipment.

3.2 The NHS Standard Contract should have regard to the violence prevention and reduction standard, and are required to review their status against it and provide board assurance that they have been met it twice a year.

3.3 Commissioners are also expected to undertake compliance assessments as part of their regular contract reviews, twice a year as a minimum or quarterly if significant concerns are identified and raised.

4. Definitions

4.1 Physical Assault

Physical assault is defined as: "the intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort."

(Secretary of State Directions, Department of Health. 2003).

4.2 Non Physical Assault

Non Physical assault is defined as: "the use of inappropriate words or behaviour causing distress and/or constituting harassment."

(Secretary of State Directions, Department of Health. 2003).

Examples of physical and non-physical assault including harassment, unacceptable behaviour both verbal & written together with guidance on abusive phone calls can be found at **Appendix C – Examples Physical and Non-Physical Assault including abusive telephone calls.**

4.3 Clinically Related Challenging Behaviour

Clinically related challenging behaviour is often a manifestation of a patient's distress and an attempt by the person to communicate their unmet needs. For further advice and guidance see **Appendix D – Clinically Related Challenging Behaviour**.

4.4 Perpetrator

A person responsible for committing an offence and or crime i.e. physical assault.

4.5 Victim

A person who is adversely affected by an action as a consequence of the perpetrators actions

4.6 Restrictive Practices

Restrictive practices refer to the implementation of any practice or practices that restrict an individual's movement, liberty and/or freedom to act independently without coercion or consequence. For further information see Restraint & Restrictive Practices Policy

5. Responsibilities

5.1. Role of the Chief Executive

The Chief Executive has overall responsibility for ensuring a safe and secure environment. The Chief Executive has delegated this responsibility to the Chief People Officer.

5.2. Role of Chief People Officer as the Executive Violence & Reduction Lead & Security Management Director (SMD)

The Chief People Officer is the Trusts nominated Executive Violence & Reduction lead & SMD. The Chief People Officer is responsible for the following:

- Security of hospital premises as far as is reasonably practicable with regard to the nature of our services and functions.
- To support and promote the Violence Prevention and Reduction Policy

5.3. Role of the Local Security Management Specialist

The Local Security Management Specialist is responsible for:

- Promote a pro-security culture throughout the Trust
- Provide advice and guidance to managers in conducting physical security assessments and risk assessments relating to violence and aggression.
- Analysis of the Trust's Incident Reporting system to identify trends and take appropriate action to minimise any reoccurrence.
- Provide support to victims of violence and aggression whilst signposting staff and managers affected by incidents to the Trusts Supporting Staff Involved in an Incident, Complaint or Claim Policy.
- Provide advice and guidance to the Security Management Director as required including investigations, sanctions and redress against perpetrators.
- Ensure full co-operation with the Police and / or other agencies in investigations and subsequent actions i.e. sanctions and redress.
- Attend Health & Safety Group meetings and other relevant groups (e.g. Restraint & Restrictive Practices Working Group) to discuss violence and aggression and other security incidents trust wide.
- To ensure compliance with NHS Provider Contract Security Standards.
- The Trusts LSMS is the named Violence Prevention & Reduction Lead.

5.4. Role of Fire & Security Advisor

The Trust Fire & Security Advisor will work with the Local Security Management Specialist to:

- Support the implementation of this policy.

- Implement measures (relevant to role and job description) as is reasonably practicable concerning the management of fixed building and asset security arrangements, also where actions are required to mitigate identified violence and aggression risks.

5.5. Role of Health and Safety Manager

The role of Health and Safety Manager has been merged with the role of Local Security Management Specialist and as such is a dual / combined role. Health and Safety responsibilities (in addition to LSMS responsibilities listed under section 4.6) are outlined in the Health and Safety Policy.

5.6. Role of Senior Managers and Line Managers

Senior managers and line managers will:

- Ensure staff work in an environment that is as safe as possible which includes community visits to a patient's home.
- Complete Violence and Aggression risk assessments and reduce the risks identified.
- Ensure support is offered to staff following violent or distressing incidents in accordance with the Supporting Staff Involved in an Incident, Complaint or Claim Policy.
- Ensure that safety measures are reviewed following an incident.
- Ensure staff are appropriately trained in local procedures and incident reporting requirements.
- Ensure all front line staff complete conflict resolution training.
- Ensure patient facing staff complete Customer Care training.
- Ensure all staff are risk assessed where appropriate for the requirement and attendance at Dementia, Breakaway and Physical Intervention Training.
- Challenge harassment including racial harassment and offer all appropriate protection and support to the victim. In cases where staff members are victims, this may include referral to the counselling service.
- Where incidents of violent, aggressive or challenging behaviour occur, the line manager must conduct a full debriefing of all staff involved. Actions to be completed can be found at Appendix 6: Violence and Aggression Action Card.
- The Line Manager of the staff involved in the incident should ensure it is reported on the Trust incident reporting system, to enable central monitoring of incidents and responses. This may also support equality monitoring.

5.7. Role of Employees

Employees will:

- Employees should ensure the health, safety and welfare of themselves and other persons by being vigilant in respect of themselves and others.
- Employees should ensure that they act in accordance with the training they have received (See Section 10 for relevant training).

- Staff are required to report incidents of violent, aggression or challenging behaviour using the Trust incident reporting system on the Trust intranet, in line with the Incident Reporting, Analysing, Investigating and Learning Policy and Procedures.

5.8. Role of Sodexo

Security officers are employed under contract by the Trusts partnered hotel services provider. Sodexo are responsible for the day to day line management of the security officers who work 24/7 at the NDDH site (one officer per day shift, two per night shift). The nominated line manager is the Portering Manager, Sodexo.

The Security contract is monitored by the Facilities Manager.

Operational support concerning the proactive and reactive management of violence & aggression and theft is undertaken by the Trust Health and Safety Manager and Local Security Management Specialist.

Operational support concerning proactive management of fixed buildings and asset security arrangements is undertaken by the Trust Fire and Security Officer.

Sodexo Security Officers will:

- Provide 24–hour assistance to patients, visitors and staff whilst maintaining appropriate order and preventing public disorder at North Devon District Hospital
- Support and assists in the protection of patients, staff, volunteers, contractors and visitors against acts of violence, aggression and abuse.
- Assist with violent, aggressive and challenging behaviour patients at ward level and carries out regular patrols of the Trust car parks and support car parking staff when required.
- Support senior manager (e.g. clinical site, nurse in charge of shift, service manager, matron) in the instigation of Police response to any suspicious incidents or offences that warrant Police attendance.

6. Violence and Aggression Risk Management

6.1. Risk Management Process

Prevention of violence at work must start with a full assessment of the risks. The risk assessment should be carried out by appropriately trained staff gathering information from a number of sources at both organisational and employee level, help and assistance can be obtained from the Local Security Management Specialist.

The risk assessment process should be:

- For the identification of violence and aggression hazards;
- For evaluating violence and aggression risks;
- To agree action plans; and
- To implement monitor and review measures to reduce risk.

The risk assessor must ensure they have completed a suitable and sufficient risk assessment for all the activities being undertaken and must produce control measures that reduce the risk to the lowest level that is reasonably practicable.

The Trust's approved General Risk Assessment Form must be used for general risk assessments.

Additional advice and guidance can be found at Appendix F – Managing Risk and Assessing Behaviours.

See Appendix A for the patient specific challenging behaviour risk assessment tool.

6.2. Risk Assessments for Locations and Terms

Where a risk of violence and aggression has been identified a risk assessment should be undertaken in accordance with the Risk Management Policy for each ward, unit, department or team. The assessment should identify areas where a more detailed risk assessment is required and should include an examination of the physical layout and security measures of the area assessed.

It is recognised that there are some specific circumstances and situations where the risk in the Trust may be higher. These include:

- Where the employee is a lone worker.
- Where staff are dealing with relatives and carers who may be anxious, angry.
- Where patients that have medical conditions that may well give rise to challenging behaviour.
- Where staff are making home visits.
- When patients are being seen alone or with single chaperone.
- When the number and locality of staff that may be able to respond to situation does not provide adequate support.
- Where environmental factors which may give rise to violence and aggressive behaviour such as levels of lighting, noise, distractions, number of people present, location of furniture, clear lines of sight, potential weapons, colour schemes.

6.3. Risk Assessments of Individual Service Users

Individual service users may be subject to a risk assessment for Violence and Aggression. This assessment, where appropriate, will support existing patient care plans for a patient presenting with challenging behaviour. Where it is identified that an individual service user may present a risk to staff or others, the appropriate health care professional must ensure that:

- Completion of a Challenging Behaviour risk assessment (see Appendix A) with relevant action / care plans is completed with support from their respective teams and specialist advisers, where appropriate.
- The assessment and actions are documented in the patient's healthcare record and if appropriate on Trust information systems in accordance with Trust policy.
- All appropriate staff and services are informed of any actions that need to be taken.

- A process is put in place to ensure that where there are shift changes; information is passed on via the handover process.
- Where care is delivered by staff outside of their immediate team, e.g. out of hours weekends, the information is shared in a timely and effective manner.
- A review of the risk assessment and control measures is undertaken if a further incident occurs or at the set review date.

6.4. Markers on Patient Records

Following certain violence and aggression incidents where circumstances warrant placing an alert against a patient's healthcare record, the warning marker will be placed once approved following procedures outlined in the Violence and Aggression Warning Marker Standard Operating Procedure.

6.5. Risk Assessments for Community, Home Visits and Lone Workers

Staff undertaking community and home visits may be particularly vulnerable. Local teams and managers are expected to ensure that systems are in place that meet their staff requirements and comply with Trust policy.

Where the risk of violence to staff is assessed as significant, or liable to arise because of the work activity, and where that risk cannot be avoided e.g. by providing the service in another suitable location such as a Medical Centre, appropriate risk control measures must be taken to reduce the risk of violence & aggression to the absolute minimum so far as reasonably practicable.

The Trust has a Lone Working Policy which details how lone workers can protect themselves to minimise the risk and make their working environment safer. This policy is accessible on the Trust's intranet. Managers who have identified Lone Workers within their departments / wards must complete a Lone Worker Risk Assessment. This is particularly important for high risk staff undertaking community or home visits.

If the risk is related to an individual service user, the process described in 6.3 must be implemented.

Based upon national guidance, best practice and following an overarching assessment, lone worker safety devices have been identified as an appropriate additional layer of protection to complement existing control measures to manage the risk of violence and aggression in patient homes and other community settings.

Devices have been issued to certain community teams where lone working activities carry risk factors that warrant their use.

Community staff must use lone working safety devices and / or other forms of technology issued to them, subject to risk assessment (e.g. work mobile phones, tablets).

Handovers must be completed in accordance with applicable policies and procedures such as the Community Nursing Safe Effective Handover Tool.

6.6. Risk Assessments for Work Environment and Building Design

The Local Security Management Specialist will work in collaboration with the Trust Fire and Security Advisor and Departmental Managers, as well as design and estate facilities teams, to ensure work environments are as safe and secure as possible to reduce the risk of violence and aggression.

7. Incident Reporting

All incidents of physical and non-physical violence and aggression including unacceptable behaviour should be reported in accordance with the Trust's Incident Reporting, Analysing, Investigating and Learning Policy and Procedures The immediate supervisor and/or line manager must also be informed at the first available opportunity.

The Local Security Management Specialist will monitor violence and aggression reported incidents.

The Compliance Team will investigate all reported incidents of intentional Violence and Aggression and monitor incidents involving challenging behaviour due to medical factors.

8. Security at NDDH

Where staff are unable to manage risks of violence and aggression, Sodexo Security can be contacted to provide support via bleep 357 (emergency) or through Switchboard by dialling 0 (non-emergency).

When called to assist clinical staff caring for a patient, should talk down and de-escalation fail and the proportionate use of restraint as a last report is necessary and lawful, it must be clinically led in accordance with the Trusts Restraint & Restrictive Practices Policy.

9. Contacting the Police

Trust Wide inclusive of all sites and locations occupied or visited by staff where Police assistance is considered necessary in the event of an emergency that cannot be dealt with by Trust and / or contracted staff (e.g. Security Officer), staff must be satisfied that at least one of the following criteria has been met:

- There is an identifiable and immediate risk to life or property
- The person at risk is suffering or is at risk of suffering immediate and significant harm
- It is reasonably believed that a crime has been committed or is about to be committed and / or
- Attendance of a Police Officer is necessary to prevent a breach of the peace.

Where the criteria has been met and in emergency situations: Dial 9 (internal) followed by 999.

In non-emergency situations for example reporting a theft or criminal damage discovered after the event to obtain a crime reference number and to log the incident, the Police can be contacted via 101 or via the Devon & Cornwall Police Online crime reporting form.

Concerning Police involvement regarding any incident of physical or non-physical violence and aggression (e.g. physical assault, hate crime, threats made). Prior to Police

involvement and upon investigation with clinical advice and input, it may be established that the assault was not intentional.

Contributory factors to non-intentional assaults or the like include:

- Medical factors; the patient not fully aware of their actions due to illness or treatment;
- Mental ill health or severe learning disability; or
- Adverse reactions to medication administered.

The view of the person assaulted should also be sought in each incident.

The manager allocated to the incident (via DATIX) is responsible for the ensuring an investigation is conducted in a manner proportionate to the incident with advice support and assistance provided where required by specialist advisors such as the Local Security Management Specialist as is necessary.

10. Communication

Where patients are identified as being violent or potentially violent, it will be necessary to share information about such patients in accordance with the employer's duty to protect the health and safety of staff and to protect the staff of other organisations in accordance with Data Protection and Caldicott requirements and the Crime and Disorder Act 1998.

Employees of the Trust must communicate to their colleagues if there is a likelihood of a patient displaying violent or aggressive behaviour. This information must be recorded clearly in the patient care plan and referral documentation.

The sharing of and disclosure of information to other organisations may occur for the purposes of community safety and security provided requirements are satisfied as outlined in the Violence and Aggression Warning Marker Standard Operating Procedure.

11. Support for Staff

The Trust acknowledges that its staff may be affected physically and emotionally following a violent or other security incident. For further advice and guidance please refer to the Supporting Staff Involved in and Incident, Complaint or Claim Policy and the Stress and Mental Wellbeing Policy

12. Sanctions Management

A wide range of sanctions can be taken for intentional physical and non-physical assaults dependent on the severity of the incident. These measures may include:

- Verbal Warning
- Warning Letter
- Acceptable Behavioural Agreement
- Exclusion from premises
- Secure Controlled Access
- Civil Proceedings and / or Crime Prevention Orders

- Criminal Prosecution

Full guidance on application and authorisation of sanction management refer to Appendix G: Sanctions Management.

13. Training

Conflict Resolution Training

The Trust requires that all front line staff (those dealing directly with the public) receive the National Syllabus in Conflict Resolution Training. This training is intended to help prevent situations escalating and to diffuse potentially abusive and violent incidents. This training includes the causes of violence, the recognition of warning signs and de-escalation techniques.

Higher Risk Groups

Staff in higher risk groups may require a more in-depth level of training in defusing situations where aggression is being displayed or in responding to physical violence. This training may include the following:

- Dementia Training
- Breakaway Training
- Physical Intervention Training

Physical intervention training is applicable to staff in patient facing situations and the training course is still applicable to staff in patient facing situations working at the NDDH site (in addition to the presence of 24/7 security staff).

Training requirements will be determined by risk assessment conducted by the service manager and staff. The Health & Safety Manager and the Local Security Management Specialist will support risk assessment and identification of available training.

Training matrix and booking

Training can be booked via Learn+.

Staff can use Learn+ to access bookings for learning events and complete e-Learning. Staff have access to a personalised compliance dashboard to view mandatory training requirements and search for learning opportunities.

14. Monitoring Compliance with and the Effectiveness of the Policy

14.1. Standards/ Key Performance Indicators

The Trust undertakes to evaluate the effectiveness of this policy and the associated guidelines, the key performance indicators comprise:

- Number of incidents being reported
- Number of significant event reports

- Number of serious investigations
- NHS Staff survey results (Violence & Aggression section)
- The uptake of training programmes

14.2. Process for Monitoring Compliance and Effectiveness

Monitoring compliance of this policy against all minimum requirements in Clause 24 of the NHS Standard Provider Contract will be the responsibility of the Local Security Management Specialist. This will be monitored on a continuous basis using the Trust's Incident reporting system. It will provide baseline information on the number, nature and location of incidents of violence and aggressive behaviour within the Trust.

Where non-compliance is identified, support and advice will be provided to improve practice.

Responsibility

The Local Security Management Specialist will be responsible for monitoring and reporting violence and aggression incidents to the Health & Safety Committee.

15. References

- National Institute for Health and Care Excellence (NICE) (2015): Violence and aggression: short-term management in mental health, health and community settings (NICE Guidance NG10). [online]. Available at: https://www.nice.org.uk/guidance/ng10
- The Nursing and Midwifery Council (NMC) (2010). Code of professional conduct. London: CMC. [online]. Available at; http://www.nmc-uk.org/Documents/Guidance/NMC-Guidance-on-professional- conduct-for-nursing-and-midwifery-students.pdf
- Health & Safety Executive [HSE] (n.d.) Work-related violence (HSE Guidance). HSE. [online]. Available at: http://www.hse.gov.uk/violence/
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- Human Rights Act 1988 [online]. Available at: http://www.legislation.gov.uk/ukpga/1998/42/contents
- Mental Health Act 2007 [online]. Available at:

http://www.legislation.gov.uk/ukpga/2007/12/contents

- Mental Capacity Act 2005 [online]. Available at: http://www.legislation.gov.uk/ukpga/2005/9/contents
- The Mental Health Act 1983 Code of Practice [online]. Available at: https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983
- Criminal Law Act 1967 [online]. Available at: http://www.legislation.gov.uk/ukpga/1967/58
- Criminal Justice and Immigration Act 2008http://www.legislation.gov.uk/ukpga/2008/4/contents

16. Associated Documentation

- Challenging Behaviour Strategy
- Deprivation of Liberty Safeguards (DoLS) Policy
- Health and Safety Policy
- Incident Reporting, Analysing, Investigating and Learning Policy and Procedures
- The Use of Ligature Cutters Standard Operating Procedure
- Lone Worker Policy
- Mental Capacity Policy
- North Devon Healthcare NHS Trust Code of Conduct leaflet
- Observation of Patients Policy
- Patient Safety Briefing and bedside Handover SOP
- Police Welfare Checks Standard Operating Procedure
- Restraint and Restrictive Practice Policy
- Risk Management Policy
- Safeguarding Adults Policy
- Safeguarding Children Policy
- Search of Persons & Property Standard Operating Procedure
- Secure Environment Policy
- Violence and Aggression Warning Markers Standard Operating Procedure

Appendix A: Challenging Behaviour - Patient Risk Assessment

Challenging Behaviour - Patient Risk Assessment

Section A - Patient details:

Patient Name: …… DOB: / / Patient No ……

Address……..

Postcode: ……... Date of Assessment: / / Time: ……

Unit …… Ward/ Dept. ……

Section B – Risk indicators: (answer all statements below)

Is the patient displaying physical signs? **Yes** □ **No** □
(E.g. tense and agitated, sweating profusely, voice/ pitch change, dilation of pupils, physical signs of aggression etc.)

Is the patient a risk to staff or others? **Yes** □ **No** □
(E.g. aggression, violence)

Has there been a previous episode of violence/ aggression? **Yes** □ **No** □
(E.g. patient lashing out, verbal threat etc. this admission or previous admissions)

Is the patient presenting challenging behaviour? **Yes** □ **No** □
(E.g. inappropriate demands, poor service response etc.).

Is the patient a risk to themselves? **Yes** □ **No** □
(E.g. suicide, self-harm etc.).

Section C - Initial Management Plan to manage risks identified:

(See Appendix E and / or Restraint & Restrictive Policy for further guidance – Challenging Behaviour)

……
……
……
……
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Section D - Action Stages Available: (this section must be completed)

1. Is the Initial Management Plan above suitable to manage risks?

   □ Yes, no further action at this stage

   □ No, go to question 2

2. Has the Patient Management Plan been amended and the risk managed?

   □ Yes, detailed below and no further action at this stage

   □ Further action required, go to question 3

3. Has a consultation/ discussion taken place with Team Leader/ Nurse in Charge/ Head of Department and outstanding actions agreed to manage risk?

   □ Yes, detailed below and no further action at this stage

   □ Further action required, go to question 4

4. Team Leader/ Nurse in Charge/ Head of Department must organise a meeting with senior members of staff - Patient Management Team/ Manager on Call/ Medical staff/ Modern Matron/ Senior Nurse/ Local Security Management Specialist

   □ Actions agreed and detailed below

Further Actions taken to manage risk following action stages 2, 3 and/ or 4

Action must include next review time no later than 24 hours

……
……
……
……
……
……

Section E – Person completing risk assessment:

Completed by: …… Signed: ……

Designation:…… Date……

CHECK LIST

Risk Assessments of Individual Service Users

Individual service users may be subject to a risk assessment for Violence and Aggression.

Where it is identified that an individual service user may present a risk to staff or others, the appropriate health care professional must ensure that:

- A Violence and Aggression risk assessment with relevant action plans is completed with support from their respective teams and specialist advisers such as the Local Security Management Specialist, where appropriate.
- The assessment and actions are documented in the patient's healthcare record and if appropriate on Trust information systems in accordance with Trust policy.
- All appropriate staff and services are informed of any actions that need to be taken.
- A process is put in place to ensure that where there are shift changes; information is passed on via the handover process.
- Where care is delivered by staff outside of their immediate team, e.g. out of hours weekends, the information is shared in a timely and effective manner.
- A review of the risk assessment and control measures is undertaken if a further incident occurs or at the set review date.

If this risk assessment was completed following an incident, please ensure the incident is reported on the Trusts incident reporting system (DATIX) in accordance with the Incident Reporting and Management Policy

Appendix B: Violence & Aggression Will Not Be Tolerated - Poster

NHS
Northern Devon Healthcare
NHS Trust

We want NDHT to be safe and secure for all our patients, visitors and staff.

Intentional violence, aggression and threatening or abusive behaviour will **not** be tolerated**.**

We may decide to withhold treatment or services from patients or visitors who are violent or abusive towards our staff.

Patients or visitors who are violent or abusive may be removed from our premises or grounds and could face Prosecution.

POLICING IN PARTNERSHIP

Appendix C: Examples of Physical & Non-physical Assault Including Abusive Telephone Calls

Examples of physical and non-physical assault including abusive telephone calls:

1. **Physical assault;** Examples could include:

- Intentional physical contact on a person that has resulted in bodily harm and injury such as a bite, scratch, bruise, reddening of the skin etc.
- An intentional, unlawful threat to cause bodily harm or injury.
- A circumstance which creates in the other person a well-founded fear of imminent peril or danger.
- Battery – the wilful or intentional touching of a person against that person's will by another person.
- Offensive touching.
- Sexual Assault – sexual contact against a person's consent or will.
- Unwanted physical contact by another.
- Spitting

2. **Non-physical assault;** Examples could include:

- Offensive language, verbal abuse and swearing which prevents staff from doing their job or makes them feel unsafe.
- Loud and intrusive conversation.
- Unwanted or abusive remarks.
- Negative, malicious or stereotyping comments.
- Invasion of personal space.
- Brandishing of objects or weapons.
- Offensive gestures.
- Threats or risk of serious injury to a member of staff, fellow patients or visitors.
- Bullying, victimisation or intimidation.
- Stalking.
- Alcohol and drug fuelled abuse.
- Unreasonable behaviour and non-cooperation such as repeated disregard of hospital visiting hours.
- Any of the above which is linked to destruction of or damage to property.

In short, unacceptable / inappropriate behaviour can be defined as any incident where a staff member feels harassed, abused, threatened, bullied (not by a colleague), insulted or assaulted in circumstances relating to their work or whilst they are at work.

Note: staff-on-staff bullying does not fall under the remit of security management. Any such issues will be managed by line managers and /or Human Resources.

3. **Abusive Telephone Calls**

If you experience the type of behaviour previously described in the form of a phone call, you should:

- Inform the caller that you do not wish to be spoken to in the manner being used If

the caller persists:

- Reiterate that you do not wish to be spoken to in the manner being used and that you

will terminate the call should they persist

If the caller persists:

- Inform the caller that you will not be spoken to in that manner and that you are terminating the call
- Then put the phone down and report the incident to a Senior Manager and via the Trust's Incident Reporting system

Should the caller continue to ring and display this inappropriate behaviour you must refer on to a senior member of staff with all the relevant details. If the caller is still persistent and displays this inappropriate behaviour this becomes a point of law under "The Protection from Harassment Act 1997" and must be reported to the Local Security Management Specialist and / or Police as appropriate.

It is important to note that examples of physical and non-physical assault can be either displayed in person or by telephone, letter or e-mail, or any other form of communication such as graffiti on Trust property and buildings.

Appendix D: Clinically Related Challenging Behaviour

1. COMMON CHARACTERISTICS

1.1 Individuals who manifest challenging behaviour often have some degree of cognitive impairment, either chronic (e.g. dementia or a learning disability) or acute (e.g. delirium, head or brain injury, drug or alcohol intoxication). It may also be seen in other mental health conditions such as psychosis or personality disorder.

1.2 Care is needed that the behaviour is not as a result of an underlying illness or injury which needs urgent attention.

2. TYPES OF BEHAVIOUR

2.1 Challenging behaviour may describe many kinds of deliberate or non-deliberate non-verbal, verbal or physical behaviour. Some of these behaviours (e.g. staring, crying and shouting) may represent legitimate expressions of distress.

2.2 It can include behaviours which may be less risky, such as apathy, lethargy, fatigue, hyperactivity, hypo activity, being non-compliant or withdrawn, if staff need to intervene because the behaviour poses a safety risk to staff, patients and service users or others, e.g. an individual trying to get out of bed when they cannot stand and may fall.

2.3 There is no continuum of behaviour and where someone is sufficiently distressed or alarmed; their behaviour may instantly result in a physical action.

3. PATTERNS OF CHALLENGING BEHAVIOUR

3.1 Identifying patterns to predict when challenging behaviour is more likely to occur can assist when planning, preventing and preparing for it. Challenging behaviour tends to occur in response to:

- Unmet care needs (e.g. toilet, pain, thirst, hunger)
- Care tasks, including intimate procedures
- Administering medication (especially where the patient has to wait for pain relief)
- Pre-operative period (waiting, nil-by-mouth, clinical interventions and procedures)
- Post-operative period
- Gender issues (preferences for male or female carer)
- Pressure on staff time (i.e. staff not being on the 'shop floor')
- Lack of engagement by staff
- Times when staff are otherwise engaged (mealtimes, medication, handovers etc.)
- Areas where there are less experienced staff (e.g. less aware of psychological issues)
- 'Sundowning' (i.e. behaviours are more prevalent during afternoon and evenings, due to factors such as tiredness and changes in levels of light, or sensory deprivation)
- Night time disturbance
- Over-stimulating or under-stimulating environments
- Heightened activity (e.g. mealtimes)
- Lack of meaningful activity
- Relatives leaving
- Cultural, religious or spiritual needs
- Individuals feeling that staff are not hearing or listening to what they are saying
- Staff hostility
- Inconsistent rule setting
- Provocation by other individuals, distress in other individuals.

4. TYPES OF BEHAVIOUR

Non-verbal	Verbal	Physical
• Agitation • Wandering, pacing, following • Intimidating facial expressions, staring • Intimidating body posture • Cornering, invading personal space • Interference with equipment or property • Being withdrawn, extreme passivity, refusal to move	• Shouting • Swearing • Crying • Screaming • Repetitive statements or questions • Personal comments or questions • Racist, sexist, offensive speech • Bizarre, psychotic content, not based on known reality	• Scratching • Grabbing, hair pulling • Biting • Hitting, slapping, punching • Pinching • Spitting • Kicking • Pushing, shoving, knocking into someone • Striking or throwing objects • Inappropriate touching (self or others) • Urinating, smearing • Undressing • Self-harm • Absconding • Removal of lines, masks, catheters, dressings, incontinence pads • Non-compliance, resistive behaviour (e.g. refusing medication, blood tests)

5. TRIGGERS AND ANTECEDENTS

5.1 Triggers and antecedents are factors which occur prior to an individual's challenging behaviour. These factors may include the care environment or setting, individuals or interventions, activities or objects, thoughts or feelings, pain or discomfort.

5.2 For example a person may become overwhelmed, when a high number of healthcare professionals undertake a care intervention in close proximity to them.

5.3 Observing, identifying and documenting triggers and antecedents is the first part of a proactive strategy for minimising an individual's stress or distress. This is because, once identified, many of these situations can be avoided or changed.

6. PRECURSORS

6.1 Challenging behaviours can occur without warning and staff need to be aware of, recognise and identify precursors. Precursors are behaviours and are different to triggers, which are factors that can lead to challenging behaviour.

6.2 Precursors can often be very subtle and leave staff feeling 'uncomfortable', or they may signpost the onset of challenging behaviour.

6.3 Common recognisable cues include:

- Tense and angry facial expressions
- Increased and prolonged restlessness, pacing, body tension
- Increased breathing, muscle twitching and dilated pupils
- Increased volume of speech and swearing
- Refusal to communicate, withdrawal, irritability
- Prolonged eye contact
- Confusion of thought processes, poor Concentration
- Delusions or hallucinations
- Verbal threats or gestures
- Verbalising an intention that suggests distress, e.g. 'I want to go…'
- Replicating behaviour which preceded earlier disturbed or challenging episodes
- Reporting anger or violent feelings
- Generally, anything that seems out of character, e.g. excessive crying or laughing hysterically.

7. REASONS FOR CHALLENGING BEHAVIOUR

7.1 There is always a cause of clinically related challenging behaviour, even if it is not evident at the time. An overall approach that looks to prevent distress by identifying, categorising and understanding its reasons should reduce the likelihood of these potentially 'unforeseen' events occurring. The main categories are:

- Physical factors
- Cognitive factors
- Psychological and emotional factors
- Environmental or social factors

8. Reasons for challenging behaviour – Summary

This table is not exhaustive and is only examples of what may cause challenging behaviour.

Physical	Cognitive	Psychological/ Emotional	Environmental/social
• Hypoxia • Hyperglycaemia • Hypoglycaemia • Electrolyte abnormality • Dehydration • Constipation • Infection • Pain • Visual or hearing impairment • Sleep deprivation • Medication (effects) • Illicit drugs or alcohol • Drug or alcohol withdrawal • Pre or postoperative • Hunger, thirst • Incontinence, urgent toilet needs • Earache • Epilepsy	• Communication problems (expression and understanding) • Memory loss • Difficulty with language or dialect • Reduced spatial awareness • Learning disabilities • Disorientation • Poor executive function (reasoning, planning, foresight) • Loss of insight • Autism	• Fear • Anxiety • Anger • Depression • Social isolation • Mania • Fixed beliefs or current thinking • Separation anxiety • Loss of self-worth	• Noise • Lights • Temperature • Overcrowding, or busy environment • Inappropriate signage • Lack of information • Long waiting times • Cultural factors • Lack of continuity of staffing, or care • Loss of routine • Unfamiliar surroundings • Pace of surroundings • Lack of meaningful activity • Over-stimulation • Under-stimulation • Imposed boundaries or routine • Stopping a habit/behaviour (e.g. smoking)

9. Physical factors

9.1 The physical causes which may lead to challenging behaviour include features of an individual's condition that pre-dispose him or her to distress (such as sensory impairments e.g. a loss of sight, hearing) unpleasant symptoms, pain and discomfort. They can all cause irritability and agitation or trigger distress.

9.2 Patho-physiological changes that cause delirium can be a significant factor and it is worth mentioning them specifically. Delirium is a short term confused state, or worsening of pre-existing confusion, due to a physical cause. It comes on suddenly (days to hours), fluctuates with time and is characterised by cognitive impairment and inattentiveness (distractibility) or drowsiness. Delusions, hallucinations and emotional changes (fear, anger) are common and symptoms are often worse at night. Delirium usually resolves with treatment of the underlying cause, but it may persist and rarely does not always recover. Suspicion of delirium requires assessment by a suitably skilled doctor. Supporting information can be found in the Alcohol Withdrawal Guidelines.

9.3 Poor sleep is common in illness and in hospital, and leaves people fatigued and irritable. Hunger, thirst and urinary symptoms are associated with strong urges in an individual and may manifest as challenging behaviours if they cannot be communicated.

10. Cognitive factors

10.1 Cognitive factors include the inability to remember new information, explanations or instructions, the loss of inhibitions, poor judgment and planning and importantly communication problems.

10.2 They often result in an inability to articulate needs or a difficulty in understanding and interpreting the communication of those around them (both verbal and non-verbal) and can all lead to distress or difficult behaviours.

10.3 Staff needs to translate the reasons for challenging behaviour into unmet needs before identifying strategies to meet these needs.

10.4 Staff and carers can sometimes lack an understanding of communication impairment and overestimate a person's ability to understand information and make choices.

11. Psychological or emotional factors

11.1 Individuals suffering from delusions, especially paranoid, can feel they are being threatened and this can lead to defensive and challenging responses on their part. People with personality disorders may have difficulty foreseeing the consequences on others of their actions and may become acutely distressed. Fear is powerful in provoking difficult or aggressive behaviours. Anger can arise at a time of threat, as part of bereavement, or if needs are not being met.

12. Environmental or social factors

12.1 Factors relating to an individual's surroundings (e.g. excessive noise) can be provocative particularly if they are prolonged or persistent and may also interfere with the individual's rest and sleep. People with cognitive impairment often find care surroundings overwhelming and over-stimulating and may not keep up with the speed or volume of information or activity they are exposed to.

12.2 A lack of stimulation and activity, engaging in meaningless activity or over-activity can lead to frustration in individuals. This may be exacerbated by a lack of communication and dialogue between staff and patients or service users, poor care planning and a lack of coordination of activities between multi-disciplinary teams (MDTs).

12.3 Finally, a lack of understanding of an individual's culture and related behaviour can lead to frustration and agitation on their part. This can lead to a lack of trust, misinterpretation of their behaviour and miscommunication. Cultural sensitivity is important in dealing with this kind of challenging behaviour.

Appendix E: Violence & Aggression Action Card

VIOLENCE/AGGRESSION ACTION CARD
A PATIENT WHO EXHIBITS AGGRESSIVE OR VIOLENT BEHAVIOUR (PHYSICALLY OR VERBALLY)
FOR USE BY: Senior Staff **LIASE WITH: Site Management/Matron/Senior staff**
E NSURE 'ALL' RELE V ANT ACTIONS ARE DOCUME NTED!
CORE RESPONSIBILITIES:
Are staff OK? Is the patient ok?
Does the member of staff /patient require medical?
Does security/police need to be contacted? (bleep 357 / 999)
Does the member of staff need a break period from the bay/cohort bay?
Consider if the staff involved can continue working and if so, do they need to work elsewhere?
If restraint or rapid tranquilisation used, record details in patient notes and increase observations refer to Trust Policy on Rapid Tranquilisation.
Debrief with the rest of the team
Refer to Trust Policy on Violence and Aggression
Complete Incident Report on DATIX
Inform senior staff e.g. Matron or Manager of incident
ASSESS AND CONSIDER POTENTIALLY REVERSIBLE CONDITION, PAIN, INFECTION, ETC.
Identify any clinical explanation for aggressive behaviour (i.e. head injuries, infection, medication, delirium or dementia etc.)
Medication review by the medical team
Review/Create Challenging Behaviour Patient Risk Assessment to identify a plan of appropriate measures of control (Appendix A)
If patient remains unsettled, consider calling the security team on Bleep 357 to also alert to possible reoccurrences and possible requirement for Police attendance
M AT RO N'S RE S PO NSIB I L IT IES:
Follow up with staff involved as soon as possible after the incident
Consider referral to Occupational Health or Counselling Service
Hold team debrief
Refer to Trust Policy on Violence and Aggression
Make other staff aware through safety brief
Consider enhanced observations

WHEN AN INCIDENT OF VIOLENT OR ANTI-SOCIAL BEHAVIOUR OCCURS OUTSIDE TRUST BUILDINGS THE PERSON AT THE SCENE MUST CONSIDER/ADOPT THE FOLLOWING ACTION:

Request Security team via bleep 357, if the nature of the assault more serious, request the police via 999

Always ensure others within the immediate area such as patients, staff, relatives are protected and where/when possible moved to a safe environment

Provide a detailed brief to the site manager as soon as possible, also to the security team upon their arrival

Support the security team if needed/requested until conclusion met

Appendix F: Managing Risk & Assessing Behaviours

1. RISK FACTORS

2. Risk factors increase the likelihood of challenging behaviour and require quick management decisions. Risk factors may include a person's previous history and current clinical presentations. Historical and current factors may operate independently or interact together, and they may combine with environmental and situational triggers to heighten the risk of challenging behaviour.

3. The following factors point to an increased risk of challenging behaviour:

Person	Environment	Situational
Historical factors History of aggressive/violent behaviour History of intent to harm others History of mental condition(s)/self-harm/suicide attempts Cognitive impairment Previously detained under a section of the Mental Health Act Forensic, criminal related history, e.g. prisoners in hospital etc. History of abuse or trauma History of substance and alcohol abuse or withdrawal History of disruption to service delivery and resources, e.g. damage to property, equipment, disruption to staffing levels etc. **Current presentation** Specific diagnoses, physical, cognitive, (especially communication) and psychological/emotional factors.	Environmental factors, e.g. new environments, busy, active, crowded treatment areas Other agitated or distressed patients or service users Lack of meaningful activities.	Activities being undertaken, e.g. washing, dressing, giving medications etc. Services being provided and the client group Staff member, e.g. inconsistent staff attitudes, awareness and approach Staffing, e.g. staffing levels, skill levels and training Certain times of day Patient, e.g. mix/tensions, patient on patient incidents Restrictions, denial or confrontation, e.g. a person wanting to leave, cigarette requests.

4. PREVENTING THE RISK OF CHALLENGING BEHAVIOUR

4.1 Preventing the risk of challenging behaviour relies on meeting personalised care needs: *'Care where the patient is an equal partner with the healthcare professional and where both parties work together to make an assessment, identify options for the delivery of the most appropriate care. The care provided is holistic and the 'whole person' sits at the centre of the care package, which may be delivered by a range of health and social care professionals.'* (NHS Education for Scotland, 2010)

4.2 This approach is based on positive staff attitudes, high levels of tolerance, compassion and empathy. Dignity is important and requires that the individual is kept comfortable, valued, respected, is in control, and that they have choices in their treatment and care.

Empathic understanding means seeing problems from the perspective of the patient or service user.

It requires strong leadership, skilled staff confident in their own abilities and adequate resources. It requires training, practice and often role-modelling by people who know how to do it and can share their expertise.

In acute health settings, staff are often instilled with the belief that they need to work quickly in order to be effective. However, the approach presented here relies on staff being able to talk to the patient or service user and understand their psychological, emotional and physical care needs.

Personalised care means staff building positive relationships with the person being cared for, their family and carers. The rewards equally apply to those delivering the care as well as the person being cared for, as staff tend to feel empowered and supported by this approach.

Staff should understand that the way they interact is vital in helping the patient communicate the reasons for their distress and their unmet needs. They also need to be aware (and this should be reiterated through training) of how their interaction with the patient can positively or negatively reinforce challenging behaviours and of the need to communicate with them in a sensitive way.

A collaborative approach is the most effective way of preventing a person's challenging behaviour, which involves all staff having a unified understanding of an individual's behaviours, antecedents, triggers, reinforces and consequences and what everyone needs to do to prevent the behaviours. This understanding requires developing a personal profile and wherever possible observing and analysing what is happening and designing effective interventions – a functional assessment can assist where possible

5. MANAGEMENT TOOLS AND TECHNIQUES

Aggressive behaviour can nearly always be explained by the "fight or flight" reaction to a situation that is deemed "dangerous" by the victim. In such situations, the following points need to be remembered (however where a diagnosis of delirium has been made, refer also to the Clinical Guidelines for the Diagnosis and Management of Delirium):

- Reduce noise and stimulation
- Allow patients to "wander" safely
- Do not physically restrain patients unless they are a real danger to themselves or others. If absolutely necessary, use the minimal force possible.
- Remember that a uniform may not inspire confidence and may have the reverse effect
- Provide 1:1 care. Use friends or relatives if they are happy to come in; usually relatives are more than happy to be involved in the care, but additional staff may be needed, particularly over the first 24 hours
- Ensure adequate hydration, nutrition and comfort
- Do not be offended if the patient takes a dislike to you. Do not argue with the patient. Find someone that has a good rapport to do the bulk of the care; but make sure that they are supported and have regular breaks during an acute confusion period, as this is very

energy demanding.

- Use of bed rails. This may increase the patient's feeling of being trapped or held against their will. It often results in injury to the patient by either entrapment in the bed rails or climbing over the bed rails and falling from a greater height. A Risk Assessment from the Slips, Trips & Falls Policy (Inpatients) may be required. If necessary nurse the patient on a Hi-Lo Bed on the floor, or put the bed to its lowest height and place Crash Mats around the bed.
- Use a calm but firm approach so that the patient feels there is someone in control of the situation. Keep the voice calm and reassuring; do not shout or speak
- unnecessarily loudly. Keep commands/information short and concise; the patient
- will not be able to deal with too much information at once.
- Maintain consistency of approach by the whole team by through good handovers.
- Avoid the use of sedatives if at all possible. If this is the only safe way of managing the patient it should be used as a last resort and expert advice should be sought regarding appropriate drugs and dosage.

6. Keeping patients and visitors informed

The provision of information to patients, their relatives and friends and ensuring that patients' concerns and complaints are dealt with quickly and fairly is extremely important and can prevent the risk of violence. This is particularly the case in situations of acute distress and/or long waiting periods and is more relevant to areas such as the Emergency Department and Outpatients.

7. Keeping staff informed

Staff involved with patient care should ensure information is communicated to relevant staff, e.g. at handover, particularly when the following applies:

- New members of staff are involved
- New patients are admitted
- There has been a change in the patient's medical/physical state, medication, behaviour or mood, etc.
- Known violent patients/clients are being transferred from one department to another
- Where domiciliary visits are made to patients with a known or suspected history of aggressive or violent behaviour. Further details are available in the separate
- Lone Working Policy

8. Environment

It is important that the workplace environment and surroundings are subject to Risk Assessments in line with the Trust Risk Assessment Policy & Procedure. Where a risk assessment is to be made regarding violence & aggression a Matron or Senior Nurse will carry out the assessment. Further advice and guidance can be obtained from the Local Security Management Specialist.

The patient's environment can have a significant impact on their behaviour, specialty areas, mobility, etc. Items available to them within their environment may also become a hazard to others and/or a means to facilitate self-harm.

As part of the CBMP consideration should be given to:

- Bed location – can the patient be managed in a bay or is a side room more appropriate,

will their behaviour impact on the care and/or recovery of other patients including demands on nursing time

- Potential weapons – remove any non-essential items that may be used to strike and/or be thrown including patients personal property, consider using plastic cutlery
- and non-ceramic crockery, ensure that "hot drinks" are not hot enough to
- scald or injure
- If appropriate, remove sharps bins from the immediate vicinity of the patient, be aware of items on your person such as scissors
- Ensure the patient's visitors do not compromise safety by passing unsuitable items or substances during visits. Consider checking patient's property and local environment following visits.
- Giving each patient a defined personal space
- Providing distraction activities where appropriate
- Encouraging play areas and activities for younger patients with disturbed behaviour
- Providing activities and wandering space for patients with dementia
- Monitoring the mix of patients
- Removing aggressive patients to a single room or cubicle to protect both the health and safety of other patients and that of the aggressor himself/herself
- For patients with dementia and delirium there is also an argument for cohorting patients to reduce the risk of incidents of falls and aggression
- Request check of personal belongings for offensive weapon(s) and potential incendiary devices (matches, cigarette lighters).

9. Personal Safety of Staff

As well as managing the care of the patient concerned, the personal safety of all disciplines and groups of staff must be ensured as far as is reasonably practicable. Although patient care is the primary focus this must not be at the expense or risk of personal injury where the task being attempted is not of an essential and/or life preserving nature.

- Routine, non- essential tasks - bed making, room cleaning, patient hygiene etc. should not be undertaken or attempted when the patient is showing challenging behaviour (unless there is a risk to skin breakdown leading to pain and further aggression)
- Ensure that all staff that may have reason to have contact with the patient – doctors, nurses, (including departments such as x-ray, fracture clinic, cardiology),
- housekeepers, porters, chaplain – are aware of the potential or actual risk/s in
- dealing with the patient
- To avoid a one on one confrontation situation consider setting a minimum 2:1 staff to patient ratio at all times and document this in the patient care plan
- Report all challenging behaviour incidents involving the patient by completing a Trust incident report on Datix and ensure the CBMP is regularly updated and that
- new and/or revised information is communicated to all relevant staff
- Line managers should be aware that caring for challenging behaviour patients can be demanding and stressful and staff caring for challenging patients may require additional management support.
- In more serious or traumatic cases line managers should ensure staff are debriefed and if necessary counselling should be offered to staff. Refer to Action Card at Appendix 6.

10. Care planning

Risk assessment and management should inform the care plan as to whether specific interventions are required to manage challenging behaviour. The risk assessment

documentation should sit alongside the care plan and should be cross-referenced and updated accordingly if new risks emerge.

11. De-escalation

If prevention has failed, is failing or has never had a chance to work, staff need to be skilled in de-escalation. This is based around highly developed communication skills, fostering good relationships, empathy, calming, non-confrontation, minimising threat, negotiation, compromise, agreeing to any reasonable requests, distraction, activities and changes of staffing which are all key here.

12. Doing nothing/ watch and wait

Doing nothing and 'watch and wait' are important strategies in high risk situations where it is safe to apply them, although they require staff confidence as they may seem counter-intuitive. Challenging behaviour around the time of transition (e.g. hospital or care home admission, or ward or bed moves) often settles down within 2 or 3 days without intervention other than trying to keep the individual, staff and other people safe and offering comfort and reassurance. The latter meets psychological and emotional needs and improves the individual's experience of care.

13. Leave and return

'Leave and return' is a strategy when someone is resisting care. Staff need to employ good judgment here. If a patient or service user absolutely needs medical intervention or another essential intervention (e.g. a soiled incontinence pad needs changing), brief physical interventions may be necessary. But in the majority of cases things can wait (washing or shaving, for example). Constant informal risk assessment is needed, along with adequate supervision, opportunities to discuss and debrief dilemmas and staff being trusted to use their judgment.

14. Better understanding and tolerance

Some challenging behaviours may be difficult, or unnecessary, to stop (e.g. wandering or persistent 'vocalisation'). It is important for staff to be able to understand these behaviours, tolerate them (where they are not offensive), accommodate them within the confines of the care environment, keep the patient or service user and others safe and sometimes mitigate effects. For example, someone who is persistently shouting may have to be isolated to reduce stimulation and keep the environment tolerable for others, as well as to avoid provoking others or 'setting them off'.

15. Observation

Observation that goes beyond normal therapeutic engagement and assists in building relationships with patients or service users should be considered for the immediate and long term prevention and management of challenging behaviour. It must not be intrusive, should respect dignity and privacy and must be conducted safely. Organisations should have an action plan for checking availability of internal staff for observation (e.g. staff bank, temporary staff, central response team, movement of staff from other areas). An observation policy should clarify observation levels according to risk and what is expected of staff (a prior knowledge of the person's history is desirable) and how to initiate or discontinue higher level support.

16. Physical intervention and rapid tranquillisation

It is important for staff to be able to recognise situations where physical intervention and/or rapid tranquillisation (refer to Clinical Guidelines for Rapid Tranquilisation of Adults and / or Pharmacological Management of Disturbed Young People including Rapid Tranquilisation are required. Clinical staff need to be confident about when these short term intervention strategies are required, e.g. immediate control of a dangerous situation and when they are not required, i.e. where de- escalation, non-pharmacological means, or use of more routine medication (e.g. pain relief) should be attempted first.

During care planning, 'advance directives' (decisions) may be considered by asking a person to indicate what forms of treatment they would or would not prefer, should they lack capacity to refuse or consent in the future. This includes any treatment preferences that they may have in the event that they become challenging. Where a person has memory/understanding issues a formal capacity assessment is necessary and a plan made in their best interest following the process set out in the MCA Code of Practice taking into account views of relatives and those close to the patient.

Appendix G: Sanctions Management

1. A staged approach will be generally undertaken to manage any sanctions in respect of **intentional** violence and aggression. In such cases a 'Verbal Warning' would precede any 'Written Warning' and this would precede any 'Acceptable Behavioural Contract' or 'Exclusion'. There is no requirement to escalate the response in any particular order should the situation warrant immediate action.

2. Verbal Warning

Where a patient, relative or visitor is violent or abusive, the member of staff or senior member of staff should explain to the patient what is and is not acceptable behaviour and he/she should outline what the possible consequences of any further repetition of unacceptable behaviour could be. An experienced member of staff and / or security should always witness this explanation. Identification of any triggers for the behaviour may be useful in future prevention.

The main aim of the Verbal Warning process is twofold:

- To ascertain the reason of the behaviour displayed as a means of preventing further incidents or reducing the risk of them reoccurring; and
- To ensure that the patient, relative or visitor is aware of the consequences of further unacceptable behaviour.
- In the case of a patient, it may be appropriate to issue a Code of Conduct leaflet which contains information useful to prevent further escalation in
- their behaviour.
- The incident and local actions taken must be reported and investigated in accordance with the Trust incident reporting procedures. The fact that a Verbal Warning has been given should be recorded in the patient's notes.

NB: A Verbal Warning should be delivered no more than twice.

2.1 Written Warning

If having issued one or more verbal warnings, further incidents are reported, the local manager should consider if appropriate to issue a warning letter. Template letter is at **Appendix 8.1**

Any warning letters must be attached to the relevant electronic incident report.

The presence of a mental disorder should not preclude appropriate action from being taken, and it is important to note that the incident must still be recorded in accordance with directions.

2.2 Application

Applications detailing the reason for a 'Warning Letter' should be made directly to the Trust Local Security Management Specialist. The evidence will be reviewed by the Local Security Management Specialist.

2.3 Authorising & Serving

Where it is felt that there is sufficient evidence the case will be referred to the Divisional

Director for the Operations Support Division for authorisation. The serving of the 'Warning Letter' will be recorded delivery or by the Local Security Management Specialist.
The 'Warning Letter' will be attached to the appropriate incident report and the Security Management Specialist will monitor and review all 'Warning Letters' issued.

2.4 Acceptable Behavioural Contract

An Acceptable Behavioural Contract is an option that can be considered for patients, relatives or visitors, to address unacceptable behaviour where verbal warnings or a warning letter have failed, or as an immediate intervention depending on the circumstances.

An Acceptable Behavioural Contract is a written agreement between the parties aimed at addressing and preventing the recurrence of unacceptable behaviour and can be used as an early intervention process to stop unacceptable behaviour from escalating into serious behaviour both on Trust premises and in the community environment.

Where for example it is decided that an Exclusion is not justified but unacceptable or inappropriate behaviour has been identified of a patient or visitor the Trust retains the right to request that the person(s) agree to conduct themselves in a manner which is none threatening or abusive and which is not detrimental to the treatment of themselves or any other patient or safety of any Trust employee or NHS property.

The person(s) will be required to sign an Acceptable Behavioural Contract which will detail the manner of acceptable behaviour required for the continued treatment of themselves or another - see **Appendix 8.2**

2.5 Application

Applications detailing the reason for an Acceptable Behavioural Contract should be made directly to the Trust Local Security Management Specialist. The evidence will be reviewed by the Local Security Management Specialist.

2.6 Authorisation & Serving

Where it is felt that there is sufficient evidence the case will be referred to the Divisional Director for the Operations Support Division for authorisation. The serving of the Acceptable Behavioural Contract will be by recorded delivery or carried out by the Police or Police Community Support Officer in conjunction with the Local Security Management Specialist.

The Security Management Group will monitor all Acceptable Behavioural Contracts in force and the circumstances quarterly. Acceptable Behavioural Contracts will be reviewed every 12 months. Where an Acceptable Behavioural Contract has been signed by a patient a copy will be held on the patient's notes. A record of the Acceptable Behavioural Contract will be retained by the Local Security Management Specialist for a period of three years.

Where a person has an Acceptable Behavioural Contract in force but fails to comply with the conditions the person should be reported to the Local Security Management Specialist for consideration of Exclusion in line with this policy.

3. Exclusion

3.1 The Trust reserves the right to exclude any person or persons, who, in the considered opinion

of the Trust, threatens the safety and or security of the Trust's employees, patients, visitors or property by:

- Having been Convicted or Cautioned for a Criminal Offence, which has been committed on Trust premises or grounds, or
- In the case of a juvenile, is the subject of a Formal Warning or Final Reprimand

3.2 Where the above criteria is not met but a person or persons:

- Causes Trust employees, patients or visitors to fear for their safety, or
- Prevents Trust employees or their agents delivering healthcare, or
- In the professional opinion of the Trust Security Management Specialist or Acute Security Manager and / or in the opinion of a Trust Senior Manager is a threat to the safety and/or security of the Trust's employees, patients, visitors or property, an emergency exclusion order may be issued by the Trust Security Management Specialist or Acute Security Manager and/or a Trust Senior Manager.

3.3 It is not the intention of the Trust to prevent any excluded person from attending the site where they are:

- In need of emergency treatment or care, or
- Fulfilling a pre-arranged hospital appointment.

3.4 It is recognised that there must be sufficient justification for exclusion.

- The Trust must be able to clearly show the process by which any decision was made and in what way the named person is a perceived threat.
- The Trust must be able to show details where any decision has been reviewed such as altering any period of exclusion, and by whom.
- The Trust should determine whether the exclusion covers the whole of the Trust or selected sites or areas.
- The Trust must be able to show that the named person has been advised of any relevant decisions and by whom.

3.5 However, where an excluded person requires or wishes to visit Trust property for one or more of the reasons below then that person must seek permission to do so by writing to the Divisional Director for the Operations Support Division:

- Visiting a relative who is an in-patient within the Trust.
- In order to take part in bona fide lawful business on Trust property.
- They must include full details of the reason for them visiting the site, the time and duration of any visits and include a contact home address and telephone number, and give the Trust not less than 48 hours' notice to respond (not including weekends or Bank Holidays). This will allow time for the Trust to advise the excluded person of any decision.

3.6 The Divisional Director for the Operations Support Division, in consultation with the Chair of the Security Management Group will decide whether permission will be given to enter Trust property.

3.7 Any decision to refuse access to the excluded person will be made on the following criteria:

- The circumstances do not fall within guidelines laid out in section 2.4.
- It is believed the excluded person still constitutes a significant risk to persons or property.

3.8 Where permission is granted the excluded person can be advised verbally (a written record will be made for the file) or by letter if appropriate. They will be instructed to collect from the relevant site main reception and keep in their possession to show if requested by any representative of the Trust, a letter from the Divisional Director for the Operations Support Division giving permission to enter the site within laid down parameters.

3.9 It is recognised that it may be impossible for an excluded person to give sufficient notice in extreme circumstances such as when a relative is suddenly taken seriously ill and the named person attends at that time. In such cases the named person will advise staff immediately upon their arrival at the site that they are excluded, but circumstances had prevented them from complying with the requirements to give a minimum 48 hours' notice as laid out in section 2.5.

3.10 In such circumstances staff dealing with the named person will ensure the Divisional Director for the Operations Support Division is advised that an excluded person is visiting the site and the circumstances of that visit.

3.11 If further visits are likely the Divisional Director for the Operations Support Division in consultation with the Chair of the Security Management Group and Police, will determine what action is required. The excluded person will be contacted and advised of any decision and previously laid down procedures will be followed.

4. EXCLUSION PERIOD

4.1 Exclusion periods can be made for any period of time but are likely to be for periods of one to five years. After each 12-month period a risk assessment will be made by the Divisional Director for the Operations Support Division in consultation with the Chair of the Security Management Group and Police, to determine whether exclusion is still relevant and a record of that process and decision will be made.

4.2 Any decision to subsequently alter the length of any period of exclusion will be ratified at the next Security Management Group meeting.

4.3 The excluded person will be notified in writing of the result of that annual risk assessment.

4.4 An emergency exclusion order will usually be issued for a period of 14 days, or until ratified or overturned by the Chair of the Security Management Group and Divisional Director for the Operations Support Division if sooner, but will not exceed 31 days.

5. PROCEDURE

5.1 The Trust may consider information from any person or agency, advising that a named person maybe someone whom they believe should be the subject of exclusion notice.

5.2 Detailed records must be obtained and kept by the Divisional Director for the Operations Support Division. The Trust must be in a position to confirm all its actions, when they were made and by whom. These records must include (where available and applicable):

- Circumstances of the incident under discussion to include details of the provider of the information.
- Full name, address, date of birth and physical description of the named person (photograph if available).
- Highlight any specific warnings e.g. violence to staff or carries weapons, etc.
- A summary of any deliberations by the Trust.
- Any corroborative information or documentation that can be obtained and its source.
- All details of any correspondence between the Trust and the named person or other persons connected.
- Details of any further incidents involving the named person and any action instigated by the Trust.
- Details of any legal procedures.
- Any other relevant information.
- Records to be kept for a minimum of three years after exclusion period ends.

5.3 Where an emergency exclusion order has been issued by the Trust Local Security Management Specialist and/or a Trust Senior Manager it must be ratified or overturned by the Chair of the Security Management Group and the Divisional Director for the Operations Support Division (or their deputies) at the earliest opportunity. A written record of the decision must be made and tabled at the next Security Management Group meeting.

5.4 Where a person is to be excluded then the Divisional Director for the Operations Support Division will ensure a written notice of the Exclusion is delivered by hand to their last known address. Details of when and by whom the letter was delivered are to be attached to the file. The Exclusion notice will include:

- Confirmation that the Trust has decided formally to exclude them from Trust property (listing all the Trust addresses or selected areas or properties as appropriate).
- The reason for the period of Exclusion.
- Duration of the Exclusion.
- Any exemptions to the Exclusion (listed in sections 2. and 2.5)
- The procedure for an appeal.
- The consequences of breaching the terms of the Exclusion notice.
- How to contact the Divisional Director for the Operations Support Division.
- The Trust reference number if applicable.

5.5 If any person breaches their Exclusion notice then an injunction may be sought from the Court.

6. APPEAL

6.1 A named person has the right of appeal against an Exclusion notice by writing to the designated contact within the Trust who will be:

Patient Experience Manager Patient Advice and Liaison Service,
NDDH, Raleigh Park, Barnstaple, EX31 4JB
Raising a concern on line form

6.2 The appellant has the right to be accompanied by a friend or colleague not acting in a legal capacity and will be advised of this at the appropriate time by the Divisional Director for the Operations Support Division

6.3 The appeal panel will consist of two Trust Board Directors (one Executive and one Non-Executive Director). The decision of the panel will be final and binding and the named person will be informed in writing of their decision by the Divisional Director for the Operations Support Division.

Appendix G: Warning Letter

Northern Devon Healthcare NHS Trust

< insert address>

Dear <insert name>

Warning letter – unacceptable behaviour

The Northern Devon Healthcare NHS Trust has evidence which suggests on the <insert date> you <insert name> used/threatened unlawful violence/acted in an anti-social manner to a member of NHS staff/whilst on NHS premises **(delete as applicable)**.

Behaviour such as this is unacceptable and will not be tolerated. This Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse.

Such behaviour also deprives the Trust of valuable staff time and resources and may result in other patients having their treatment delayed or postponed. Just as the NHS has a responsibility to you, so you have a responsibility to use its resources and treat NHS staff in an appropriate way

Should there be any repetition of this type of behaviour; consideration will be given to taking action against you.

Such action may include the following:

- Excluding you from premises
- Seeking an Acceptable Behaviour Agreement
- Reporting to the police where your behaviour constitutes a criminal offence and fully supporting any prosecution they may pursue.
- Consideration of a private criminal prosecution

If you do not agree with the details contained in this letter about your alleged behaviour or feel that this action is unwarranted, please contact in writing < insert details of local complaints procedure> who will review the decision in light of your account of the incident(s).

A copy of this letter will be retained for 12 months and where appropriate kept with your Medical Records.

Yours sincerely,

Local Security Management Specialist

Appendix G: Acceptable Behaviour Contract

Northern Devon Healthcare NHS Trust

Date

Acceptable Behaviour Contract between, Northern Devon Healthcare NHS Trust, Devon & Cornwall Police and *(Insert name here)*

I am writing to you as the Local Security Management Specialist (LSMS) for Northern Devon Healthcare NHS Trust. The LSMS has responsibility in all aspects of security operational matters relating to the deterrence, prevention, detection, investigation and management of security in Northern Devon Healthcare NHS Trust.

One of my roles is to protect NHS staff from abusive and violent behaviour and NHS resources from misuse and it is in connection with this that we are writing to you. I have received (number) reports in which it is alleged that on (date) whilst attending ****** , you [details of incident or offence] causing [details of impact] .

Behaviour such as this is unacceptable and will not be tolerated. Northern Devon Healthcare NHS Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse, property loss or damage. Such behaviour also deprives Northern Devon Healthcare NHS Trust of valuable resources, causes other patients unacceptable distress and directly affects their quality of care and treatment whilst a patient on Northern Devon Healthcare NHS premises.

It is my view that your actions in the above incident could be considered as constituting criminal offences, in particular -
[Details of offence]

The NHS has a responsibility to provide a service, those using the service have a responsibility to use its resources and treat its staff in an appropriate way.

When attending NHS premises in the future you must comply with the following conditions:

- You will treat all people and property with respect that you come into contact with whilst on NHS Property.
- You will not use abusive, insulting or threatening words or behaviour to any member of Trust over the phone or in person.
- You will not use or threaten violence towards Northern Devon Healthcare NHS Trust staff, patients or visitors.
- You will pursue any complaint using the NHS procedure for doing so.

If you fail to act in accordance with these conditions and continue to demonstrate unacceptable behaviour, consideration will be given to taking action against you.
Such action will include the following:

- Reporting to the police where your behaviour constitutes a criminal offence and fully supporting any prosecution they may pursue.

- Seeking a court order to restrict your behaviour.

- Excluding you from the Trust for anything other than emergency medical care.

If any legal action is necessary any costs incurred will be sought from you and these may be considerable.

Enclosed are two copies of this letter for your attention. I would be grateful if you could sign the attached agreement at the declaration and return one of these in the envelope provided.

This agreement (should you sign it) will be reviewed in 12 months' time. If your behaviour causes no further concern and no further incidents have been reported to us it will be withdrawn.

If you do not agree with the conditions set out in this letter, or have any other representations to make in relation to this matter these should be submitted in writing to;

Local Security Management Specialist
North Devon District Hospital
EX31 4JB

Yours sincerely

Local Security Management Specialist

Northern Devon Healthcare NHS Trust

Appendix G: ACCEPTABLE BEHAVIOUR CONTRACT AGREEMENT

This agreement is between:

Northern Devon Healthcare NHS Trust & Devon and Cornwall Constabulary and (*Insert Name*)

Date of Birth:

I agree to the following in respect of my future behaviour -

- I will treat all people and property with respect that I come into contact with whilst on NHS Property.
- I will not use violence, or foul or abusive language or threatening behaviour towards any person while on NHS premises.
- I will not threaten violence or use foul or abusive language towards any NHS staff while on the telephone.
- I will follow the NHS procedure when making a complaint.

Declaration

I accept the conditions set out above and agree to abide by them accordingly.

Signed:

Dated:

Northern Devon Healthcare NHS Trust

Signed: Print name:

Position: Local Security Management Specialist Dated

For noting – NDHT acceptable behaviour contracts may be arranged at ward level and signed by divisional directors of nursing – recommend for NDHT post holder who could sign letter is extended to cover options such as senior nursing management, clinical site management, or matron

Appendix H: Equality Impact Assessment Tool

Name of document	Policy on the Management of Violence, Aggression & Challenging Behaviour
Division/Directorate and service area	Compliance Team
Name, job title and contact details of person completing the assessment	[redacted] Local Security Management Specialist, [redacted]
Date completed:	September 2021

The purpose of this tool is

- **Identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

To outline responsibilities and best practice in the management of violence and aggression.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☒ Staff ☒ Patients ☒ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)***Please insert an "x" in the appropriate box*** *(x)*

Protected characteristic	Relevant	Not relevant
Age	☒	☐
Disability	☒	☐
Sex - *including: Transgender, and Pregnancy/Maternity*	☐	☒
Race	☒	☐

Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

Please specify any groups you think may be affected in any significant way:

None identified

5. Do you think the document meets our human rights obligations? ☒Yes

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:

***Fairness** – how have you made sure it treat everyone justly?*
Respect – how have you made sure it respects everyone as a person?
Equality – how does it give everyone an equal chance to get whatever it is offering?
Dignity – have you made sure it treats everyone with dignity?
Autonomy – Does it enable people to make decisions for themselves?

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

Please give a brief summary- identifying:

Race

Racial harassment is known to undermine confidence of ethnic minority staff. The policy directly recognises and addresses racially based violence and aggression from patients to staff. The issue is clearly recognised and managers are made responsible for challenging racist attitudes. The policy makes managers responsible for challenging harassment, clearly defines racial hate crime as being within its scope and recognises that race of the carer can be a trigger of violent or aggressive behaviour from patients.

Age

Elderly patients can be especially violent and aggressive, due to delirium or confusion. The policy directly recognises and addresses this issue and refers to published guidelines. Practical advice is made available on best practice in managing violence and aggression from confused, elderly patients. A detailed appendix is provided, outlining the causes of violence and aggression in some confused and delirious patients and how best to manage this

Disability

Disability (in the person requiring restraint) is directly mentioned as a factor which would lead to restraint being applied with extra caution.

7. If you have noted any 'missed opportunities', or perhaps noted that

there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

"Protected characteristic":	None
Issue:	

How is this going to be monitored/ addressed in the future:	N/A
Group that will be responsible for ensuring this carried out:	Health & Safety Group

Royal Devon and Exeter NHS Foundation Trust

Violence Prevention and Reduction Policy

Post holder responsible for Procedural Document	[redacted] Security Management Specialist
Author of Policy	[redacted] Security Management Specialist
Division/ Department responsible for Procedural Document	Estates and Facilities Management/Security Dept
Contact details	[redacted]@nhs.net
Date of original document	July 2004
Impact Assessment performed	**Yes**/ No
Ratifying body and date ratified	Health and Safety Group 3 September 2021
Review date	March 2026 (every 4½ years)
Expiry date	September 2026
Date document becomes live	26 October 2021

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience		Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute services	
CQC Fundamental Standards - Regulation: **13, 15, 18**		Infection Control	
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		Status: Final	
Version	Date	Author	Reason
1.0	July 2004	Security Management Specialist (SMS)	New Policy
2.0	Dec 2007	SMS	Reviewed, minor amendments
3.0	Oct 2009	SMS	Reviewed, minor amendments
4.0	Jan 2011	SMS	Minor amendments
4.1	March 2013	SMS	Minor amendments, not published
5.0	March 2014	SMS	Minor amendments
6.0	Sep 2015	SMS	Inclusion of guidance on Restrictive Interventions and Physical Restraint
7.0	October 2017	SMS	• Removed references to NHS Protect which has been decommissioned • Section 6: Risk Assessment • Section 7: Reporting Crime & violence and aggression incidents. • Section 8: Support for staff • Section 9: Sanctions Management (linked to Security Policy) • Appendix 2: Definitions Physical & Non Physical Assault (including abusive telephone call procedure)
7.1	September 2018	Security Management Specialist	• Section1: Removal of Trust reference to 'Zero Tolerance' towards violence and aggression. • Section 9: Inclusion of 'Sanctions Management' • Appendix 8: Sanctions Management • Section 10: Training section updated
8.0	April 2021	Security Management Specialist	Removal of restrictive practices guidance Amendments to align with NDHT policy Amendments to align with NHS

			England Violence Prevention and Reduction Standards Name change of policy title

Associated Trust Policies/ Procedural documents:	Security Policy Harassment & Bullying at Work Policy Risk Assessment Standard Operating Procedure Lone Working Policy Equality & Diversity Policy Stress Management: Prevention, Recognition and Support Policy Supporting staff involved in an Adverse Event Procedure Incident Reporting, Analysing, Investigating and Learning Policy Slips, Trips & Falls Policy (Inpatients) Clinical Guidelines for the Diagnosis and Management of Delirium Clinical Guidelines for Rapid Tranquilisation of Adults Pharmacological Management of disturbed Young People including Rapid Tranquilisation
Key Words	Violence, Aggression, Challenging, Behaviour
In consultation with and date: Head of Facilities Management – 21 June 2021, Divisional Directors - 21 June 2021 Assistant Directors of Nursing, Senior Nurses - 21 June 2021 Governance Managers - 21 June 2021 Site Management - 21 June 2021 Equality and Diversity Manager – 21 June 2021 Security Management Group (Chair) – 28 July 2021 Quality Assurance – 6 August 2021 FM SGG – 24 August 2021 Health and Safety Group 3 September 2021	
Contact for Review:	Security Management Specialist
Executive Lead Signature: Chief Nursing Officer	[redacted]

CONTENTS

KEY POINTS OF THIS POLICY:

This policy is concerned with violence, aggressive and challenging behaviour, both physical and verbal, towards employees of the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust) from patients, relatives, visitors or other members of the public. Working in an atmosphere of continuing threat is profoundly damaging to the confidence and morale of staff. There are also costs to the Trust in terms of reduced efficiency, sickness or absence.

The Trust recognises that as an employer, it has a duty of care towards its staff and that reasonable steps should be taken to ensure their health and safety at all times.

The Trust does not tolerate intentional violence and aggression towards its staff. This will be publicised in public notices displayed in Trust premises (**Appendix 1: Violence and Aggression Poster).**

This policy will provide guidance and advice for all employees of the Trust and persons providing services on the management of intentional violence and aggression and challenging behaviour due to medical factors.

It is important that staff feel safe in their working environment. Violent behaviour not only affects staff personally but it also has a negative impact on the standard of services and the delivery of patient care. In terms of tackling violence against staff, this policy provides information and guidance on a range of measures introduced to make the NHS a safer place to work.

1 INTRODUCTION

1.1 This policy is concerned with violence, aggressive and challenging behaviour, both physical and verbal, towards employees of the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust) from patients, relatives, visitors or other members of the public. Working in an atmosphere of continuing threat is profoundly damaging to the confidence and morale of staff. There are also costs to the Trust in terms of reduced efficiency, sickness or absence.

1.2 The Trust recognises that as an employer, it has a duty of care towards its staff and that reasonable steps should be taken to ensure their health and safety at all times.

1.3 The Trust does not tolerate intentional violence and aggression towards its staff. This will be publicised in public notices displayed in Trust premises (**Appendix 1: Violence and Aggression Poster).**

1.4 The Trust recognises enforcing zero tolerance towards individuals for acts of violence and aggression is not achievable due to the occasions when there will be violent and abusive incidents when the person exhibiting challenging behaviour is unable to control their actions due to medical factors.

1.5 This policy will provide guidance to the Trust to pro-actively manage intentional violent and aggressive behaviour and challenging behaviour due to medical factors on the most effective interventions required to minimise risk to staff, patients and visitors.

1.6 The Trust reserves the right to implement a range of sanctions against persons using intentional violence and aggression including the right to exclude any person who in the considered opinion of the Trust threatens the safety and or security of the Trust employees, patients, visitors or property. For further information and guidance refer to **Section 9 Sanctions Management**.

1.7 The Trust also acknowledges the need for staff to be skilled in the de-escalation of aggressive and violent behaviour. Additionally identified staff should be trained in a range of restrictive practices refer to **Section 10: Training**.

2. PURPOSE

2.1 This policy will provide guidance and advice for all employees of the Trust and persons providing services on the management of intentional violence and aggression and challenging behaviour due to medical factors.

2.2 It is important that staff feel safe in their working environment. Violent behaviour not only affects staff personally but it also has a negative impact on the standard of services and the delivery of patient care. In terms of tackling violence against staff, this policy provides information and guidance on a range of measures introduced to make the NHS a safer place to work.

3. LEGISLATION

3.1 Underpinning Legislation

Employers (including NHS employers) have a general duty of care to protect staff from threats and violence at work. Five pieces of health and safety legislation cover violence at work:

- Health and Safety at Work Act 1974 (HASAWA)

- Management of Health and Safety at Work Regulations 1999
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013(RIDDOR)
- Safety Representatives and Safety Committees Regulations 1977
- Health and Safety (Consultation with Employees) Regulations 1996.

3.2 Associated Legislation

- The Corporate Manslaughter and Corporate Homicide Act 2007
- Protection from Harassment Act 1997 – Legislation.gov.uk
- Assaults on Emergency Workers (Offences) Act 2018
- Equality Act 2010 - Legislation.gov.uk
- Offences against the person legislation
- Section 39 Criminal Justice Act 1988

3.3 Regulatory Framework

The provision of a safe working environment is embedded in the Care Quality Commission's Fundamental Standards (CQC, 2015) Regulation 13: Safeguarding service users from abuse and improper treatment and Regulation 15: Premises and equipment.

The NHS Standard Contract should have regard to the violence prevention and reduction standard, and are required to review their status against it and provide board assurance that they have been met it twice a year.

Commissioners are also expected to undertake compliance assessments as part of their regular contract reviews, twice a year as a minimum or quarterly if significant concerns are identified and raised.

4. DEFINITIONS

4.1 **Physical Assault** is defined as: "the intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort."

(Secretary of State Directions, Department of Health 2003)

4.2 **Non Physical Assault** is defined as "the intentional use of inappropriate words or behaviour causing distress and/or constituting harassment."

(Secretary of State Directions, Department of Health 2003)

Examples of Physical and Non-Physical Assault including harassment, unacceptable behaviour both verbal and written together with guidance on abusive phone calls can be found at **Appendix 2 – Examples Physical and Non-Physical Assault including abusive telephone calls.**

4.3 **Clinically related challenging behaviour** is often a manifestation of a patient's distress and an attempt by the person to communicate their unmet needs. For further advice and guidance see **Appendix 3** – **Clinically Related Challenging Behaviour**.

4.4 **Perpetrator:** A person responsible for committing an offence and or crime i.e. physical assault

4.5 **Victim:** A person who is adversely affected by an action as a consequence of the

perpetrators actions

4.6 **Restrictive Practices -** Restrictive practices refer to the implementation of any practice or practices that restrict an individual's movement, liberty and/or freedom to act independently without coercion or consequence. For further advice and guidance see **Restrictive Practices Policy (currently under review).**

5. DUTIES AND RESPONSIBILITIES OF STAFF

5.1 **Role of the Chief Executive** has overall responsibility for ensuring a safe and secure environment. The Chief Executive has delegated this responsibility to the Chief People Officer.

5.2 Role of the **Executive Violence and Reduction Lead** and **Security Management Director (SMD)** is the Trust's designated Lead Executive responsible for the following:

- Security of hospital premises as far as is reasonably practicable with regard to the nature of our services and functions.
- To support and promote the Violence Prevention and Reduction Policy

The SMD has delegated the position of Chair of the Security Management Group to the Head of Facilities Management.

5.3 Role of the **Head of Facilities Management** delegated by the SMD is to Chair the Security Management Group where security issues are discussed and strategies monitored for effectiveness.

5.4 **Role of the Local Security Management Specialist** is the following:

- Promote a pro-security culture throughout the Trust
- Provide advice and guidance to managers in conducting physical security assessments and risk assessments relating to violence and aggression.
- Analysis of the Trust's Incident Reporting system to identify trends and take appropriate action to minimise any reoccurrence.
- Provide support to victims of violence and aggression whilst signposting staff and managers affected by incidents to the Trusts Supporting Staff Involved in an Incident, Complaint or Claim Policy.
- Provide advice and guidance to the Security Management Director as required including investigations, sanctions and redress against perpetrators.
- Ensure full co-operation with the Police and / or other agencies in investigations and subsequent actions i.e. sanctions and redress.
- Attend Security Management Group meetings to discuss violence and aggression and other security incidents trust wide.
- To ensure compliance with NHS Provider Contract Security Standards

5.5 **Role of Security Manager and Violence Reduction Lead**

5.5.1 Operational responsibility for the Security Operations Officers and delivery of security across the Heavitree and Wonford sites to minimise violence and aggression towards staff, patients and visitors.

5.5.2 To liaise with the Training Manager (Workforce Planning & Development) to ensure Conflict Resolution and relevant Physical Intervention training is delivered through a risk based approach Accountable for the design, maintenance, documentation and improvement of the organisational violence prevention and reduction systems and

processes.

5.6 **Role of Security Operations Officers**

- Provide 24–hour assistance to patients, visitors and staff whilst maintaining appropriate order and preventing public disorder on Heavitree and Wonford Sites.
- Support and assists in the protection of patients, staff, volunteers, contractors and visitors against acts of violence, aggression and abuse.
- Assist with violent, aggressive and challenging behaviour patients at ward level and carries out regular patrols of the Trust car parks and supports car parking
- staff when required.
- Instigate Police response to any suspicious incidents or offences

5.7 **Role of Senior & Line Managers**

5.7.1 Senior managers and line managers will:

- Ensure staff work in an environment that is as safe as possible which includes community visits to a patient's home.
- Complete Violence and Aggression risk assessments and reduce the risks identified.
- Ensure support is offered to staff following violent or distressing incidents in accordance with the Supporting Staff Involved in an Incident, Complaint or Claim Policy.
- Ensure that safety measures are reviewed following an incident.
- Ensure staff are appropriately trained in local procedures and incident reporting requirements.
- Ensure all front line staff attend conflict resolution training.
- Ensure all staff attend Customer Care training where appropriate.
- Ensure all staff are risk assessed where appropriate for the requirement and attendance at Dementia, Breakaway and Physical Intervention Training.

5.7.2 Where a risk of violence and aggression is identified appropriate control measures to be implemented and escalated accordingly.

5.7.3 A medical and/or psychiatric opinion should be professionally obtained at the earliest possible stage where appropriate.

5.7.4 As part of the risk assessment process, identify the training needs of their staff in regard to violence and aggression and control and restraint.

5.7.5 Challenge harassment including racial harassment and offer all appropriate protection and support to the victim. In cases where staff members are victims, this may include referral to the counselling service.

5.7.6 Where incidents of violent, aggressive or challenging behaviour occur, the line manager must conduct a full debriefing of all staff involved. Actions to be completed can be found at **Appendix 4: Violence and Aggression Action Card**.

5.7.7 The Line Manager of the staff involved in the incident should ensure it is reported on the Trust incident reporting system, to enable central monitoring of incidents and responses. This may also support equality monitoring.

5.8 **All Staff**

5.8.1 Employees should ensure the health, safety and welfare of themselves and other persons by being vigilant in respect of themselves and others.

5.8.2 Employees should ensure that they act in accordance with the training they have received (See Section 10 for relevant training).

5.8.3 Staff are required to report incidents of violent, aggression or challenging behaviour using the Trust incident reporting system on the Trust intranet, in line with the Trust Reporting, Investigating and Learning Policy & Procedure.

5.9 The **Security Management Group** meetings are held quarterly and the responsibility of the group include:

- Strategic planning and operational security issues.
- Reviewing current practice and making recommendations for improvement, in particular the need for crime reduction and the maintenance of a safe environment. Ensuring that both costs and risks are included in any security review process and forwarding information and results, as appropriate, to the Health and Safety Group.
- Ensuring systems are in place to monitor violence and aggression incidents.
- Producing a quarterly report to the Health and Safety Group to review progress.
- To liaise with the Learning and Development Service over the development of staff training programmes required to support safe practice and risk reduction.
- To maintain working partnership with the Police and the organisation.

6. VIOLENCE AND AGGRESSION RISK MANAGEMENT

6.1 Risk Management Process

The general risk of violence and aggression must be included in annual Health and Safety Audit Risk Assessments undertaken.

6.1.1 Prevention of violence at work must start with a full assessment of the risks. The risk assessment should be carried out by appropriately trained staff gathering information from a number of sources at both organisational and employee level, help and assistance can be obtained from the Local Security Management Specialist.

6.1.2 The risk assessment process should be:

- For the identification of violence and aggression hazards;
- For evaluating violence and aggression risks;
- To agree action plans; and
- To implement monitor and review measures to reduce risk.

6.1.3 The risk assessor must ensure they have completed a suitable and sufficient risk assessment for all the activities being undertaken and must produce control measures that reduce the risk to the lowest level that is reasonably practicable. The Trust's approved General Risk Assessment Form must be used. Additional advice and guidance can be found at **Appendix 5 – Managing Risk and Assessing Behaviours**.

6.2 Risk Assessments for Locations and Teams

6.2.1 Where a risk of violence and aggression has been identified a risk assessment should be undertaken using the General Risk Assessment Form in each ward, unit, department or team. The assessment should identify areas where a more detailed risk assessment is

required and should include an examination of the physical layout and security measures of the area assessed.

6.2.2 It is recognised that there are some specific circumstances and situations where the risk in the Trust may be higher. These include:

- Where the employee is a lone worker.
- Where staff are dealing with relatives and carers who may be anxious, angry.
- Where patients that have medical conditions that may well give rise to challenging behaviour.
- Where staff are making home visits.
- When patients are being seen alone or with single chaperone.
- When the number and locality of staff that may be able to respond to situation does not provide adequate support.
- Where environmental factors which may give rise to violence and aggressive behaviour such as levels of lighting, noise, distractions, number of people present, location of furniture, clear lines of sight, potential weapons, colour schemes.

6.2.3 The risk assessment and supporting action plan will be recorded on the divisional risk register and performance monitored via the Trust risk management process.

6.3 Risk Assessments of Individual Service Users

6.3.1 Individual service users may be subject to a risk assessment for Violence and Aggression. This assessment, where appropriate, will support existing patient care plans for a patient presenting with challenging behaviour. Where it is identified that an individual service user may present a risk to staff or others, the appropriate health care professional must ensure that:

- Completion of a Challenging Behaviour Management Plan risk assessment and communication tool (**see Appendix 5 Section 3 Managing Risk and Aggressive Behaviour**) with relevant action / care plans is completed with support from their respective teams and specialist advisers, where appropriate.
- The assessment and actions are documented in the patient's healthcare record and if appropriate on Trust information systems in accordance with Trust policy.
- All appropriate staff and services are informed of any actions that need to be taken.
- A process is put in place to ensure that where there are shift changes; information is passed on via the handover process.
- Where care is delivered by staff outside of their immediate team, e.g. out of hours weekends, the information is shared in a timely and effective manner.
- A review of the risk assessment and control measures is undertaken if a further incident occurs or at the set review date.

6.4 Risk Assessments for Community, Home Visits and Lone Workers

6.4.1 Staff undertaking community and home visits may be particularly vulnerable. Local teams and managers are expected to ensure that systems are in place that meet their staff requirements and comply with Trust policy.

6.4.2 Where the risk of violence to staff is assessed as significant, or liable to arise because of the work activity, and where that risk cannot be avoided e.g. by providing the service in

another suitable location such as a Medical Centre, appropriate risk control measures must be taken to reduce the risk of violence & aggression to the absolute minimum so far as reasonably practicable.

6.4.3 The Trust has a Lone Working Policy which details how lone workers can protect themselves to minimise the risk and make their working environment safer. This policy is accessible on the Trust's intranet. Managers who have identified Lone Workers within their departments / wards must complete a Lone Worker Risk Assessment. This is particularly important for high risk staff undertaking community or home visits.

6.4.4 The risk assessment and supporting action plan will be recorded on the corporate risk register and performance monitored via the Trust's risk management process.

6.4.5 If the risk is related to an individual service user, the process described in 6.3 must be implemented.

6.5 Risk Assessments for Work Environment and Building Design

6.5.1 The Local Security Management Specialist will work in collaboration with Departmental Managers, as well as design and estate facilities teams, to ensure work environments are as safe and secure as possible to reduce the risk of violence and aggression.

7. REPORTING OF CRIME AND VIOLENCE & AGGRESSION INCIDENTS

7.1 Contacting Security Team (Acute)

For security assistance on the acute site – Telephone #6450 or bleep 430 (routine) or dial 6666 (urgent). The Security Team is available 24hrs a day 7 days a week.

For security advice and information follow the link to the Security site on the Trust intranet.

7.2 Contacting the Police

- Dial 9 (Internal) followed by 999 if immediate action is required – life is threatened, persons are injured or threatened and need help, and offenders at or nearby the scene.
- Dial 9 (internal) followed by 101 to report a crime or incident where an immediate response is not required
- Non-urgent crime can also be reported through the on-line service https://services.devon-cornwall.police.uk/crimereporting/
- Or by emailing 101@devonandcornwall.pnn.police.uk

7.3 Incident reporting

All Violence and Aggression incidents should be reported in accordance with the Trust's Incident Reporting, Analysing, Investigating and Learning Policy and Procedure. The immediate supervisor and / or line manager must also be informed at the first available opportunity. The Local Security Management Specialist will monitor all violence and aggression reported incidents.

7.1.1 The Security Management team will investigate all reported incidents of intentional Violence and Aggression and monitor incidents involving challenging behaviour due to medical factors.

8. SUPPORT FOR STAFF

8.1 The Trust acknowledges that its staff may be affected physically and emotionally following a violent or other security incident. For further advice and guidance please refer to the

Supporting Staff Involved in an Adverse Event Procedure and the Stress Management: Prevention, Recognition and Support Policy.

9. SANCTIONS MANAGEMENT

9.1 Available Sanctions

A wide range of sanctions can be taken for **intentional** physical and non-physical assaults dependent on the severity of the incident. These measures may include:

- Verbal Warning
- Warning Letter
- Acceptable Behavioural Contract
- Exclusion from premises
- Secure Controlled Access
- Civil Proceedings and / or Crime Prevention Orders
- Criminal Prosecution

9.1 Full guidance on application and authorisation of sanction management refer to **Appendix 6: Sanctions Management.**

10. TRAINING

10.1 Conflict Resolution Training

The Trust requires that all front line staff (those dealing directly with the public) receive the Conflict Resolution Training via E-Learning during their first year in the Trust. This training is intended to help prevent situations escalating and to diffuse potentially abusive and violent incidents. This training includes the causes of violence, the recognition of warning signs and de-escalation techniques.

10.2 Higher Risk Groups

Staff in higher risk groups may require a more in-depth level of training in defusing situations where aggression is being displayed or in responding to physical violence. This training may include but not exclusively the following:

- Dementia Awareness Workshops
- Breakaway training
- Breakaway and Safe Handling combined training

10.2.1 The Break-away and Safe Handling combined training is a one day course, led by two specialist trainers. It is highly participative, using discussion of real life incidents and giving the chance to practice the skills necessary to defuse and manage incidents of aggressive communication, challenging behaviour, and physical violence.

NOTE: Physical Intervention training is under review and currently only the combined Breakaway and Safe Handling training is available to identified high risk staff within the acute environment.

10.2.2 Training requirements will be determined by risk assessment conducted by the service manager and staff. The Operational Security Manager / Physical Intervention Trainer and / or the Local Security Management Specialist will support the risk assessment and identification of available training.

10.2.3 If an employee has any health issues e.g. physical limitations or conditions like epilepsy that

may impact on their ability to undertake restrictive activities, the manager is to seek advice from Occupational Health to determine their fitness for these activities. There is a question in the annual Health Risk/ Hazards and Health Surveillance at Work Questionnaire where staffs who undertake restrictive practices can inform managers if they have any concerns about their ability to undertake restrictive practices.

10.2.4 Staff will have the training they require added to their individual skills matrix on Electronic Staff Record (ESR).

10.2.5 Both Conflict Resolution Training and Breakaway and Safe Handling Training are renewable every 3 years.

10.2.6 All training will be recorded on the Electronic Staff Record (ESR).

11. ARCHIVING ARRANGEMENTS

The original of this policy, will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

12. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

12.1 In order to monitor compliance with this policy, the auditable standards will be monitored as follows:

What areas need to be monitored?	How will this be evidenced?	Where will this be reported and by whom?
All Services / Departments in which incidents of Violence and Aggression occur.	Review incidents reported through the Trust incident reporting system.	LSMS Quarterly Report to Security Management Group.
Violence and aggression statistics for all Divisions recorded inclusive of Non-Physical and Physical Assaults	Report through the Trust Incident Reporting System	LSMS Quarterly to H&S Committee
Compliance with violence prevention and reduction standard which supports a safe and secure working environment	Compliance with NHS Provider annual contract.	LSMS annually to H&S Committee
Suitable and sufficient training is provided by the Trust	Training reports	Violence and Prevention & Reduction Lead report to the Security Management Group.

13. REFERENCES

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APPENDIX 1: VIOLENCE AND AGGRESSION WILL NOT BE TOLERATED - POSTER

Royal Devon and Exeter NHS
NHS Foundation Trust

We want the RD&E to be safe and secure for all our patients, visitors and staff.

Intentional violence, aggression and threatening or abusive behaviour will **not** be tolerated**.**

We may decide to withhold treatment or services from patients or visitors who are violent or abusive towards our staff.

Patients or visitors who are violent or abusive may be removed from our premises or grounds and could face Prosecution.

POLICING IN PARTNERSHIP

APPENDIX 2: EXAMPLES OF PHYSICAL AND NON-PHYSICAL ASSAULT INCLUDING ABUSIVE TELEPHONE CALLS

Examples of physical and non-physical assault including abusive telephone calls:

1. Physical assault; Examples could include:

- Intentional physical contact on a person that has resulted in bodily harm and injury such as a bite, scratch, bruise, reddening of the skin etc.
- An intentional, unlawful threat to cause bodily harm or injury.
- A circumstance which creates in the other person a well-founded fear of imminent peril or danger.
- Battery – the wilful or intentional touching of a person against that person's will by another person.
- Offensive touching.
- Sexual Assault – sexual contact against a person's consent or will.
- Unwanted physical contact by another.
- Spitting

2. Non-physical assault; Examples could include:

- Offensive language, verbal abuse and swearing which prevents staff from doing their job or makes them feel unsafe.
- Loud and intrusive conversation.
- Unwanted or abusive remarks.
- Negative, malicious or stereotyping comments.
- Invasion of personal space.
- Brandishing of objects or weapons.
- Offensive gestures.
- Threats or risk of serious injury to a member of staff, fellow patients or visitors.
- Bullying, victimisation or intimidation.
- Stalking.
- Alcohol and drug fuelled abuse.
- Unreasonable behaviour and non-cooperation such as repeated disregard of hospital visiting hours.
- Any of the above which is linked to destruction of or damage to property.

In short, unacceptable / inappropriate behaviour can be defined as any incident where a staff member feels harassed, abused, threatened, bullied (not by a colleague), insulted or assaulted in circumstances relating to their work or whilst they are at work.

Note: staff-on-staff bullying does not fall under the remit of security management. Any such issues will be managed by line managers and /or Human Resources.

3. Abusive Telephone Calls

If you experience the type of behaviour previously described in the form of a phone call, you should:

Inform the caller that you do not wish to be spoken to in the manner being used If the

caller persists:

Reiterate that you do not wish to be spoken to in the manner being used and that you will

terminate the call should they persist

If the caller persists:

Inform the caller that you will not be spoken to in that manner and that you are terminating the call

- Then put the phone down and report the incident to a Senior Manager and via the Trust's Incident Reporting system

Should the caller continue to ring and display this inappropriate behaviour you must refer on to a senior member of staff with all the relevant details. If the caller is still persistent and displays this inappropriate behaviour this becomes a point of law under "The Protection from Harassment Act 1997" and must be reported to the Local Security Management Specialist and / or Police as appropriate.

It is important to note that examples of physical and non-physical assault can be either displayed in person or by telephone, letter or e-mail, or any other form of communication such as graffiti on Trust property and buildings.

APPENDIX 3: CLINICALLY RELATED CHALLENGING BEHAVIOUR

1. COMMON CHARACTERISTICS

1.1 Individuals who manifest challenging behaviour often have some degree of cognitive impairment, either chronic (e.g. dementia or a learning disability) or acute (e.g. delirium, head or brain injury, drug or alcohol intoxication). It may also be seen in other mental health conditions such as psychosis or personality disorder.

1.2 Care is needed that the behaviour is not as a result of an underlying illness or injury which needs urgent attention.

2 TYPES OF BEHAVIOUR

2.1 Challenging behaviour may describe many kinds of deliberate or non-deliberate non-verbal, verbal or physical behaviour. Some of these behaviours (e.g. staring, crying and shouting) may represent legitimate expressions of distress.

2.2 It can include behaviours which may be less risky, such as apathy, lethargy, fatigue, hyperactivity, hypo activity, being non-compliant or withdrawn, if staff need to intervene because the behaviour poses a safety risk to staff, patients and service users or others, e.g. an individual trying to get out of bed when they cannot stand and may fall.

2.3 There is no continuum of behaviour and where someone is sufficiently distressed or alarmed; their behaviour may instantly result in a physical action.

3. PATTERNS OF CHALLENGING BEHAVIOUR

3.1 Identifying patterns to predict when challenging behaviour is more likely to occur can assist when planning, preventing and preparing for it. Challenging behaviour tends to occur in response to:

- Unmet care needs (e.g. toilet, pain, thirst, hunger)
- Care tasks, including intimate procedures
- Administering medication (especially where the patient has to wait for pain relief)
- Pre-operative period (waiting, nil-by-mouth, clinical interventions and procedures)
- Post-operative period
- Gender issues (preferences for male or female carer)
- Pressure on staff time (i.e. staff not being on the 'shop floor')
- Lack of engagement by staff
- Times when staff are otherwise engaged (mealtimes, medication, handovers etc.)
- Areas where there are less experienced staff (e.g. less aware of psychological issues)
- 'Sundowning' (i.e. behaviours are more prevalent during afternoon and evenings, due to factors such as tiredness and changes in levels of light, or sensory deprivation)
- Night time disturbance
- Over-stimulating or under-stimulating environments
- Heightened activity (e.g. mealtimes)
- Lack of meaningful activity
- Relatives leaving
- Cultural, religious or spiritual needs
- Individuals feeling that staff are not hearing or listening to what they are saying
- Staff hostility
- Inconsistent rule setting
- Provocation by other individuals, distress in other individuals.

4. TYPES OF BEHAVIOUR

Non-verbal	Verbal	Physical
• Agitation • Wandering, pacing, following • Intimidating facial expressions, staring • Intimidating body posture • Cornering, invading personal space • Interference with equipment or property • Being withdrawn, extreme passivity, refusal to move	• Shouting • Swearing • Crying • Screaming • Repetitive statements or questions • Personal comments or questions • Racist, sexist, offensive speech • Bizarre, psychotic content, not based on known reality	• Scratching • Grabbing, hair pulling • Biting • Hitting, slapping, punching • Pinching • Spitting • Kicking • Pushing, shoving, knocking into someone • Striking or throwing objects • Inappropriate touching (self or others) • Urinating, smearing • Undressing • Self-harm • Absconding • Removal of lines, masks, catheters, dressings, incontinence pads • Non-compliance, resistive behaviour (e.g. refusing medication, blood tests)

5 TRIGGERS AND ANTECEDENTS

5.1 Triggers and antecedents are factors which occur prior to an individual's challenging behaviour. These factors may include the care environment or setting, individuals or interventions, activities or objects, thoughts or feelings, pain or discomfort.

5.2 For example a person may become overwhelmed, when a high number of healthcare professionals undertake a care intervention in close proximity to them.

5.3 Observing, identifying and documenting triggers and antecedents is the first part of a proactive strategy for minimising an individual's stress or distress. This is because, once identified, many of these situations can be avoided or changed.

6 PRECURSORS

6.1 Challenging behaviours can occur without warning and staff need to be aware of, recognise and identify precursors. Precursors are behaviours and are different to triggers, which are factors that can lead to challenging behaviour.

6.2 Precursors can often be very subtle and leave staff feeling 'uncomfortable', or they may signpost the onset of challenging behaviour.

6.3 Common recognisable cues include:

- Tense and angry facial expressions
- Increased and prolonged restlessness, pacing, body tension
- Increased breathing, muscle twitching and dilated pupils
- Increased volume of speech and swearing
- Refusal to communicate, withdrawal, irritability
- Prolonged eye contact
- Confusion of thought processes, poor Concentration
- Delusions or hallucinations
- Verbal threats or gestures
- Verbalising an intention that suggests distress, e.g. 'I want to go…'
- Replicating behaviour which preceded earlier disturbed or challenging episodes
- Reporting anger or violent feelings
- Generally, anything that seems out of character, e.g. excessive crying or laughing hysterically.

7. REASONS FOR CHALLENGING BEHAVIOUR

7.1 There is always a cause of clinically related challenging behaviour, even if it is not evident at the time. An overall approach that looks to prevent distress by identifying, categorising and understanding its reasons should reduce the likelihood of these potentially 'unforeseen' events occurring. The main categories are:

- Physical factors
- Cognitive factors
- Psychological and emotional factors
- Environmental or social factors

8. REASONS FOR CHALLENGING BEHAVIOUR – SUMMARY

This table is not exhaustive and is only examples of what may cause challenging behaviour.

Physical	Cognitive	Psychological/ emotional	Environmental/social
• Hypoxia • Hyperglycaemia • Hypoglycaemia • Electrolyte abnormality • Dehydration • Constipation • Infection • Pain • Visual or hearing impairment • Sleep deprivation • Medication (effects) • Illicit drugs or alcohol • Drug or alcohol withdrawal • Pre or postoperative • Hunger, thirst • Incontinence, urgent toilet needs • Earache • Epilepsy	• Communication problems (expression and understanding) • Memory loss • Difficulty with language or dialect • Reduced spatial awareness • Learning disabilities • Disorientation • Poor executive function (reasoning, planning, foresight) • Loss of insight • Autism	• Fear • Anxiety • Anger • Depression • Social isolation • Mania • Fixed beliefs or current thinking • Separation anxiety • Loss of self-worth	• Noise • Lights • Temperature • Overcrowding, or busy environment • Inappropriate signage • Lack of information • Long waiting times • Cultural factors • Lack of continuity of staffing, or care • Loss of routine • Unfamiliar surroundings • Pace of surroundings • Lack of meaningful activity • Over-stimulation • Under-stimulation • Imposed boundaries or routine • Stopping a habit/behaviour (e.g. smoking)

9. Physical factors

9.1 The physical causes which may lead to challenging behaviour include features of an individual's condition that pre-dispose him or her to distress (such as sensory impairments e.g. a loss of sight, hearing) unpleasant symptoms, pain and discomfort. They can all cause irritability and agitation or trigger distress.

9.2 Patho-physiological changes that cause delirium can be a significant factor and it is worth mentioning them specifically. Delirium is a short term confused state, or worsening of pre-existing confusion, due to a physical cause. It comes on suddenly (days to hours), fluctuates with time and is characterised by cognitive impairment and inattentiveness (distractibility) or drowsiness. Delusions, hallucinations and emotional changes (fear, anger) are common and symptoms are often worse at night. Delirium usually resolves with treatment of the underlying cause, but it may persist and rarely does not always recover. Suspicion of delirium requires assessment by a suitably skilled doctor – Refer to Clinical Guidelines for the Diagnosis and Management of Delirium.

9.3 Poor sleep is common in illness and in hospital, and leaves people fatigued and irritable. Hunger, thirst and urinary symptoms are associated with strong urges in an individual and may manifest as challenging behaviours if they cannot be communicated.

10. Cognitive factors

10.1 Cognitive factors include the inability to remember new information, explanations or instructions, the loss of inhibitions, poor judgment and planning and importantly communication problems.

10.2 They often result in an inability to articulate needs or a difficulty in understanding and interpreting the communication of those around them (both verbal and non-verbal) and can all lead to distress or difficult behaviours.

10.3 Staff needs to translate the reasons for challenging behaviour into unmet needs before identifying strategies to meet these needs.

10.4 Staff and carers can sometimes lack an understanding of communication impairment and overestimate a person's ability to understand information and make choices.

11. Psychological or emotional factors

11.1 Individuals suffering from delusions, especially paranoid, can feel they are being threatened and this can lead to defensive and challenging responses on their part. People with personality disorders may have difficulty foreseeing the consequences on others of their actions and may become acutely distressed. Fear is powerful in provoking difficult or aggressive behaviours. Anger can arise at a time of threat, as part of bereavement, or if needs are not being met.

12. Environmental or social factors

12.1 Factors relating to an individual's surroundings (e.g. excessive noise) can be provocative particularly if they are prolonged or persistent and may also interfere with the individual's rest and sleep. People with cognitive impairment often find care surroundings overwhelming and over-stimulating and may not keep up with the speed or volume of information or activity they are exposed to.

12.2 A lack of stimulation and activity, engaging in meaningless activity or over-activity can lead to frustration in individuals. This may be exacerbated by a lack of communication and dialogue between staff and patients or service users, poor care planning and a lack of coordination of activities between multi-disciplinary teams (MDTs).

12.2 Finally, a lack of understanding of an individual's culture and related behaviour can lead to frustration and agitation on their part. This can lead to a lack of trust, misinterpretation of their behaviour and miscommunication. Cultural sensitivity is important in dealing with this kind of challenging behaviour.

APPENDIX 4: VIOLENCE AND AGGRESSION ACTION CARD

VIOLENCE/AGGRESSION ACTION CARD

A PATIENT WHO EXHIBITS AGGRESSIVE OR VIOLENT BEHAVIOUR (PHYSICALLY OR VERBALLY)

FOR USE BY: Senior Staff **LIASE WITH: Site Management/Matron/Senior staff**

ENSURE 'ALL' RELEVANT ACTIONS ARE DOCUME NTED!

CORE RESPONSIBILITIES:

- Are staff OK? Is the patient ok?
- Does the member of staff /patient require medical?
- Does security/police need to be contacted? (6666/9-999)
- Does the member of staff need a break period from the bay/cohort bay?
- Consider if the staff involved can continue working and if so, do they need to work elsewhere?
- If restraint or rapid tranquilisation used, record details in patient notes and increase observations refer to Trust Policy on Rapid Tranquilisation.
- Debrief with the rest of the team
- Refer to Trust Policy on Violence and Aggression
- Complete Incident Report on Datix
- Inform Matron of incident

ASSESS AND CONSIDER POTENTIALLY REVERSIBLE CONDITION, PAIN, INFECTION, ETC.

- Identify any clinical explanation for aggressive behaviour (i.e. head injuries, infection, medication, delirium or dementia etc.)
- Medication review by the medical team
- Review/Create Challenging Behaviour Management Plan (accessed from Forms on Security page on Hub) and patient risk assessment to identify a plan of appropriate measures of control
- If patient remains unsettled, consider calling the security team on Bleep 430 to also alert to possible reoccurrences and possible requirement for Police attendance

M AT RO N'S RE S PO NSIB I L IT IES:

- Follow up with staff involved as soon as possible after the incident
- Consider referral to Occupational Health or Counselling Service
- Hold team debrief
- Refer to Trust Policy on Violence and Aggression
- Make other staff aware through safety brief
- Consider enhanced observations

WHEN AN INCIDENT OF VIOLENT OR ANTI-SOCIAL BEHAVIOUR OCCURS OUTSIDE TRUST BUILDINGS, THE PERSON AT THE SCENE MUST CONSIDER/ADOPT THE FOLLOWING ACTION:

- Request Security team via 6666, if the nature of the assault more serious, request the police via 6666
- Always ensure others within the immediate area such as patients, staff, relatives are protected and where/when possible moved to a safe environment
- Provide a detailed brief to the site manager as soon as possible, also to the security team upon their arrival
- Support the security team if needed/requested until conclusion met

APPENDIX 5: MANAGING RISK AND ASSESSING BEHAVIOURS

1. RISK FACTORS

2. Risk factors increase the likelihood of challenging behaviour and require quick management decisions. Risk factors may include a person's previous history and current clinical presentations. Historical and current factors may operate independently or interact together, and they may combine with environmental and situational triggers to heighten the risk of challenging behaviour.

3. The following factors point to an increased risk of challenging behaviour:

Person	Environment	Situational
Historical factors • History of aggressive/violent behaviour • History of intent to harm others • History of mental condition(s)/self-harm/suicide attempts • Cognitive impairment • Previously detained under a section of the Mental Health Act • Forensic, criminal related history, e.g. prisoners in hospital etc. • History of abuse or trauma • History of substance and alcohol abuse or withdrawal • History of disruption to service delivery and resources, e.g. damage to property, equipment, disruption to staffing levels etc. **Current presentation** • Specific diagnoses, physical, cognitive, (especially communication) and psychological/emotional factors.	• Environmental factors, e.g. new environments, busy, active, crowded treatment areas • Other agitated or distressed patients or service users • Lack of meaningful activities.	• Activities being undertaken, e.g. washing, dressing, giving medications etc. • Services being provided and the client group • Staff member, e.g. inconsistent staff attitudes, awareness and approach • Staffing, e.g. staffing levels, skill levels and training • Certain times of day • Patient, e.g. mix/tensions, patient on patient incidents • Restrictions, denial or confrontation, e.g. a person wanting to leave, cigarette requests.

4. PREVENTING THE RISK OF CHALLENGING BEHAVIOUR

4.1 Preventing the risk of challenging behaviour relies on meeting personalised care needs: *'Care where the patient is an equal partner with the healthcare professional and where both parties work together to make an assessment, identify options for the delivery of the most appropriate care. The care provided is holistic and the 'whole person' sits at the centre of the care package, which may be delivered by a range of health and social care professionals.'* (NHS Education for Scotland, 2010)

4.2 This approach is based on positive staff attitudes, high levels of tolerance, compassion and empathy. Dignity is important and requires that the individual is kept comfortable, valued, respected, is in control, and that they have choices in their treatment and care.

Empathic understanding means seeing problems from the perspective of the patient or service user.

It requires strong leadership, skilled staff confident in their own abilities and adequate resources. It requires training, practice and often role-modelling by people who know how to do it and can share their expertise.

In acute health settings, staff are often instilled with the belief that they need to work quickly in order to be effective. However, the approach presented here relies on staff being able to talk to the patient or service user and understand their psychological, emotional and physical care needs.

Personalised care means staff building positive relationships with the person being cared for, their family and carers. The rewards equally apply to those delivering the care as well as the person being cared for, as staff tend to feel empowered and supported by this approach.

Staff should understand that the way they interact is vital in helping the patient communicate the reasons for their distress and their unmet needs. They also need to be aware (and this should be reiterated through training) of how their interaction with the patient can positively or negatively reinforce challenging behaviours and of the need to communicate with them in a sensitive way.

A collaborative approach is the most effective way of preventing a person's challenging behaviour, which involves all staff having a unified understanding of an individual's behaviours, antecedents, triggers, reinforces and consequences and what everyone needs to do to prevent the behaviours. This understanding requires developing a personal profile and wherever possible observing and analysing what is happening and designing effective interventions – a functional assessment can assist where possible

5. MANAGING THE RISK OF CHALLENGING BEHAVIOUR

Challenging Behaviour Management Plan

The Challenging Behaviour Management Plan accessed from Forms on Security page on Hub is a risk assessment and communication tool that is used to support staff and patients in identifying potential triggers to challenging behaviour. The information provided ensures any risks are communicated to the Security and Site Management teams. This information assists wards in providing appropriate resources and identifies the most effective support required to mitigate potential risk to patients and staff.

6 MANAGEMENT TOOLS AND TECHNIQUES

Aggressive behaviour can nearly always be explained by the "fight or flight" reaction to a situation that is deemed "dangerous" by the victim. In such situations, the following points need to be remembered (however where a diagnosis of delirium has been made, refer also to the Clinical Guidelines for the Diagnosis and Management of Delirium):

- Reduce noise and stimulation
- Allow patients to "wander" safely
- Do not physically restrain patients unless they are a real danger to themselves or others. If absolutely necessary, use the minimal force possible.
- Remember that a uniform may not inspire confidence and may have the reverse effect
- Provide 1:1 care. Use friends or relatives if they are happy to come in; usually

relatives are more than happy to be involved in the care, but additional staff may be needed, particularly over the first 24 hours

- Ensure adequate hydration, nutrition and comfort
- Do not be offended if the patient takes a dislike to you. Do not argue with the patient. Find someone that has a good rapport to do the bulk of the care; but make sure that they are supported and have regular breaks during an acute confusion period, as this is very energy demanding.
- Use of bed rails. This may increase the patient's feeling of being trapped or held against their will. It often results in injury to the patient by either entrapment in the bed rails or climbing over the bed rails and falling from a greater height. A Risk Assessment from the Slips, Trips & Falls Policy (Inpatients) may be required. If necessary nurse the patient on a Hi-Lo Bed on the floor, or put the bed to its lowest height and place Crash Mats around the bed.
- Use a calm but firm approach so that the patient feels there is someone in control of the situation. Keep the voice calm and reassuring; do not shout or speak unnecessarily loudly. Keep commands/information short and concise; the patient will not be able to deal with too much information at once.
- Maintain consistency of approach by the whole team by through good handovers.
- Avoid the use of sedatives if at all possible. If this is the only safe way of managing the patient it should be used as a last resort and expert advice should be sought regarding appropriate drugs and dosage.

7 Keeping patients and visitors informed

The provision of information to patients, their relatives and friends and ensuring that patients' concerns and complaints are dealt with quickly and fairly is extremely important and can prevent the risk of violence. This is particularly the case in situations of acute distress and/or long waiting periods and is more relevant to areas such as the Emergency Department and Outpatients.

8 Keeping staff informed

Staff involved with patient care should ensure information is communicated to relevant staff, e.g. at handover, particularly when the following applies:

- New members of staff are involved
- New patients are admitted
- There has been a change in the patient's medical/physical state, medication, behaviour or mood, etc.
- Known violent patients/clients are being transferred from one department to another
- Where domiciliary visits are made to patients with a known or suspected history of aggressive or violent behaviour. Further details are available in the separate Lone Working Policy

9 Environment

It is important that the workplace environment and surroundings are subject to Risk Assessments in line with the Trust Risk Assessment Policy & Procedure. Where a risk assessment is to be made regarding violence & aggression a Matron or Senior Nurse will carry out the assessment. Further advice and guidance can be obtained from the Local Security Management Specialist.

The patient's environment can have a significant impact on their behaviour, specialty areas, mobility, etc. Items available to them within their environment may also become a hazard to others and/or a means to facilitate self-harm. As part of the CBMP consideration should be given to:

- Bed location – can the patient be managed in a bay or is a side room more appropriate, will their behaviour impact on the care and/or recovery of other patients including demands on nursing time
- Potential weapons – remove any non-essential items that may be used to strike and/or be thrown including patients personal property, consider using plastic cutlery and non-ceramic crockery, ensure that "hot drinks" are not hot enough to scald/injure
- If appropriate, remove sharps bins from the immediate vicinity of the patient, be aware of items on your person such as scissors
- Ensure the patient's visitors do not compromise safety by passing unsuitable items or substances during visits. Consider checking patient's property and local environment following visits.
- Giving each patient a defined personal space
- Providing distraction activities where appropriate
- Encouraging play areas and activities for younger patients with disturbed behaviour
- Providing activities and wandering space for patients with dementia
- Monitoring the mix of patients
- Removing aggressive patients to a single room or cubicle to protect both the health and safety of other patients and that of the aggressor himself/herself
- For patients with dementia and delirium there is also an argument for cohorting patients to reduce the risk of incidents of falls and aggression
- Request check of personal belongings for offensive weapon(s) and potential incendiary devices (matches, cigarette lighters).

10 Personal Safety of Staff

As well as managing the care of the patient concerned, the personal safety of all disciplines and groups of staff must be ensured as far as is reasonably practicable. Although patient care is the primary focus this must not be at the expense or risk of personal injury where the task being attempted is not of an essential and/or life preserving nature.

- Routine, non- essential tasks - bed making, room cleaning, patient hygiene etc. should not be undertaken or attempted when the patient is showing challenging behaviour (unless there is a risk to skin breakdown leading to pain and further aggression)
- Ensure that all staff that may have reason to have contact with the patient – doctors, nurses, (including departments such as x-ray, fracture clinic, cardiology), housekeepers, porters, chaplain – are aware of the potential or actual risk/s in dealing with the patient
- To avoid a one on one confrontation situation consider setting a minimum 2:1 staff to patient ratio at all times and document this in the patient care plan
- Report all challenging behaviour incidents involving the patient by completing a Trust incident report on Datix and ensure the CBMP is regularly updated and that new and/or revised information is communicated to all relevant staff

Line managers should be aware that caring for challenging behaviour patients can be demanding and stressful and staff caring for challenging patients may require additional

management support. In more serious or traumatic cases line managers should ensure staff are debriefed and if necessary counselling should be offered to staff. Refer to Action Card at Appendix 4.

11 Care planning

Risk assessment and management should inform the care plan as to whether specific interventions are required to manage challenging behaviour. The risk assessment documentation should sit alongside the care plan and should be cross-referenced and updated accordingly if new risks emerge.

12 De-escalation

If prevention has failed, is failing or has never had a chance to work, staff need to be skilled in de-escalation. This is based around highly developed communication skills, fostering good relationships, empathy, calming, non-confrontation, minimising threat, negotiation, compromise, agreeing to any reasonable requests, distraction, activities and changes of staffing which are all key here.

13 Doing nothing/ watch and wait

Doing nothing and 'watch and wait' are important strategies in high risk situations where it is safe to apply them, although they require staff confidence as they may seem counter-intuitive. Challenging behaviour around the time of transition (e.g. hospital or care home admission, or ward or bed moves) often settles down within 2 or 3 days without intervention other than trying to keep the individual, staff and other people safe and offering comfort and reassurance. The latter meets psychological and emotional needs and improves the individual's experience of care.

14 Leave and return

'Leave and return' is a strategy when someone is resisting care. Staff need to employ good judgment here. If a patient or service user absolutely needs medical intervention or another essential intervention (e.g. a soiled incontinence pad needs changing), brief physical interventions may be necessary. But in the majority of cases things can wait (washing or shaving, for example). Constant informal risk assessment is needed, along with adequate supervision, opportunities to discuss and debrief dilemmas and staff being trusted to use their judgment.

15 Better understanding and tolerance

Some challenging behaviours may be difficult, or unnecessary, to stop (e.g. wandering or persistent 'vocalisation'). It is important for staff to be able to understand these behaviours, tolerate them (where they are not offensive), accommodate them within the confines of the care environment, keep the patient or service user and others safe and sometimes mitigate effects. For example, someone who is persistently shouting may have to be isolated to reduce stimulation and keep the environment tolerable for others, as well as to avoid provoking others or 'setting them off'.

16 Observation

Observation that goes beyond normal therapeutic engagement and assists in building relationships with patients or service users should be considered for the immediate and long term prevention and management of challenging behaviour. It must not be intrusive, should respect dignity and privacy and must be conducted safely. Organisations should

have an action plan for checking availability of internal staff for observation (e.g. staff bank, temporary staff, central response team, movement of staff from other areas). An observation policy should clarify observation levels according to risk and what is expected of staff (a prior knowledge of the person's history is desirable) and how to initiate or discontinue higher level support.

17 Physical intervention and rapid tranquillisation

It is important for staff to be able to recognise situations where physical intervention and/or rapid tranquillisation (refer to Clinical Guidelines for Rapid Tranquilisation of Adults and / or Pharmacological Management of Disturbed Young People including Rapid Tranquilisation are required. Clinical staff need to be confident about when these short term intervention strategies are required, e.g. immediate control of a dangerous situation and when they are not required, i.e. where de- escalation, non-pharmacological means, or use of more routine medication (e.g. pain relief) should be attempted first.

During care planning, 'advance directives' (decisions) may be considered by asking a person to indicate what forms of treatment they would or would not prefer, should they lack capacity to refuse or consent in the future. This includes any treatment preferences that they may have in the event that they become challenging. Where a person has memory/understanding issues a formal capacity assessment is necessary and a plan made in their best interest following the process set out in the MCA Code of Practice taking into account views of relatives and those close to the patient.

APPENDIX 6: SANCTIONS MANAGEMENT

1. A staged approach will be generally undertaken to manage any sanctions in respect of **intentional** violence and aggression. In such cases a 'Verbal Warning' would precede any 'Written Warning' and this would precede any 'Acceptable Behavioural Contract' or 'Exclusion'. There is no requirement to escalate the response in any particular order should the situation warrant immediate action.

1.1 Verbal Warning

Where a patient, relative or visitor is violent or abusive, the member of staff or senior member of staff should explain to the patient what is and is not acceptable behaviour and he/she should outline what the possible consequences of any further repetition of unacceptable behaviour could be. An experienced member of staff and / or security should always witness this explanation. Identification of any triggers for the behaviour may be useful in future prevention.

The main aim of the Verbal Warning process is twofold:

- To ascertain the reason of the behaviour displayed as a means of preventing further incidents or reducing the risk of them reoccurring; and
- To ensure that the patient, relative or visitor is aware of the consequences of further unacceptable behaviour.
- In the case of a patient, it may be appropriate to issue a Code of Conduct leaflet which contains information useful to prevent further escalation in their behaviour.
- The incident and local actions taken must be reported and investigated in accordance with the Trust incident reporting procedures. The fact that a Verbal Warning has been given should be recorded in the patient's notes.

NB: A Verbal Warning should be delivered no more than twice.

1.2 Written Warning

If having issued one or more verbal warnings, further incidents are reported, the local manager should consider if appropriate to issue a warning letter. Template letter is at **Appendix 6.1**

Any warning letters must be attached to the relevant electronic incident report.

The presence of a mental disorder should not preclude appropriate action from being taken, and it is important to note that the incident must still be recorded in accordance with directions.

1.3 Application

Applications detailing the reason for a 'Warning Letter' should be made directly to the Trust Local Security Management Specialist. The evidence will be reviewed by the Local Security Management Specialist.

1.4 Authorising & Serving

Where it is felt that there is sufficient evidence the case will be referred to the Chief People Officer or the Deputy Director of Estates and Facilities in their absence for authorisation. The serving of the 'Warning Letter' will be recorded delivery or by the Local Security Management Specialist. The 'Warning Letter' will be attached to the

appropriate incident report and the Security Management Specialist will monitor and review all 'Warning Letters' issued.

1.5 Acceptable Behavioural Contract

An Acceptable Behavioural Contract is an option that can be considered for patients, relatives or visitors, to address unacceptable behaviour where verbal warnings or a warning letter have failed, or as an immediate intervention depending on the circumstances.

An Acceptable Behavioural Contract is a written agreement between the parties aimed at addressing and preventing the recurrence of unacceptable behaviour and can be used as an early intervention process to stop unacceptable behaviour from escalating into serious behaviour both on Trust premises and in the community environment.

Where for example it is decided that an Exclusion is not justified but unacceptable or inappropriate behaviour has been identified of a patient or visitor the Trust retains the right to request that the person(s) agree to conduct themselves in a manner which is none threatening or abusive and which is not detrimental to the treatment of themselves or any other patient or safety of any Trust employee or NHS property.

The person(s) will be required to sign an Acceptable Behavioural Contract which will detail the manner of acceptable behaviour required for the continued treatment of themselves or another - see **Appendix 6.2**

1.6 Application

Applications detailing the reason for an Acceptable Behavioural Contract should be made directly to the Trust Local Security Management Specialist. The evidence will be reviewed by the Local Security Management Specialist.

1.7 Authorisation & Serving

Where it is felt that there is sufficient evidence the case will be referred to the Chief People Officer or the Deputy Director of Estates and Facilities in their absence for authorisation. The serving of the Acceptable Behavioural Contract will be either by recorded delivery or in person by the Local Security Management Specialist and / or in conjunction with the Police.

The Security Management Group will monitor all Acceptable Behavioural Contracts in force and the circumstances quarterly. Acceptable Behavioural Contracts will be reviewed every 12 months. Where an Acceptable Behavioural Contract has been signed by a patient a copy will be held on the patient's notes. A record of the Acceptable Behavioural Contract will be retained by the Local Security Management Specialist for a period of three years.

Where a person has an Acceptable Behavioural Contract in force but fails to comply with the conditions the person should be reported to the Local Security Management Specialist for consideration of Exclusion in line with this policy.

2. Exclusion

2.1 The Trust reserves the right to exclude any person or persons, who, in the considered opinion of the Trust, threatens the safety and or security of the Trust's employees, patients, visitors or property by:

Having been Convicted or Cautioned for a Criminal Offence, which has been committed on Trust premises or grounds, or
In the case of a juvenile, is the subject of a Formal Warning or Final Reprimand

2.2 Where the above criteria is not met but a person or persons:

Causes Trust employees, patients or visitors to fear for their safety, or

Prevents Trust employees or their agents delivering healthcare, or

In the professional opinion of the Trust Security Management Specialist or Acute Security Manager and / or in the opinion of a Trust Senior Manager is a threat to the safety and/or security of the Trust's employees, patients, visitors or property, an emergency exclusion order may be issued by the Trust Security Management Specialist or Acute Security Manager and/or a Trust Senior Manager.

2.3 It is not the intention of the Trust to prevent any excluded person from attending the site where they are:

- In need of emergency treatment or care, or
- Fulfilling a pre-arranged hospital appointment.

2.4 It is recognised that there must be sufficient justification for exclusion.

- The Trust must be able to clearly show the process by which any decision was made and in what way the named person is a perceived threat.
- The Trust must be able to show details where any decision has been reviewed such as altering any period of exclusion, and by whom.
- The Trust should determine whether the exclusion covers the whole of the Trust or selected sites or areas.
- The Trust must be able to show that the named person has been advised of any relevant decisions and by whom.

2.5 However, where an excluded person requires or wishes to visit Trust property for one or more of the reasons below then that person must seek permission to do so by writing to the Trust's Chief People Officer:

- Visiting a relative who is an in-patient within the Trust.
- In order to take part in bona fide lawful business on Trust property.

They must include full details of the reason for them visiting the site, the time and duration of any visits and include a contact home address and telephone number, and give the Trust not less than 48 hours' notice to respond (not including weekends or Bank Holidays). This will allow time for the Trust to advise the excluded person of any decision.

2.6 The Chief People Officer, in consultation with the Chair of the Security Management Group will decide whether permission will be given to enter Trust property.

2.7 Any decision to refuse access to the excluded person will be made on the following criteria:

- The circumstances do not fall within guidelines laid out in section 2.4.
- It is believed the excluded person still constitutes a significant risk to persons or property.

2.8 Where permission is granted the excluded person can be advised verbally (a written record will be made for the file) or by letter if appropriate. They will be instructed to collect from the relevant site main reception and keep in their possession to show if requested by any representative of the Trust, a letter from the Divisional Director for the Operations Support Division giving permission to enter the site within laid down parameters.

2.9 It is recognised that it may be impossible for an excluded person to give sufficient notice in extreme circumstances such as when a relative is suddenly taken seriously ill and the named person attends at that time. In such cases the named person will advise staff immediately upon their arrival at the site that they are excluded, but circumstances had prevented them from complying with the requirements to give a minimum 48 hours' notice as laid out in section 2.5.

2.10 In such circumstances staff dealing with the named person will ensure the Chief People Officer or the Deputy Director of Estates and Facilities in their absence is advised that an excluded person is visiting the site and the circumstances of that visit.

2.11 If further visits are likely the Chief People Officer in consultation with the Chair of the Security Management Group and Police, will determine what action is required. The excluded person will be contacted and advised of any decision and previously laid down procedures will be followed.

3. EXCLUSION PERIOD

3.1 Exclusion periods can be made for any period of time but are likely to be for periods of one to five years. After each 12-month period a risk assessment will be made by the Chief People Officer in consultation with the Chair of the Security Management Group and Police, to determine whether exclusion is still relevant and a record of that process and decision will be made.

3.2 Any decision to subsequently alter the length of any period of exclusion will be ratified at the next Security Management Group meeting.

3.3 The excluded person will be notified in writing of the result of that annual risk assessment.

3.4 An emergency exclusion order will usually be issued for a period of 14 days, or until ratified or overturned by the Chair of the Security Management Group and Chief People Officer if sooner, but will not exceed 31 days.

4 PROCEDURE

4.1 The Trust may consider information from any person or agency, advising that a named person maybe someone whom they believe should be the subject of exclusion notice.

4.2.1 Detailed records must be obtained and kept by the Chief People Officer The Trust must be in a position to confirm all its actions, when they were made and by whom. These records must include (where available and applicable):

- Circumstances of the incident under discussion to include details of the provider of the information.
- Full name, address, date of birth and physical description of the named person (photograph if available).
- Highlight any specific warnings e.g. violence to staff or carries weapons, etc.
- A summary of any deliberations by the Trust.
- Any corroborative information or documentation that can be obtained and its source.
- All details of any correspondence between the Trust and the named person or other persons connected.
- Details of any further incidents involving the named person and any action instigated by the Trust.
- Details of any legal procedures.
- Any other relevant information.
- Records to be kept for a minimum of three years after exclusion period ends.

4.3 Where an emergency exclusion order has been issued by the Trust Local Security Management Specialist and/or a Trust Senior Manager it must be ratified or overturned by the Chair of the Security Management Group and the Chief People Officer (or their deputies) at the earliest opportunity. A written record of the decision must be made and tabled at the next Security Management Group meeting.

4.4 Where a person is to be excluded then the Chief People Officer will ensure a written notice of the Exclusion is delivered by hand to their last known address. Details of when and by whom the letter was delivered are to be attached to the file. The Exclusion notice will include:

- Confirmation that the Trust has decided formally to exclude them from Trust property (listing all the Trust addresses or selected areas or properties as appropriate).
- The reason for the period of Exclusion.
- Duration of the Exclusion.
- Any exemptions to the Exclusion (listed in sections 2. and 2.5)
- The procedure for an appeal.
- The consequences of breaching the terms of the Exclusion notice.
- How to contact the Chief People Officer
- The Trust reference number if applicable.

4.5 If any person breaches their Exclusion notice then an injunction may be sought from the Court.

5 APPEAL

5.1 A named person has the right of appeal against an Exclusion notice by writing to the designated contact within the Trust who will be:

Chief People Officer
Royal Devon and Exeter Hospital (Wonford)
Barrack Road
Exeter
EX2 5DW

5.2 The appellant has the right to be accompanied by a friend or colleague not acting in a legal capacity and will be advised of this at the appropriate time by the Chief People Officer.

5.3 The appeal panel will consist of two Trust Board Directors (one Executive and one Non-Executive Director). The decision of the panel will be final and binding and the named person will be informed in writing of their decision by the Chief People Officer.

ANNEX 1: WARNING LETTER

Royal Devon and Exeter
NHS Foundation Trust

< insert address>

Dear <insert name>

Warning letter – unacceptable behaviour

The Royal Devon & Exeter NHS Foundation Trust has evidence which suggests on the <insert date> you
<insert name> used/threatened unlawful violence/acted in an anti-social manner to a member of NHS staff/whilst on NHS premises **(delete as applicable)**.

Behaviour such as this is unacceptable and will not be tolerated. This Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse.

Such behaviour also deprives the Trust of valuable staff time and resources and may result in other patients having their treatment delayed or postponed. Just as the NHS has a responsibility to you, so you have a responsibility to use its resources and treat NHS staff in an appropriate way

Should there be any repetition of this type of behaviour; consideration will be given to taking action against you.

Such action may include the following:

- Excluding you from premises
- Seeking an Acceptable Behaviour Agreement
- Reporting to the police where your behaviour constitutes a criminal offence and fully supporting any prosecution they may pursue.
- Consideration of a private criminal prosecution

If you do not agree with the details contained in this letter about your alleged behaviour or feel that this action is unwarranted, please contact in writing < insert details of local complaints procedure> who will review the decision in light of your account of the incident(s).

A copy of this letter will be retained for 12 months and where appropriate kept with your Medical Records.

Yours faithfully,

Local Security Management Specialist

ANNEX 2: ACCEPTABLE BEHAVIOUR CONTRACT

Royal Devon and Exeter
NHS Foundation Trust

Date

Acceptable Behaviour Contract between Royal Devon & Exeter NHS Foundation Trust and *(Insert name here)*

I am writing to you as the Local Security Management Specialist (LSMS) for Royal Devon & Exeter NHS Foundation Trust. The LSMS has responsibility in all aspects of security operational matters relating to the deterrence, prevention, detection, investigation and management of security in Royal Devon & Exeter NHS Foundation Trust.

One of my roles is to protect NHS staff from abusive and violent behaviour and NHS resources from misuse and it is in connection with this that we are writing to you. I have received (number) reports in which it is alleged that on (date) whilst attending ****** , you [details of incident or offence] causing [details of impact] .

Behaviour such as this is unacceptable and will not be tolerated. Royal Devon & Exeter NHS Foundation Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse, property loss or damage. Such behaviour also deprives Royal Devon & Exeter NHS Foundation Trust of valuable resources, causes other patients unacceptable distress and directly affects their quality of care and treatment whilst a patient on Royal Devon & Exeter NHS Foundation Trust premises.

It is my view that your actions in the above incident could be considered as constituting criminal offences, in particular -
[Details of offence]

The NHS has a responsibility to provide a service, those using the service have a responsibility to use its resources and treat its staff in an appropriate way.

When attending NHS premises in the future you must comply with the following conditions:

- You will treat all people and property with respect that you come into contact with whilst on NHS Property.
- You will not use abusive, insulting or threatening words or behaviour to any member of Trust over the phone or in person.
- You will not use or threaten violence towards Royal Devon & Exeter NHS Foundation Trust staff, patients or visitors.
- You will pursue any complaint using the NHS procedure for doing so.

If you fail to act in accordance with these conditions and continue to demonstrate unacceptable behaviour, consideration will be given to taking action against you.
Such action will include the following:

- Reporting to the police where your behaviour constitutes a criminal offence and fully supporting any prosecution they may pursue.

- Seeking a court order to restrict your behaviour.

- Excluding you from the Trust for anything other than emergency medical care.

If any legal action is necessary any costs incurred will be sought from you and these may be considerable.

Enclosed are two copies of this letter for your attention. I would be grateful if you could sign the attached agreement at the declaration and return one of these in the envelope provided.

This agreement (should you sign it) will be reviewed in 12 months' time. If your behaviour causes no further concern and no further incidents have been reported to us it will be withdrawn.

If you do not agree with the conditions set out in this letter, or have any other representations to make in relation to this matter these should be submitted in writing to;

Security Management
Royal Devon & Exeter NHS Foundation Trust
F19 First Floor Newcourt House
Newcourt Drive
Old Rydon Lane
Exeter
EX2 7JQ

Yours faithfully

Local Security Management Specialist

Royal Devon and Exeter
NHS Foundation Trust

ACCEPTABLE BEHAVIOUR CONTRACT AGREEMENT

This agreement is between:

Royal Devon & Exeter NHS Foundation Trust and (*Insert Name*)

Date of Birth:

I agree to the following in respect of my future behaviour -

- I will treat all people and property with respect that I come into contact with whilst on NHS Property.
- I will not use violence, or foul or abusive language or threatening behaviour towards any person while on NHS premises.
- I will not threaten violence or use foul or abusive language towards any NHS staff while on the telephone.
- I will follow the NHS procedure when making a complaint.

Declaration

I accept the conditions set out above and agree to abide by them

accordingly. Signed:

Dated:

Royal Devon & Exeter NHS Foundation Trust

Signed: Print name:

Position: Local Security Management Specialist Dated:

APPENDIX 7: COMMUNICATION PLAN

Royal Devon and Exeter NHS Foundation Trust

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the policy	All Staff
The key changes if a revised policy	Removal of restrictive practices guidance Amendments to align with NDHT policy Amendments to align with NHS England Violence Prevention and Reduction Standards
The key objectives	Provide guidance and advice for all employees of the Trust and persons providing services on the management of violence, aggression, challenging behaviour
How new staff will be made aware of the policy and manager action	Local induction process
Specific Issues to be raised with staff	Staff to be made aware of main changes as described above
Training available to staff	Conflict Resolution Training is provided via E-Learning Breakaway and Safe Handling training is delivered face-to-face to staff identified in the Trust's Training Needs Analysis and / or Risk Assessment.
Any other requirements	None
Issues following Equality Impact Assessment (if any)	None
Location of hard / electronic copy of the document etc.	The original of this policy, will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

APPENDIX 8: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Policy on Violence Prevention and Reduction
Division/Directorate and service area	Estates and Facilities Management, Security Dept
Name, job title and contact details of person completing the assessment	[redacted] Security Management Specialist, [redacted]
Date completed:	April 2021

The purpose of this tool is

- **Identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. **What is the main purpose of this document?**

   To outline responsibilities and best practice in the management of violence and aggression.

2 **Who does it mainly affect?** (Please insert an "x" as appropriate:)

Carers ☒ Staff ☒ Patients ☒ Other (please specify)

3 **Who might the policy have a 'differential' effect on, considering the "protected characteristics" below**? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)***Please insert an "x" in the appropriate box*** *(x)*

Protected characteristic	Relevant	Not relevant
Age	☒	☐
Disability	x	
Sex - *including: Transgender, and Pregnancy/Maternity*	☐	☒
Race	☒	☐
Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. **Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to…** (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

Please specify any groups you think may be affected in any significant way

5 **Do you think the document meets our human rights obligations?** ☐Yes

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
• ***Fairness*** *– how have you made sure it treat everyone justly?* • ***Respect*** *– how have you made sure it respects everyone as a person?* • ***Equality*** *– how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity*** *– have you made sure it treats everyone with dignity?* • ***Autonomy*** *– Does it enable people to make decisions for themselves?*

6 **Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?**

Please give a brief summary- identifying:

Race
Racial harassment is known to undermine confidence of ethnic minority staff. The policy directly recognises and addresses racially based violence and aggression from patients to staff. The issue is clearly recognised and managers are made responsible for challenging racist attitudes. The policy makes managers responsible for challenging harassment, clearly defines racial hate crime as being within its scope and recognises that race of the carer can be a trigger of violent or aggressive behaviour from patients.

Age
Elderly patients can be especially violent and aggressive, due to delirium or confusion. The policy directly recognises and addresses this issue and refers to published guidelines. Practical advice is made available on best practice in managing violence and aggression from confused, elderly patients. A detailed appendix is provided, outlining the causes of violence and aggression in some confused and delirious patients and how best to manage this

Disability
Disability (in the person requiring restraint) is directly mentioned as a factor which would lead to restraint being applied with extra caution.

6. **If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact** please note this below and how this will be monitored/addressed.

"Protected characteristic":	None
Issue:	

How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	

Royal Devon University Healthcare NHS Foundation Trust

Safeguarding Adults Policy

Post holder responsible for Procedural Document	Associate Director for Safeguarding
Author of Policy	[redacted] – Senior Specialist Nurse, Safeguarding Adults [redacted] – Head of Safeguarding (Eastern Services)
Division / Department responsible for Procedural Document	Corporate Services, Safeguarding Team
Contact details	[redacted]
Date of original document	01/01/2024
Impact Assessment performed	Yes
Ratifying body and date ratified	Safeguarding Committee
Review date	01/01/2027
Expiry date	01/07/2027
Date document becomes live	25/01/2024

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience	✓	Maintain Operational Service Delivery	✓
Assurance Framework	✓	Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute services	
CQC Fundamental Standards - Regulation: ✓ **Safeguarding from abuse**		Infection Control	
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		Status: FINAL	
Version	Date	Author	Reason
0.1	Nov 2023	Senior Specialist Nurse, Safeguarding Adults	Initial version for comment
0.2	Nov 2023	Senior Specialist Nurse, Safeguarding Adults	Minor changes responding to comments from the SARC Lead
0.3	Dec 2023	Senior Specialist Nurse, Safeguarding Adults	Minor changes following comments from named Dr for Safeguarding Adults
1.0	January 2024	Senior Specialist Nurse, Safeguarding Adults	Correct template applied. Key words revised. Introduction revised. Communication plan completed. Impact Assessment revised. Minor changes comments including from inclusion lead. Minor edits following comments MCA team. Minor changes following comments from Care Services team (Eastern). Minor changes following comments from Associate Director of Nursing clinical support and specialist services Minor changes following comments from Designate Nurse Safeguarding Adults & MCA Lead NHS Devon
1.1	January 2024	Senior Specialist Nurse, Safeguarding Adults	Minor Changes following comments from Divisional Governance Manager, Community Services Division.
1.2	January 2024	Senior Specialist Nurse, Safeguarding Adults	Final edits and addition of definition of domestic abuse.

Associated Trust Policies/ Procedural documents:	Council Emergency Housing Team - Eastern Council Emergency Housing Team - Northern County Lines Guidance Devon and Cornwall Police website

	Disclosure and Barring Service Policy - Eastern Disclosure and Barring Service Policy – Northern Domestic Abuse Affecting Patients Policy - Eastern Domestic Abuse Affecting Staff Policy - Eastern Domestic Abuse Affecting Staff Policy - Northern Domestic Homicide Review Statutory Guidance Equality and Diversity Policy FGM Health & Wellbeing for Staff Home Safety Fire checks IMCA Local Authority Housing Team – Duty to Refer Management of Allegations Policy Management of Allegations policy. MCA Policy MCA Policy Modern Slavery website Office of the Public Guardian Police Referral Promoting a Positive Working Environment Policy Raise a Concern electronically - Northern Report a loan shark online Safeguarding Guide Safeguarding Toolkit Safeguarding Training Declaration Sexual Assault and Referral Centre (SARC) TDSAP TDSAP Adult Procedures and Guidance TDSAP Adult Self Neglect Guidance TDSAP Guidance (2023)

	TDSAP Information sharing principles and agreements for adult safeguarding TDSAP PiPoT Protocol TDSAP Self Neglect & Hoarding Toolkit The Blue Light Manual. The Marriage and Civil Partnership (Minimum Age) Act 2022 Was not brought video Whistleblowing (How to Raise a Concern) Policy
Key Words	Safeguarding, Abuse, Harm, Neglect, Self-Neglect, Modern Slavery, SARC, Homeless, Domestic abuse, Financial abuse, Emotional abuse, Sexual abuse, Organisational abuse, Physical abuse, Psychological abuse, Discrimination, Safeguarding Adult Review (SAR), Domestic Homicide Review (DHR), Safeguarding Enquiry, Care Act, Police.
In consultation with: 07/12/2023 & 15/12/2023 Alcohol Liaison Team, Allied Health Professional Leads, Associate Directors of Nursing, Associate Medical Directors, Cancer Services, Care Services, Chaplaincy, Chief Medical Officer, Chief Nursing Officer, Cluster Managers, Complaints & Patient Advice and Liaison Team, Community Service Managers, Dementia Team, Dental Team, Devon & Cornwall SARC, Director of Governance, Directors of Nursing, Devon Partnership Trust, Emergency department nursing, Emergency department practice lead, Exploitation & Sexual Safeguarding Lead, Health & Safety Lead, Health IDVA – Eastern, Health IDVA – Northern, Homeless & Inclusion Nurse, Hospital Social Care Team, Human Resources, IMT Applications, Information & Governance Lead, IT Information and Application Lead, Learning Disability, Legal Team, Liaison Psychiatry, Local Authority East Safeguarding Adults Team Members, Local Authority North Safeguarding Adults Team Members, Matrons, MCA Team, Medical Director, Medical Examiners Service, Named Doctor East, Named Midwife East & North, Physiotherapy Teams, Planning & Preparedness Manager, Professional Development Team, Safeguarding Adults Operational Group Members, Safeguarding Adults Team at New Devon Integrated Care Board (ICB), Safeguarding Teams, Safety & Quality Team, Sexual Health Teams.	
Contact for Review:	Associate Director for Safeguarding
Executive Lead Signature: *(Applicable only to Trust Strategies & Policies)*	[redacted]

CONTENTS

Prefix A

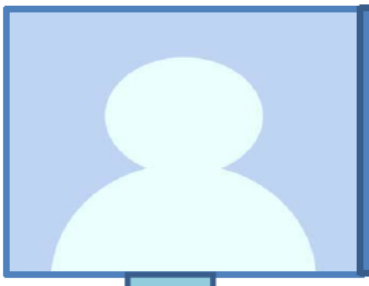
KEY POINTS OF THIS POLICY:

If you report a safeguarding concern you will be listened to, supported and involved in any decisions.

Keep 'Making Safeguarding Personal' core to practice: patient led and outcome focussed.

Where allegations relate to a member of staff also read, in conjunction with, Management of Allegations Policy.

In an emergency always call 999



Does the adult have care and support needs, and are they experiencing or at risk of abuse or neglect and unable to protect themselves? (Care Act 2014)

YES

Consider immediate protective measures that may be needed in care planning

Is there reason to doubt mental capacity to make decisions related to safeguarding?

YES

Document Mental Capacity Act Assessment

NO

NO

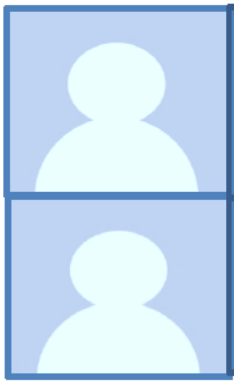
Review care planning

Consider signposting to Police/other organisations

Review again as needed

EITHER

OR



Has capacity? Support the adult with decisions & raise concern with consent

Lacks capacity? Complete a Best Interest Decision

Consider raising a safeguarding concern with the Local Authority

HAVE YOU:

- ✓ Reviewed clinical care plans to reduce risk
- ✓ Ensured Mental Capacity Act 2005 is part of Safeguarding Practice
- ✓ Evidenced working with all agencies to protect patient from risks of abuse/neglect
- ✓ Shared information aligned with Information Governance Policies
- ✓ Identified a Lead professional if needed
- ✓ Revisited and reviewed
- ✓ Considered other options e.g. Health IDVA (Independent Domestic Violence Advisor) or referral for care support

There may be a duty to raise a concern without consent if there are other justified and legal reasons to act to protect others, to report a crime or because the concerns may cause death or significant harm.

- Raise a Safeguarding concern form to Devon County Council Safeguarding Adults as per process
- If urgent call 999 or ring 01392 381206 for Eastern patients or 01392 381208 for Northern patients and complete form afterwards

Think family – if you have concerns about a child or other adult at risk there would be a duty to raise a concern

For advice:
Eastern Safeguarding Team 01392 406430
Northern Safeguarding Team: 01271 341 550

1 INTRODUCTION

1.1 A brief background to the policy and its relevance to the Trust.
Safeguarding means 'protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect' (Department of Health, 2014).

This Policy has been written following the merger of the Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust.
(Previous individual Safeguarding Adults' Policies held within archive).

This policy is compliant with this legislation.

All employees and volunteers should be supported in being able to access this Policy and apply safeguarding principles.

Failure to comply with this policy could result in disciplinary action.

2 Purpose

This policy sets out the Royal Devon University Healthcare NHS Foundation Trust organisational' Statement of Purpose for all members of staff to promote the wellbeing of everyone who uses our services, and their carers, to act positively to prevent harm, abuse or neglect (including self-neglect), and respond effectively if concerns are raised. It applies to safeguarding adults (over 18).

There is a separate Policy for safeguarding children.

2.1 The Royal Devon University Healthcare NHS Foundation Trust (Royal Devon) is committed to an organisational culture which prevents abuse and neglect, and has zero tolerance of practice that harms service users.

2.3 Royal Devon is a member of the Torbay & Devon Safeguarding Adult Partnership (TDSAP) who work to safeguard adults across Devon. This policy, therefore, should be read in conjunction with the TDSAP Adult Procedures and Guidance which are available via a link on the Royal Devon's intranet Safeguarding page.

2.4 These procedures are based on the Care Act (2014) and Guidance (DHSC, updated 2023) sets out the statutory requirement for Local Authority social services, health, Police and other agencies to both develop and assess the effectiveness of their local safeguarding arrangements. This is founded on the six key principles of:

- **Empowerment** - people being supported and encouraged to make their own decisions and give informed consent.
- **Prevention** - it is better to take action before harm occurs.
- **Proportionality** - the least intrusive response appropriate to the risk presented.
- **Protection** - support and representation for those in greatest need.
- **Partnership** - local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** - accountability and transparency in delivering safeguarding.

These six principles should inform the ways in which professionals and other staff work with adults.
They apply to all sectors and settings including care and support services, further education colleges, commissioning, regulation and provision of health and care services, social work, healthcare, welfare benefits, housing, wider Local Authority functions and the criminal justice system.

2.5 The Policy outlines a process that combines the principles of protection and harm prevention with individuals' self-determination; respecting their views, wishes and preferences in accordance with the 'making safeguarding personal' approach.

3 DEFINITIONS

3.1 Safeguarding Adults

Safeguarding Adults means protecting an adult's right to live in safety, free from abuse and neglect (Department of Health, 2014). It includes self-neglect in some circumstances. Safeguarding is everybody's business.

3.2 Adults at Risk

For the purpose of safeguarding, an 'Adult at Risk' is any person over the age of eighteen years old who:

a) "has needs for care and support (whether or not the [Local] Authority is meeting any of those needs), **and**

b) is experiencing, or is at risk of, abuse or neglect, **and**

c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."

The Care Act says that if a child, young carer or an adult caring for a child, is likely to have needs when they, or the child they care for, turns 18, the Local Authority must assess them if it considers there is 'significant benefit' to the individual in doing so. This is regardless of whether the child or individual currently receives any services.

The Local Authority staff, social workers, young people and carers need to work together to plan for the transition to adult care services.

3.3 Abuse

Abuse and neglect can take many forms. Organisations and individuals should not be constrained in their view of what constitutes abuse or neglect, and should always consider the circumstances of the individual case.

Abuse includes:

- **Physical abuse -** including hitting, slapping, pushing, kicking, misuse of medication or inappropriate sanctions or restraint.
- **Domestic abuse – including coercive control –** definition, as defined by Domestic Abuse Act 2021, is any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality.
- **Sexual abuse -** including rape, assault by penetration, and sexual assault or causing a person to engage in sexual activity without consent. Consent is defined

as ‘agrees by choice and has the freedom and capacity to make that choice’. (Sexual Offences Act 2003).

- **Psychological abuse -** this is sometimes referred to as emotional abuse and includes threats of harm or abandonment, deprivation of contact, humiliation or blaming.
- **Financial or material abuse -** including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions or the misuse or misappropriation of property, possessions or benefits.
- **Modern slavery, or servitude -** includes slavery, human trafficking, forced labour, and domestic servitude.
- **Discriminatory abuse -** this may include other types of abuse experienced by someone because of their race, gender, gender identity, age, disability, sexual orientation, or religion.
- **Organisational abuse -** formerly known as ‘Institutional Abuse’. Including abuse that takes the form of isolated incidents of poor or unsatisfactory professional practice at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other.
- **Neglect and acts of omission -** including ignoring medical or physical care needs, failure to provide access to appropriate health, social care, or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.
- **Self-neglect -** includes a wide range of behaviours involving an individual’s neglect of their personal hygiene, health, or surroundings and includes behaviours such as hoarding. (Department of Health, 2014).

The Care and Support Statutory Guidance (DHSC, updated 2023) also contains provision for the safeguarding of carers.

3.4 Section 42 of the Safeguarding Enquiry

Section 42 (Care Act 2014) places a duty on Local Authorities and the multi-agency safeguarding system to make Enquiries and take action to protect adults at risk from harm, abuse, or neglect.

A Section 42 Safeguarding Enquiry is about deciding whether or not the Local Authority, or another organisation or person, should do something to help or protect the adult at risk.

Where there is agreement between the Local Authority, Integrated Care Board (ICB) and Royal Devon, an Enquiry is ‘caused out’ to Royal Devon. This follows processes aligned to TDSAP Multi-Agency Framework for Managing risk and TDSAP Process and Expectations for Caused out Enquiries, TDSAP Business Process for Caused out S42 Enquiries, TDSAP allocation grid and Royal Devon Incident reporting process for safeguarding concerns / Section 42 Enquiries. The lead agency is responsible for appointing an Enquiry Lead to chair and co-ordinate the Enquiry.

The outcome of caused out Enquiries will always be fed back to the Local Authority, who under the Care Act retain legal responsibility for the Enquiry. The objectives of the Enquiry will be quality assured by the Local Authority, who is able to challenge the body making

the Enquiry if it considers that the process and/or outcome is unsatisfactory. Devon County Council will have the responsibility for updating their case management system.

Where there is a Section 42 Enquiry about the Trust, investigation needs to be undertaken in parallel with Clinical Governance and Safeguarding Teams so that the principles of safeguarding are adhered to whilst ensuring any learning or recommendations are implemented in the Trust.

It is important to recognise the potentially high level of adverse incidents that would be reportable as safeguarding concerns. All incidents reported as 'safeguarding' are reviewed by a member of the specialist safeguarding team to provide assurance that safeguarding responsibilities are followed. Whilst satisfying all requirements, when investigating an incident relating to safeguarding, there needs to be an avoidance of duplication making best use of resources and to be consistent with the principle of proportionality.

3.5 Safeguarding Adults Reviews (SAR)

A SAR is arranged by TDSAP and completed when:

- An adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

- An adult is still alive but has experienced serious neglect or abuse and there is concern that partner agencies, including the Trust, could have worked more effectively to protect the adult.

- The Trust has a duty to cooperate in and contribute to the carrying out of a review where the person has accessed Trust services or was a member of staff.

SARs are a way for all agencies of the partnership to identify the lessons that can be learned from particularly complex or difficult safeguarding adult cases and to implement changes to improve services in the light of these lessons. The main objectives of the report are to:

- Establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults.

- Review the effectiveness of procedures.

- Inform and improve local inter-agency practice.

- Improve practice by acting on learning, and

- Highlight good practice.

The purpose of having a SAR is not to reinvestigate or to apportion blame. It is an opportunity to derive learning for all agencies involved and to make changes to practices in the future.

3.6 Domestic Homicide Review

Introduced by the Home Office in 2011 (Statutory Guidance, updated 2016), Domestic Homicide Reviews (DHRs) are designed to look at what lessons can be learned about agency and inter-agency practice and procedures when the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) A person to whom they were related or with whom they were or had been in an intimate personal relationship, or

(b) A member of the same household.

The purpose is not to apportion blame but to reflect on what happened with a view to preventing domestic homicides in the future. A DHR will be called by the local Community Safety Partnership for the area in which the person lived, and will in turn have been informed of the case by the local Police.

4 DUTIES AND RESPONSIBILITIES OF STAFF

4.1 Role of Safeguarding Adults Executive and Non-Executive Leads:

The Chief Nursing Officer (CNO) for Royal Devon has executive responsibility. The CNO chairs the Safeguarding Committee (SC) and reports to the Trust Board Directors through the Governance Committee.

The portfolio holder is the Director of Nursing, Northern Services.

They are accountable for the governance of safeguarding to the service, partners and regulators.

4.2 Responsibilities of the Named Professional for Safeguarding Adults (Associate Director for Safeguarding and the Head of Safeguarding, Eastern Services) supported by members of the Safeguarding Team:

To offer advice and support to staff on all aspects of safeguarding adults.

To identify safeguarding adults training needs according to agreed training standards and the Intercollegiate Document for Adult Safeguarding (2018) and to facilitate the delivery of the training.

To maintain the quality of the implementation of the Safeguarding Adult policy in conjunction with Trust managers via the clinical governance process.

To advise the Chief Executive and senior managers of the Trust on safeguarding adults matters.

To ensure that the Trust has up-to-date Safeguarding Adults Policy.

To attend the TDSAP meetings as appropriate and to participate in TDSAP subgroups ensuring effective communication and inter-agency working between all partners.

4.3 Responsibilities of Managers:

Ensure that all staff are aware of their role in safeguarding adults.

Support staff to access safeguarding adults training appropriately as outlined in their training needs compliance matrix.

Support staff to make comprehensive and accurate healthcare records in relation to patients where there are safeguarding adult concerns.

Support staff to work effectively and share relevant information with professionals from other organisations in order to safeguard adults.

Ensure that safeguarding responsibilities are reflected in job descriptions.

Support the rights of any staff member who raises concerns about Trust services.

Support staff to raise concerns where these are held: Whistleblowing (How to Raise a Concern) Policy and Management of Allegations Policy.

Out of hours, the Senior Manager on call and/or the Site Manager will help with the 'decision making journey' and actions described herein.

4.4 All members of staff:

All employees (including bank & agency staff), volunteers and contractors are required to adhere to the policies, procedures and guidelines of the Trust, including their roles and responsibilities under this policy. All staff should make sure that they have familiarised themselves with their local multi-agency safeguarding policy as the Trust policy is designed to complement rather than replace the multi-agency policies which define the local practice that must be followed, and the local responsibilities of the Trust staff within multi-agency safeguarding practice.

Staff must also work at all times within the guidelines of their professional codes of conduct and the policies of the Trust to prevent abuse through an act or omission to act. Omissions to act and poor professional practice can amount to neglect even if the abuse was unintentional.

4.5 Responsibility of Safeguarding Committee (SC):

To assure the Governance Committee that the effective implementation of the infrastructure and processes for safeguarding is embedded within corporate and divisional structures.

To provide a focus for performance management of the delivery of the safeguarding agenda through corporate and divisional infrastructures and to escalate where necessary.

To provide expert safeguarding adult advice to the Trust Executive Lead and the Executive Team.

To ensure that multi-agency partnership working is strengthened and any shared issues identified are given a focus.

To identify, commission and monitor the Trust's safeguarding adults training needs and attainment of the required training standards.

To oversee and monitor the Trust responses and action plan to the findings of SARs and DHRs or complaints relating to safeguarding adults.

To agree an annual audits programme both internally and externally.

To receive reports from the Safeguarding Adults Operational Group (SAOG) in accordance with the SC schedule of reports.

4.6 The Safeguarding Adults Operational Group is responsible:

- To monitor the implementation of the Safeguarding Adults Policy.
- To monitor and implement the training strategy.
- To ensure robust systems of communication with Devon County Council Social Services, Police and other partner agencies.
- To define and monitor key performance indicators for quarterly review by the SC.
- To review and oversee implementation of any actions from SARs and DHRs.
- To implement an on-going system of audit and to review those results.
- To identify themes from review of incidents and complaints.
- Effective communication with all staff groups regarding lessons learned from Safeguarding Adult Reviews (SARs) locally and nationally.

5 MAKING SAFEGUARDING PERSONAL

5.1 Making safeguarding personal

Is core to safeguarding practice and encompasses the principles of safeguarding, particularly ‘empowerment’ and ‘proportionality’.

Safeguarding should be person led and outcome focussed with professionals considering how they work with individuals to ensure the principle of “Making Safeguarding Personal” is applied in practice.

There should be a culture within Royal Devon of focussing on personalised outcomes for the person with care and support needs who may be at risk, or has been abused.

Points to consider:

- Ensure patient participation is core throughout any safeguarding care planning.
- Providing accessible information to help the individual participate.
- Ensure advocacy is provided when needed.
- Ensure person centred approaches are supported.

What does this look like in practice?

- When any safeguarding concern is identified have ‘conversations’ with the patient at the very beginning.
- What outcomes does the patient want and how do they think those outcomes can be achieved?
- Record conversations with the patient.
- Involve the patient and their family (with consent) in development of any safeguarding care plans.
- Keep the patient updated with any agreed actions / outcomes.

Note: Even if the patient is deemed to lack mental capacity for specific decisions related to safeguarding it is still important to have these conversations with the patient to develop an understanding of known patient wishes and beliefs in order that ‘Best Interests’ decisions can be reached.

6 WHAT TO DO WHEN ABUSE IS SUSPECTED

The flowchart above on page 8 is designed to assist staff in the decision making and reporting process for safeguarding adult concerns.

6.1 Role of the reporter

Anyone can raise a safeguarding concern, which may be about a specific incident or it could be about an on-going situation or something a patient discloses to you. If a patient makes a disclosure of abuse or neglect, you should:

- Remain calm and listen carefully to what you are being told, and only ask questions for clarification.
- Do not promise confidentiality but where necessary, should reassure the adult at risk that they will be kept safe.
- You must record in writing your observations and any relevant conversations at the earliest opportunity, while the memory is fresh. For staff who have access to Epic, these records should be held within the Epic records system and marked ‘safeguarding’. This record will form the basis of the other reports.
- Staff can gather information but not become involved in full investigation at this stage, to avoid compromising any potential investigation.
- Respect the confidentiality of staff and patients and only discuss this situation with persons who need to know.
- Share information as appropriate in accordance with this Policy and principles within Information Governance Policy.

You must take action that is aligned to the Principles of Safeguarding including ‘Making Safeguarding Personal’

Here is a step by step guide for what you must do:

Step 1
Assess the immediate risk

Where people are in immediate danger and the adult is identified as being at significant risk the Police should be called immediately. Dial 999.

If safe to do so at this point you need to ask (and record those conversations) the patient what outcomes they want.

The professional should consider if there is reason to doubt Mental Capacity, and a formal Mental Capacity Act (MCA) assessment should be completed where indicated. Decision making should then be aligned to the core principles of the Mental Capacity Act (2005). MCA Policy.

Advocacy support may be indicated (Refer to section 6.3).

(The professional should have the knowledge and skills to complete the MCA assessment, and if not to speak to their line manager requesting support.)

Step 2
Report your concern

Where you have concerns that a patient is at risk of abuse or neglect and would be unable to protect themselves you should raise a concern to the Local Authority, preferably with consent however there may be circumstances a concern is raised without consent. The practitioner should consider discussing with their line manager but this is not essential and should not be a barrier to raising a concern.

Step 3
A safeguarding 'concern' should be raised

This should be done with patient consent to the Local Authority, but there are exceptions to this see below (Eastern: 01392 381 206 / Northern: 01392 381 208) There is a link to the electronic reporting form on the Trust internal website.

If the possible abuse has taken place outside of Devon County Council footprint (e.g. Torbay, Plymouth, Cornwall or other Local Authority area) then the Concern should be reported directly to that Local Authority. (Contact the Trust Safeguarding Team if needing advice.)

Adults have a general right to independence, choice and self-determination including control over information about themselves.

In the context of adult safeguarding these rights can be overridden in certain circumstances (See Section 7):

- The person lacks the mental capacity to make that decision – this must be properly explored and recorded in line with the Mental Capacity Act (2005)
- Other people are, or may be, at risk, including children
- Sharing the information could prevent a crime
- The alleged abuser has care and support needs and may also be at risk
- A serious crime has been committed
- An allegation is in relation to a member of staff
- The person has the mental capacity to make that decision but you suspect they may be under duress or being coerced
- The risk of harm is unreasonably high and the sharing information can be justified

- The court order or other legal authority has requested the information
- The Care Act (2014, s.11) places responsibility on the Local Authority to carry out a needs assessment if the adult is experiencing or at risk of abuse or neglect, even if the adult is refusing services

You may wish to discuss the concern with the Trust Safeguarding Team prior to formally raising. Contact details in Appendix E for Eastern and Northern Safeguarding teams, Eastern and Northern DCC professional line, and DCC emergency duty team.

Step 4
Where the adult at risk is a patient of Royal Devon

All concerns of abuse should also be clearly and accurately documented in the patient's Electronic Patient Record: date, time and specific concerns and all conversations and actions should be documented. Comments from family members or the patient should be stated as quotes and opinions should be documented as such. The nature of the abuse suspected or otherwise should be clearly outlined and any unexplained injuries noted on a body map 'Avatar'. Safeguarding records should be labelled 'safeguarding' within Epic.

There may be an indication for a 'safeguarding FYI flag' to be added to Epic records. The purpose of a safeguarding flag will be to bring to the attention of treating professionals, the potential risks which can then be considered when the patient presents to services. The flags are added to the patient record by a specialist within the Safeguarding Team and should be reviewed regularly. If staff think there is a need for a patient to have a safeguarding FYI flag or they see a flag which they believe to be inaccurate, they should contact the Safeguarding Team.

'Break the Glass' flag can be added to patients records where there is a risk of information being inappropriately shared with perpetrators, visitors or staff which may increase the risk of harm or where there are particular sensitivities. Safeguarding Team, Site Management, Information Governance and senior nurses can add this flag.

The Safeguarding progress notes and FYI flags cannot be seen by patients and proxies on MyChart. If a patient or their Lasting Power of Attorney makes a Subject Access request to see their records, the safeguarding notes are reviewed to consider what should be redacted, except in exceptional cases where the patient is already aware and/or has given consent to share.

6.2 Safeguarding Meeting

A safeguarding meeting is a professionals' planning meeting. This may be arranged by the Local Authority, community lead, social worker or other practitioner within the Trust. It may form part of a Safeguarding Enquiry, or as part of providing a safeguarding response within discharge planning.

- The patient (with any representative they choose) may or may not be present. (If not present they should be informed of the meeting and its purpose).
- The primary aim is to ensure that the principles of safeguarding the individual are applied.
- Representatives may be invited from all agencies who are involved with the patient, and all those having an interest or responsibility for safeguarding.
- Those invited have a responsibility to produce reports for the meeting if they are unable to attend so that a decision can be reached regarding the next steps.

- It is important that this decision is based on all pertinent information available.

A Safeguarding meeting chair is appointed and formal minutes should be recorded and circulated.

The Enquiry lead draws on the knowledge and experience of other professionals to inform the Safeguarding Enquiry.

'Making Safeguarding Personal' must be core to all safeguarding practice and this also includes any professionals' meeting, considering what the patient has expressed as wishes /outcomes or taking into account the views of appointed Lasting Power of Attorney for Health and Welfare (advise this is formally checked) or IMCA or ICAA (see section 6.3). The views of family member or friends may also be taken into consideration at any safeguarding meeting.

6.3 Involvement of Advocacy and Independent Mental Capacity Advocates (IMCA) and Independent Care Act Advocate (ICAA)

The Care Act 2014 requires that a Local Authority must arrange, where appropriate, for an independent advocate to represent and support an adult who is the subject of a safeguarding Enquiry where the adult has 'substantial difficulty' in being involved in the process and where there is no other appropriate individual to help them.

When someone lacks capacity to make decisions about safeguarding, in many instances the most appropriate person to support the adult at risk and act as an advocate is the primary carer.

Where the carer is acting in the role of advocate they may need support to do so, therefore professionals need to provide information and ensure that it is understood. The carer themselves may be also in need of an advocate.

If the carer is the person who is allegedly abusing or neglecting the adult at risk, it would not be suitable for them to be the primary support for safeguarding. An advocate should be appointed if there is no other suitable person to support the person at risk.

6.4 Referral to the Police

The Police are a key safeguarding partner.

At what point the Police should become involved in a safeguarding investigation will depend on a number of factors including:

- The views and wishes of the adult at risk
- Whether a criminal offence as defined by law has been disclosed
- The exact circumstances surrounding each individual case of suspected abuse or neglect.

If there are concerns that an adult is at immediate risk of serious harm, the Police have powers to intervene if a person needs immediate assistance due to a health condition, injury or other life-threatening situation.

If the situation is not an emergency, it is important to find out from the person whether they want the Police to be involved, especially where there are complex family dynamics or complex personal relationships. Risk of harm to others should also be considered in these circumstances, so the person's wishes would not be the sole consideration.

If there is a reasonable suspicion that a crime may have been committed and the harm caused to the adult concerned was deliberate, malicious or reckless, then referral to Police may be required. If it is urgent ring 999 or you can contact the Police if it is not urgent by ringing 101 or use the online referral platform. Make a note of the Crime or Incident Log Number. Document in patient's records details of the conversation with Police, including any action they have asked staff to take or Police plan to undertake.

6.5 If a referral has already been made

If a Police referral has already been made and staff need further safeguarding advice call 0845 605 1166 or email centralsafeguardingteam@devonandcornwall.pnn.Police.uk

7 TYPES OF ABUSE

7.1 Domestic Abuse

Domestic abuse includes any incident or pattern of incidents of controlling, coercive or threatening, degrading or violent behaviour, including sexual violence of those aged 16 or over who are or have been, intimate partners or family members regardless of gender or sexuality. Family members are defined as mother, father, son, daughter, brother, sister and grandparents whether directly related, in laws or step family. However, this is not an exhaustive list and may be extended to aunts, uncles and cousins etc... Domestic abuse covers a range of types of abuse, including, but not limited to, psychological, physical, sexual, emotional, financial, economic, harassment, stalking, or online abuse.

Domestic abuse is rarely a one-off incident and it is often the cumulative impact of this type of abuse that has a particularly damaging effect on the victim. It also includes so called 'honour' based violence, female genital mutilation and forced marriage. The Trust has separate policies on Domestic Violence and Abuse Affecting Patients and also one for Domestic Abuse Affecting Staff.

The principles of safeguarding practice should apply. If there is significant risk, contact the Police on 999 for immediate assistance or complete a MARAC referral, or seek advice. (Refer to Domestic Abuse Policies.)

A safeguarding concern may be raised if the person has care and support needs and meets criteria under safeguarding practice. Consent will be needed unless there is a 'duty to raise'. If they do not have care and support needs, then you can seek advice / support by contacting the Safeguarding team or, with consent, the Health IDVA (Independent Domestic Violence Adviser). Refer to HUB (Trust internal website) for contacts.

Eastern:

Domestic Abuse Affecting Patients Policy

Domestic Abuse Affecting Staff Policy

Northern:

Domestic Abuse Affecting Staff Policy

Domestic Violence and Abuse Policy

7.2 Hidden Harms

Hidden harms and harmful traditional practice

Every social grouping in the world has specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women.

The terms ‘hidden harms’ and ‘harmful traditional practices’ can be used to describe a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such abuse can occur when perpetrators perceive that a relative has shamed the family and/or community by breaking their honour code.

Harmful traditional practices are forms of abuse which have been committed primarily against women and girls in certain communities and societies for so long that they can be considered by some, or presented by perpetrators, as part of accepted cultural practice.

The most common are:

- Forced or early marriage
- So called 'honour' based abuse
- Female Genital Mutilation or ‘cutting’ (FGM)

These practices violate human rights and may be a form of domestic and/or sexual abuse. There is no, and cannot be any, honour or justification for abusing the human rights of others.

Forced Marriage (FM) is a marriage conducted without the valid consent of one or both parties and where duress is a factor. FM is now a specific offence under Section 121 of the Anti-Social Behaviour, Crime and Policing Act 2014 and this came into force on 16 June 2014.

See also The Marriage and Civil Partnership (Minimum Age) Act 2022 which received Royal Assent 27/2/23. The Act has raised the age of marriage and civil partnership to 18 in England and Wales to protect children from the risk of forced marriage.

With Hidden Harms the abuse is often undetected and unreported. It can also include:

- Modern slavery
- Online child abuse
- Domestic abuse
- Hate crime

7.3 Sexual Assault and Abuse

When a patient who has experienced sexual assault presents to services there needs to be an understanding how the effects of trauma can impact on the presentation, including understanding behaviours and being able to support a patient with decision making, from a trauma informed approach.

Sexual Assault and Referral Centre (SARC) provides specially trained medical and counselling staff to help all victims of sexual crime when they most need it. If someone discloses sexual assault or rape you can call the SARC 24hr helpline on 0300 303 4626. Victims may need time to think about what has happened to them although should consider getting medical help as soon as possible, as they may be at risk of sexually transmitted infections or pregnancy. If victims have not yet decided whether they want to report to Police, forensic evidence can still be gathered within 7 days and stored until the victim feels able to report.

In the case where a victim lacks capacity for the specific decision regarding Police involvement the Police should always be informed with decision making aligned to the principles of the MCA 2005, and also in consideration of wider public protection.

If a victim has capacity to make specific decisions, and is at risk of ongoing harm but does not want to report to police, consult with the Trust Safeguarding Team and SARC for advice as to the most patient centred/ trauma informed way forwards.

7.4 Self-Neglect

Five key areas should be considered when assessing whether harm is being caused:

- Impact on physical health
- Impact on emotional well-being
- Impact on social functioning
- Impact on environment
- Impact on other people.

An understanding of the application of the Mental Capacity Act (MCA) 2005 in practice underpins work undertaken with adults who self-neglect. Where a patient lacks capacity with regard to how their self-neglect impacts themselves or others, care planning should follow a Best Interest approach with decisions aligned to the principles of MCA.

The dilemma for practitioners is often in determining whether self-neglect is due to lacking mental capacity, or unwillingness to maintain societal norms of standards of self-care.

Where a person is unwilling to recognise the potential risks of self-neglect, there may be a potential limited likelihood of them engaging with support.

Practitioners should assess whether the person is able to make links between self-neglect and the impact on physical wellbeing, emotional wellbeing, social functioning, home environment and other people. Do they understand the potential consequences? Professionals should firstly review care planning and give immediate, appropriate offers of referrals to possible support services.

A safeguarding adult concern referral should be completed if others are at risk or if the patient does not have capacity to make decisions relating to safeguarding, or if the risks are significantly high where you can justify sharing information without consent. Contact the Trust safeguarding team if needing further advice.

Keep 'Making Safeguarding Personal' core to practice: Patient led and outcome focussed.

It is often valuable to hold a meeting to consider care planning with key professionals involved and including the patient. A 'professionals only' meeting may be indicated, keeping the patient updated with any decisions made as appropriate. Identifying a lead practitioner would be best practice.

There should be a multi-agency approach to supporting a patient who is at risk of self-neglect. Alongside statutory agencies the team should consider the role of all agencies including housing, drug and alcohol support services, mental health teams and voluntary sector services.

The risk of fire is significant in those who self-neglect. This must be considered in any risk assessment and care planning. The Fire Service have a very supportive role with all patients at risk and will offer free Home Safety Fire checks when requested (check eligibility criteria). Contact: 08000502999. Consent should be gained where possible but consider if risk is high to person/others that referral without consent may be needed.

A referral can be made via email to: firekills@dsfire.gov.uk or online Home Safety Fire checks.

Further advice:
Self-neglect Toolkit on the TDSAP site and TDSAP Multi-agency Risk Management Meeting (MARMM) guidance. Additional resources see 12: References

7.5 Pressure Ulcers

Clinical care and prevention of further harm is the priority, however where there is skin damage a safeguarding response may be indicated.

If there is concern that the pressure ulcer may have arisen as a result of poor practice, neglect/abuse or an act of omission, a safeguarding concern should be raised with the Local Authority. This may require patient consent.

If the patient has been receiving care from another service prior to presentation the professional should consider contacting the manager of the service (Care Home/ Care Agency/Community Nursing Team/ Hospital) involved in the care of this patient to inform them that a Concern has been raised.

Government guidance regarding pressures ulcers can be found here.

7.6 Homelessness

From the 1st October 2018, as part of the Homelessness Reduction Act (2017), hospitals providing inpatient care, Emergency Departments and MIU's are bound by the Duty to Refer to the Local Authority Housing team. This requires all named public bodies including the Trust to refer anyone they believe may be homeless or threatened with homelessness (with consent).

There may be a number of intersecting risks when someone is homeless.

It is important to consider presenting risks aligned to safeguarding practice, with assurances that principles of MCA 2005 applied, agencies evidence working together and ideally a lead professional is identified.

Additional resources: Homelessness Toolkit

Links to Council emergency housing teams:
Northern
Eastern

7.7 Financial Abuse and Exploitation

Financial abuse can present in many different ways including theft, fraud, false representation, exploitation, online abuse and misuse of a power of attorney, deputy, appointeeship or other legal authority.

There may be economic abuse where someone is being prevented from earning their own money or not allowed to drive a car to work in order to earn money, so cannot get a job. This can be a feature of coercion and control, particularly in domestic abuse.

Staff may need to support a person to contact their bank or family, social worker, their solicitor, Age UK etc to take the initial steps to prevent ongoing financial abuse. Staff can provide a telephone to inpatients to make the necessary calls.

7.8 Illegal Money Lending

The Trust is a recognised 'partner agency' with the (England) Illegal Money Lending Team.

Loan sharks are illegal moneylenders who often charge very high interest rates. You can check if a company is authorised to lend money and report loan sharks anonymously.

If anyone is concerned that they think a patient has been exploited by a loan shark this can be reported anonymously:

On-Line: Report a loan shark online
Email: reportaloanshark@stoploansharks.gov.uk
Telephone: 0300 555 2222 24-hour service.
Text a lender's details to 07860 022 116.

For further advice contact the Trust Safeguarding Team.

7.9 County Lines and 'Cuckooing'

'County lines' is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of "deal line".

They are likely to exploit children and vulnerable adults to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

There may be 'cuckooing' related to County Lines drug gangs where someone is living in their home in order to deal drugs.

For further information on exploitation associated with 'County Lines please see Home Office Guidance (2023) and TDSAP Guidance (2023).

The safeguarding response should be considered in line with Section 6.

7.10 Modern Slavery

Human trafficking and modern slavery are happening every day across the UK, affecting thousands of men, women and children.

Trafficked and exploited persons are often forced to live and work at the margins of society so that they remain hidden and are unable to ask for help. However, given the high-risk jobs they do, victims often require healthcare services to treat problems such as broken bones caused by accidents on dangerous work sites, or sexual health conditions linked to sexual exploitation. This gives the NHS a unique opportunity to make a difference to these victims' lives.

Spotting the signs of modern slavery is not always easy. Victims are often fearful of their controllers and may try to hide their situation due to fear of retributions against themselves, friends or family. However, many NHS staff are already aware of potential victims; in fact, one-in-eight NHS staff in England think they have seen a victim of trafficking in their clinical practice. (Ref: NHS England)

If it is an emergency call 999.

For help and advice call any time on **0800 0121 700.** It is free from landlines and most mobile phones. Or visit the Modern Slavery website 'Unseen'.

The Unseen APP makes reporting to the modern slavery and exploitation helpline even easier:

The Principles of safeguarding practice apply.

Any individual referral (unless an exception applies) should be with patient consent and 'making safeguarding personal' should be core to practice.

If you think slavery is happening you need to ensure the safety of a potential victim and your own safety. More information is available through the Devon and Cornwall Police website.

7.11 Patients who are not brought to appointments in the context of safeguarding.

If a patient is not brought to an appointment or misses an appointment / fails to answer the door to a member of the community team this should be considered aligned to safeguarding practice. Refer to appendix B.

7.12 Concerns raised regarding abuse or neglect within the Trust - This includes raising concerns in relation to 'People in Positions of Trust' (PiPoT)

Where an allegation or suspicion of abuse is raised about a Trust hospital, service or member of staff please contact Human Resources (HR) and/or the Head of Safeguarding or Senior Safeguarding Nurse to manage this following the Management of Allegations Policy.

There may well be immediate protection arrangements which are required and a safeguarding adult concern referral may be needed and/or referral to the Police. The Trust Designated Allegations Officer (HR) and the Head of Safeguarding will determine the course of action to be taken. This normally will include informing the senior nurse/manager, Assistant Director of Nursing and/or Director of Nursing. The NHS Devon ICB Safeguarding Team may also need to be informed.

These concerns are often highly sensitive and the manager will need to deal appropriately with staff within the service while considering the safety of other adults at risk.

The member of staff may be suspended from duty pending an investigation according to the Trust's Promoting a Positive Working Environment Policy. Advice should be sought from Human Resources.
The manager of the member of staff should ensure that the member of staff can access support from Occupational Health during any investigation process.

A multi-agency practice agreement has been approved. Refer to: TDSAP PiPoT Protocol

The Trust therefore has a duty to refer relevant information, as it is a provider of regulated activity to the Disclosure and Barring Service, where this is indicated. Please refer to the Disclosure and Barring Service Policy (Northern) or Disclosure and Barring Service Policy (Eastern). The DBS website provides guidance on when employers should make a referral to them.

Safeguarding Adults National Network (SANN, 2022) 'What is PiPoT' 7 minute Briefing: Appendix C
Safeguarding Adults National Network (SANN, 2022) 'DBS' 7-minute Briefing: Appendix D

8 SHARING INFORMATION

Under the GDPR and Data Protection Act 2018 staff may share information without consent, if in their judgement there is a lawful basis to do this.

Wherever possible consent to share any information should be sought from the adult at risk of abuse or neglect with their preferred outcomes expressed.

There may be situations where:

- Consent is withheld, or
- The person is unable to give informed consent
- Another person is at risk e.g. in neighbourhood, care home, care agency, hospital

Information may still be shared between professionals if consent is withheld **if** there is reasonable belief that:

- There is a high risk of serious harm to the adult at risk, or
- Consent was withheld under duress

OR

- When the courts have made an order, or
- To prevent or detect or prosecute a serious crime.

Absolute assurances of confidentiality cannot be given, especially where other adults at risk of abuse or neglect, or children may be at risk.

If consent is **withheld** and the risk of harm is not assessed as high at that time, the responsible manager should consider what can be offered to the adult at risk, to enable them to get help in the future.

The law does not prevent the sharing of sensitive personal data between organisations, provided that the sharing is lawful and is consistent with information sharing guidance issued by the Information Commissioner's Office (ICO).

If the person is **unable to give informed consent** and is assessed as lacking capacity to consent, but information needs to be shared in order to prevent or protect them from abuse, then the 'best interest' principle must be followed. Please refer to: MCA Policy and TDSAP Information sharing principles and agreements for adult safeguarding.

9 DISCHARGING PATIENTS WHERE THERE ARE OUTSTANDING SAFEGUARDING CONCERNS

When a safeguarding concern has been raised to the Local Authority about a patient at risk in their home setting, should this continue to place the person at risk, advice can be sought from the Trust Safeguarding Team or contact Devon County Council (DCC) Safeguarding Hubs via professional's telephone numbers as follows:

- Eastern (Exeter, East and Mid Devon): 01392 381206 Option 5, safeguardingadultseast-mailbox@devon.gov.uk
- Northern: 01392 381208 option 2, option 3, safeguardingadultsnorth-mailbox@devon.gov.uk
- Southern: 01392 381211 safeguardingadultssouth-mailbox@devon.gov.uk

Please note that these numbers are intended for professionals use only.

In some circumstances the adult may insist on being discharged to an unsafe environment. In these circumstances it would be necessary to ensure there is a formal assessment of the patient's mental capacity to make this decision and the outcome clearly

recorded in the patient's notes. A person with mental capacity has a right to make what might be considered as unwise decisions (MCA 2005).

It is the responsibility of the member of staff discharging the patient to ensure effective communication to appropriate agencies on discharge, e.g. Social Services, General Practitioners (GPs), community services. It is important that a record of this communication is made in the patient's notes.

COMMUNICATION: Do not document safeguarding concerns or domestic abuse in discharge summaries unless you are sure that the perpetrator of the abuse will NOT see or have access to the summary. If necessary, write a separate letter to the GP or relevant professionals.

The Trust Information Governance Team, Safeguarding Team and Caldicott Guardian can support with advice.

10 LASTING POWER OF ATTORNEYS & ABUSE BY A LASTING POWER OF ATTORNEY OR COURT APPOINTED DEPUTY

10.1 Office of the Public Guardian (OPG)

The Office of the Public Guardian (OPG) is a public body that works closely with the Court of Protection. Its main role is to register applications for powers of attorney.

A lasting power of attorney (LPA) is a legal appointment of one or more people (known as 'attorneys') to help them make decisions on their behalf.

The LPA is made whilst the donor has capacity.

There are 2 types of LPA:

- Health and welfare, and
- Property and financial affairs. (See MCA Policy for full details)

If a person has lost capacity and has not granted a power of attorney to anyone, it may be necessary to apply to the Court of Protection to appoint a 'deputy'. These are usually appointed to manage finances. Deputies are often family members, specialist solicitors or a Local Authority representative.

An LPA has to follow the statutory principles of the Mental Capacity Act 2005 and make decisions in the best interest of the person (donor). The LPA must also respect any conditions or restrictions that the LPA document contains.

Some attorneys and deputies abuse their positions and exploit the person they are appointed to support. This is often financial abuse or neglect but may involve failing to act in the person's best interests in other ways, such as bullying or threatening behaviour.

If it is suspected that the LPA is not following these principles then you should report your concern to the OPG https://www.gov.uk/report-concern-about-attorney-deputy-guardian

The OPG can investigate allegations of abuse against a court-appointed deputy or registered attorney. They may refer the case to a Local Authority or investigate the concerns themselves. If the case needs urgent action, for example to stop someone emptying a person's bank account, they can initiate court proceedings via the Court of

Protection and the Court can freeze the funds or order urgent action it thinks needs to be taken.

If someone declares that they have an LPA for someone it is important to check that this has been formally registered with the OPG. The LPA document can be uploaded to the patient's electronic record in the "Demographics" section under "Advanced Decisions".

A check for an LPA can be done quickly and easily by applying to the Office of the Public Guardian with an email to OPGurgent@publicguardian.gov.uk using a secure NHS email account and giving details of the patient's name, address and date of birth.

10.2 The Court of Protection

The Court of Protection is based in London and can make decisions on financial or welfare matters for people who can't make decisions at the time they need to be made where this is indicated.

There will be certain situations when the Trust will need to apply to the Court of Protection so that the court can decide what is in the patient's best interest. For example, if there is lack of agreement regarding which course of action or medical treatment is in the patient's best interest. The mental capacity team will support with these applications.

The Court of Protection might intervene where there is abuse by people appointed to look after the finances or welfare of someone without mental capacity to do so themselves.

11 WHEN DOES POOR CARE BECOME A SAFEGUARDING ISSUE?

The aim of every commissioner and service provider should be effective, high-quality care and support for every individual. When this falls short, people are put at risk and safeguarding referrals rise.

There is evidence that many of the issues raised as safeguarding concerns, (such as falls, pressure sores, wrongly administered medication or poor nutritional care) are not rooted in malicious harm but in poor practice and poor-quality care. Nonetheless, the impact on the adult at risk can be just as great, regardless of whether harm is intended.

It is important to differentiate between the two, in order to address problems in the right way, so that all adults at risk receive safe, high-quality care and support.

If you have concerns about poor quality practice or care then you should raise a Concern to the Local Authority. You can seek advice from the Trust Safeguarding Team or Local Authority Safeguarding Team.

The Trust has a role to alert the ICB and CQC where repeated patterns of harm are identified.

Repeated instances of poor care indicate serious underlying problems and point towards organisational abuse, which happens when standards of care are so poor that adults are put at increased risk. The importance of recording everything, and regularly reviewing records, cannot be overstated. Only through good recording can patterns of incidents over time be tracked and analysed, and therefore addressed. Report incidents of poor care through the Datix reporting system where incidents, and possible themes, can be reviewed within the framework of Trust Governance.

If there are general safeguarding concerns about the care home affecting multiple residents, please complete one safeguarding referral form.

If there are specific different concerns about a number of residents, please complete separate safeguarding concern forms for each person to ensure that each concern is looked at.

Where there are concerns that abuse and neglect is occurring in a care home, hospital, prison or other institution; or being perpetrated by domiciliary or care providers, a whole service Enquiry may need to be undertaken by DCC Safeguarding Adults Team. Trust staff may be asked to support this process.

The Community Services Manager involved in whole service safeguarding meetings will need to be mindful of the resource commitments that any Safeguarding Enquiry will require and its' impact on service delivery. There are Specialist Safeguarding Professionals and Care Services Educators working in the Eastern Care Services Team who work closely with DCC Safeguarding Adults Team to identify, prevent, and investigate issues relating to whole service safeguarding concerns in a timely manner. This team work collaboratively with the Care Quality Commission to influence best practice within a variety of care settings through the provision of advice, support and education on a range of care and quality issues.

12 TRAINING REQUIREMENTS

The delivery of effective training is crucial to the success of the safeguarding adults' practice. There are differing levels of safeguarding training dependent on roles and responsibilities.

The Trust has aligned its staff statutory training requirements to the Skills for Health Core Skills Training Framework (Skills for Health 2016). Included in this is the need for completion of Safeguarding training for adults and children which is underpinned by the 'Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)'.

Each level of training requires staff to complete a minimum number of hours training over a three-year period. These training hours can be met by undertaking a variety of different training interventions. Training requirements are aligned to the individual training Matrix.

The Trust recognises that staff undertake many episodes of training that are relevant to safeguarding adults and children and some that are core to both adults and children.

The three yearly Safeguarding Training Declaration enables staff to document the variety of training that they undertake at Level 3 and above.

E-learning can be accessed through Learn+.

13 SAFEGUARDING SUPERVISION AND SUPPORT FOR STAFF

The Safeguarding Team aim to provide compassionate leadership and support to all staff across the Trust in line with the Trust Values.

Supporting safeguarding patients can be challenging and decisions that are made can be complex and involve understanding of risk management. Witnessing the abuse and

trauma of others can be deeply distressing to practitioners. Practitioners may have lived experience of personal trauma, and may experience vicarious trauma through their work.

We aim to work in partnership with all agencies to support safeguarding practice.

Staff should be able to access support from their line-manager, senior leadership, IDVA, Trust Well-Being services and Chaplaincy.

Safeguarding Supervision can provide the opportunity to reflect on decisions made and an opportunity for support, challenge and learning around safeguarding cases.

Safeguarding supervision can be provided to a group or individual. Please refer to the Trust Safeguarding Team where needing support.

14 ARCHIVING ARRANGEMENTS

The original of this policy will remain with the author(s). An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

15 MONITORING COMPLIANCE WITH AND THE EFFECTIVENESS OF THE POLICY

15.1 Standard/Key Performance Indicators

Key performance indicators comprise:

- Percentage of staff completing Safeguarding training
- Number of safeguarding concerns raised by The Trust
- Number of safeguarding concerns raised about The Trust staff or services
- Number of DBS referrals

15.2 Process for Monitoring Compliance and Effectiveness

This Policy will be shared across the Trust for implementation.

The Associate Director for Safeguarding will be responsible for reporting compliance to the Operational Group and to the SC.

Alongside the reporting of key performance indicators, the Trust Safeguarding Team will also undertake audits, as agreed within the Annual Report and Work Plan for that team.

This Policy and its implementation will be monitored through the SC. The Chief Nurse / executive lead has operational oversight of Safeguarding and holds responsibility for Safeguarding Adults.

The Associate Director for Safeguarding reports to the Director of Nursing and is a member of the TDSAP operational group and sub groups.

All line managers have a responsibility to ensure the Safeguarding Adults Policy is followed by staff that they directly manage. Where non-compliance is identified, support and advice will be provided to improve practice.

In cases where this Policy is not followed immediate assurance of patient safety is of primary importance.

The manager of the individual / service should investigate any non-compliance and report through established Governance and HR Policies.

This should be escalated to the Associate Director for Safeguarding and/or Head of Safeguarding or to the Director of Nursing dependant on level of concern.

Support should be made available to staff where this is appropriate. This may take the form of safeguarding supervision. There are wide ranging support services for staff.

16 REFERENCES

Care Act 2014, London: The Stationary Office

Department of Health and Social Care (DHSC) (2023) *Care and Support Statutory Guidance*. Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed 13/6/23].

Home Office*: Criminal exploitation of children, young people and vulnerable adults: County lines* Available at: https://www.careknowledge.com/media/57217/county_lines_guidance_2023.pdf [Accessed 27/11/23].

Homelessness Reduction Act 2017, London: The Stationary Office.

Mental Capacity Act 2005, London: The Stationary Office

Northern Devon Healthcare Trust (NDHT), (2018) Domestic Violence and Abuse Policy

NDHT (2021) Domestic Abuse and Violence Policy (for Staff)

NDHT (2020) Female Genital Mutilation Policy

NDHT (2021) Freedom to Speak up: Raising Concerns (Whistleblowing) Policy

NHS England (2017) Safeguarding Adults: A guide for healthcare staff https://www.england.nhs.uk/publication/safeguarding-adults-a-guide-for-health-care-staff/

Royal Devon and Exeter NHS Foundation Trust (2020) Domestic Abuse Affecting Patients Policy

Royal Devon and Exeter NHS Foundation Trust (2021) Domestic Abuse affecting staff (Perpetrators and Victims) Policy

Royal Devon (2021) Whistleblowing (How to raise a concern) Policy

Royal College of Nursing (2018) Adult Safeguarding: Roles and Competencies for Health Care Staff: https://www.rcn.org.uk/professional-development/publications/pub-007069

Torbay and Devon Safeguarding Adults Partnership (TDSAP) (2021), Devon multi-agency safeguarding adult procedures and guidance. Available at:

https://www.devonsafeguardingadultspartnership.org.uk/document/multi-agency-safeguarding-adults-guidance-and-procedures/ [Accessed 1/12/23]

Torbay and Devon Safeguarding Adults Partnership (TDSAP) (2020) *Multi Agency Framework for managing risk*. Available at: https://www.devonsafeguardingadultspartnership.org.uk/document/multi-agency-frameworks-for-managing-risk/ [Accessed 1/12/23].

Torbay and Devon Safeguarding Adults Partnership (TDSAP) (2020) *Allegations Against People in Position of Trust (PiPoT) Protocol*. Available at: https://www.devonsafeguardingadultspartnership.org.uk/document/allegations-against-people-in-position-of-trust/ [Accessed 1/12/23].

Torbay and Devon Safeguarding Adults Partnership (TDSAP) (2023) Guidance for working with adults at risk of exploitation: Cuckooing. Available at: https://www.devonsafeguardingadultspartnership.org.uk/document/tdsap-guidance-for-working-with-adults-at-risk-of-exploitation-cuckooing/ [Accessed 1/12/23].

Torbay and Devon Safeguarding Adults Partnership (TDSAP) Self Neglect: Available at: https://www.devonsafeguardingadultspartnership.org.uk/abuse/self-neglect/ [Accessed 1/12/23].

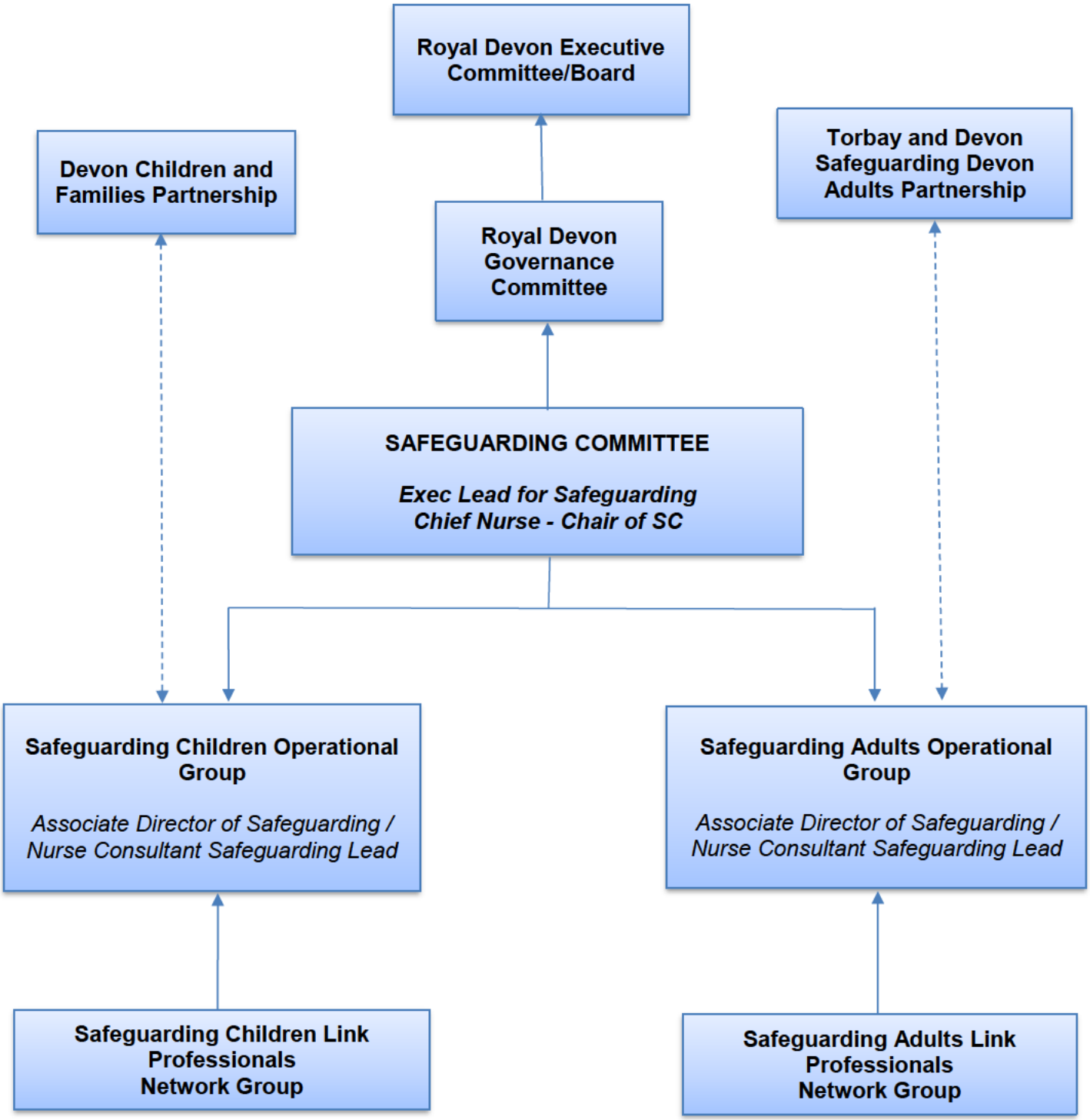
17 Acknowledgements

Material on Self Neglect based on work of Suzy Braye, Independent Researcher and Consultant, ***s.braye@sussex.ac.uk***

Administrative Team within the Safeguarding Team.

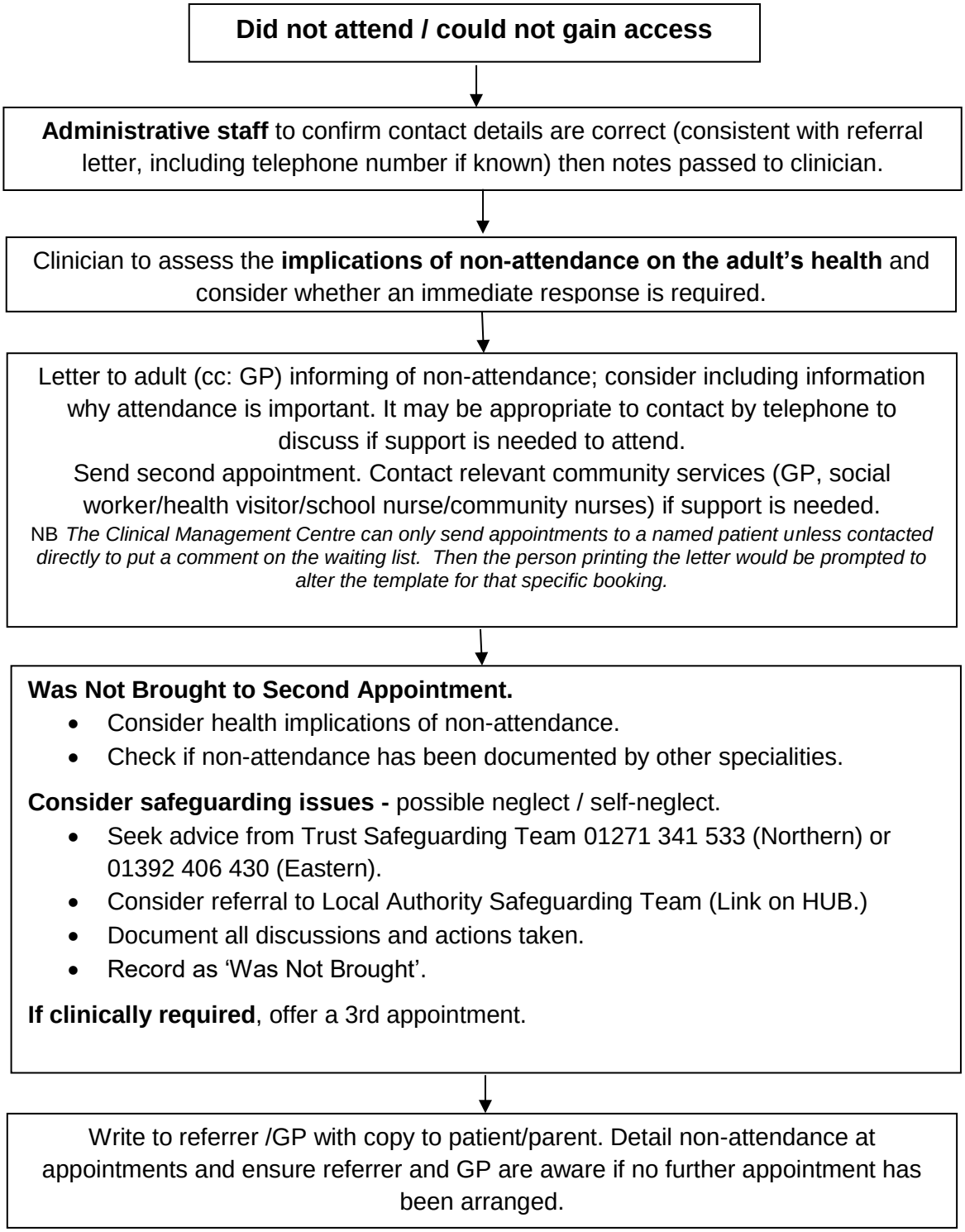
All staff who have supported the development of this Policy.

18 APPENDIX A: ORGANISATIONAL CHART



19 APPENDIX B: DID NOT ATTEND

Actions to take when an adult reliant on the support of others is not brought to an appointment / did not attend / could not gain access at home.



The Trust has produced a video about adults who are not brought to appointments. If they do not have the capacity or independence to attend on their own, please do not record in notes "Did not attend" but write "Was not brought" to the appointment. https://vimeo.com/392944939

20 APPENDIX C: 7 MINUTE BRIEFING 'WHAT IS PiPoT'

7 minute briefing
What is PiPoT final.p

21 APPENDIX D: 7 MINUTE BRIEFING 'PiPoT & DBS'

7 minute briefing
PiPoT and DBS final.

22 APPENDIX E: CONTACTS

Title	Area	Address	Telephone	E-mail
Chief Nursing Officer	Trustwide	RD&E, Barrack Road, Exeter EX2 5DW	[redacted]	[redacted]
Director of Nursing	Northern	North Devon District Hospital Raleigh Park, Barnstaple EX31 4JB	[redacted]	[redacted]
Associate Director of Nursing / Safeguarding Lead	Trust wide	Integrated Safeguarding Team, Devon Healthcare NHS Trust, Barnstaple EX31 4JB	Tel: [redacted]	rduh.safeguardingadults@nhs.net
Head of Safeguarding - Eastern	Eastern	Integrated Safeguarding Team G5, Child Health, Wonford. EX2 5DW	Tel: [redacted]	rduh.safeguarding@nhs.net
Senior Safeguarding Nurse Specialists	Eastern	Integrated Safeguarding Team G5, Child Health, Wonford. EX2 5DW	Tel: [redacted]	rduh.safeguarding@nhs.net
Safeguarding Adults Specialist Nurses	Northern	Integrated Safeguarding Team, Devon Healthcare NHS Trust, Barnstaple EX31 4JB	Tel: [redacted]	rduh.safeguardingadults@nhs.net
Safeguarding Specialists	Eastern	Integrated Safeguarding Team G5, Child Health, Wonford. EX2 5DW	Tel: [redacted]	rduh.safeguarding@nhs.net
Named Midwife	Northern	Ladywell Unit North Devon District Hospital, Raleigh Park, Barnstaple EX31 4JB	Tel: 01271 322 673	rduh.maternitysafeguarding@nhs.net
Named Midwife	Eastern	Centre for Women's Heath, RD&E, Exeter. EX2 5DW	Tel: [redacted]	
Safeguarding Midwife	Eastern	G5, Child Health, Wonford. EX2 5DW	Tel: [redacted]	rduh.midwiferysafeguarding@nhs.net
Named Doctor for Safeguarding Adults	Eastern	Integrated Safeguarding Team G5, Child Health, Wonford. EX2 5DW	Tel: [redacted]	rduh.safeguarding@nhs.net
Named Doctor for Safeguarding Adults	*Northern*	*No post holder*	-	-
Emergency Department Safeguarding Lead Doctor	Northern	Emergency Department North Devon District Hospital, Raleigh Park, Barnstaple EX32 4JB	01271 311 527	rduh.edreceptionists@nhs.net

Royal Devon University Healthcare NHS Foundation Trust

Title	Area	Address	Telephone	E-Mail
MCA / LPS Leads	Eastern	G8, Child Health, Wonford. EX2 5DW	[redacted]	rduh.mca@nhs.net
MCA / LPS Lead	Northern	Munro House North Devon District Hospital, Raleigh Park, Barnstaple EX31 4JB	[redacted]	rduh.mcaleads@nhs.net
Health IDVA (Independent Domestic Violence Advisor)	Eastern	G6, Child Health, Wonford. EX2 5DW		rduh.health.idva@nhs.net
Health IDVA (Independent Domestic Violence Advisor)	Northern	North Devon District Hospital, Raleigh Park, Barnstaple, EX31 4JB	[redacted]	IDVA
Safeguarding Adults Administrator	Northern	Barnstaple Health Centre, Vicarage Street, Barnstaple EX32 7BH	[redacted]	ndht.safeguardingadults@nhs.net
Safeguarding Secretary	Eastern	G6, Child Health, Wonford. EX2 5DW	[redacted]	rduh.safeguarding@nhs.net rduh.health.idva@nhs.net rduh.maternitysafeguarding@nhs.net
MCA/LPS/Safeguarding Administrator	Eastern	G8, Child Health, Wonford. EX2 5DW	[redacted]	rduh.mca@nhs.net
MCA/LPS/Safeguarding Administrator	Northern	Munro House North Devon District Hospital, Raleigh Park, Barnstaple EX31 4JB	[redacted]	rudh.dols@nhs.net
Devon District Council Social Care	Eastern	Topsham Road, Exeter EX2 4QD	01392 381 206 (opt 2, option 3)	-
Devon District Council Social Care	Northern	Taw View, North Walk, Barnstaple, EX31 1EE	01392 381 208 (opt 2, option 3)	-
Devon District Council Social Care	Emergency Duty Service	County Hall, Topsham Road, Exeter EX2 4QD		-

Royal Devon University Healthcare NHS Foundation Trust

23 APPENDIX F: LINKS

Council Emergency Housing Team - Eastern

Council Emergency Housing Team - Northern

County Lines Guidance

Devon and Cornwall Police website

Disclosure and Barring Service Policy - Eastern

Disclosure and Barring Service Policy – Northern

Domestic Abuse Affecting Patients Policy - Eastern

Domestic Abuse Affecting Staff Policy - Eastern

Domestic Abuse Affecting Staff Policy - Northern

Domestic Homicide Review Statutory Guidance

Equality and Diversity Policy

FGM

Health & Wellbeing for Staff

Home Safety Fire checks

IMCA

Local Authority Housing Team – Duty to Refer

Management of Allegations Policy

Management of Allegations policy.

MCA Policy

MCA Policy

Modern Slavery website

Office of the Public Guardian

Police Referral

Pressure Ulcers Government Guidance

Promoting a Positive Working Environment Policy

Raise a Concern electronically - Northern

Report a loan shark online

Safeguarding Guide

Safeguarding Toolkit

Safeguarding Training Declaration

Sexual Assault and Referral Centre (SARC)

TDSAP

TDSAP Adult Procedures and Guidance

TDSAP Adult Self Neglect Guidance

TDSAP Guidance (2023)

TDSAP Information sharing principles and agreements for adult safeguarding

TDSAP PiPoT Protocol

The Blue Light Manual.

The Marriage and Civil Partnership (Minimum Age) Act 2022

Was not brought video

Whistleblowing (How to Raise a Concern) Policy

Royal Devon University Healthcare NHS Foundation Trust

24 APPENDIX G: COMMUNICATION PLAN

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the strategy/policy	All staff and volunteers within Trust
The key changes if a revised policy/strategy	Please see version history.
The key objectives	This policy sets out the organisation's statement of purpose for all members of staff to promote the wellbeing of everyone who uses services, and their carer's, to act positively to prevent harm, abuse or neglect (including self-neglect), and respond effectively if concerns are raised.
How new staff will be made aware of the policy and manager action	To be communicated as core to induction. Manager to support staff in being able to access Policy and in applying Policy to practice.
Specific Issues to be raised with staff	All staff should be aware of their responsibilities, appropriate to role, to protect patients from abuse and neglect.
Training available to staff	See training section
Any other requirements	Safeguarding practice can be complex, and staff may have their own experiences of abuse, and possibly experience vicarious trauma themselves. There is a need for all staff and volunteers to be supported in line with principles of compassionate leadership.
Issues following Equality Impact Assessment (if any)	Positive impacts for those with protected characteristics.
Location of hard / electronic copy of the document etc.	G:\integrated safeguarding folder\policies & sops\01 adults\adults safeguarding policy\01. sga policy

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25 APPENDIX H: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Safeguarding Adults Policy
Division/Directorate and service area	Corporate
Name, job title and contact details of person completing the assessment	[redacted] Senior Specialist Nurse Safeguarding Adults
Date completed:	01/01/2024

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

This policy sets out the organisation's statement of purpose for all members of staff to promote the wellbeing of everyone who uses services, and their carer's, to act positively to prevent harm, abuse or neglect (including self-neglect), and respond effectively if concerns are raised.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☒ Staff ☒ Patients ☒ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	☒	☐
Disability	☒	☐
Sex - *including: Transgender, and Pregnancy / Maternity*	☒	☐
Race	☒	☐
Religion / belief	☒	☐

Sexual orientation – *including: Marriage / Civil Partnership*	☒	☐

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

Adults over 18 who have "needs for care and support (whether or not the [Local] Authority is meeting any of those needs), **and**

a) is experiencing, or is at risk of, abuse or neglect, **and**

b) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it."

5. Do you think the document meets our human rights obligations? ☒

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:

- **Fairness** – The Policy aims to treat everyone justly, and support those who may be unable to protect themselves.
- **Respect** – Through 'making safeguarding personal' and application of the Mental Capacity Act 2005 within safeguarding practice the individual is respected.
- **Equality** – Safeguarding supports those who may not be able to protect themselves, and those who have protected characteristics (Equality Act 2010), supporting equality and equity of service provision.
- **Dignity** – Through the principles of safeguarding responding to situations where there are risks or the person is experiencing abuse / neglect dignity for the individual can be supported.
- **Autonomy** – Through applying the Principles of the Mental Capacity Act 2005 and 'making safeguarding personal' and supporting people make their own decisions (as far as possible) and autonomy is supported.

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

Safeguarding practice supports those who may be marginalised and at most risk in society and specifically those unable to protect themselves (Care Act 2014).
The consideration of Equality and Human Rights is integrally linked to safeguarding practice and reflected within this Policy.
This Policy will have a positive impact for those with Protected Characteristics (Equality Act 2010).

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7. If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

"Protected characteristic":	*Age/sex/religion etc.*
Issue:	*Missed opportunity that has been noted*
How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	

Royal Devon University Healthcare NHS Foundation Trust

Management of complaints policy

Post holder responsible for Procedural Document	[redacted] Deputy Director of Nursing (patient experience)
Author of Policy	[redacted] Patient Experience Matron
Division/ Department responsible for Procedural Document	Corporate Nursing (Patient Experience)
Contact details	[redacted]@nhs.net
Date of original document	This is the first version following integration and the launch of the new complaint's standards.
Impact Assessment performed	**Yes**/ No
Ratifying body and date ratified	Patient Experience Operational Group
Review date	November 2024
Expiry date	April 2025
Date document becomes live	29/09/2023

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience	✓	Maintain Operational Service Delivery	
Assurance Framework	✓	Integrated Community Pathways	
Monitor/Finance/Performance	✓	Develop Acute services	
CQC Fundamental Standards - Regulation:		Infection Control	
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		**Status: Draft** or **Final**	
Version	Date	Author	Reason
1.0	05.04.2023	Patient Experience Matron	Merged and redeveloped policy post integration and reflective of the new national complaints standards (RDUH Early Adopter Site)

Associated Trust Policies/ Procedural documents:	Access to Records Policy (Northern services policy) Health Records Policy (Eastern Services) Information Governance Policy Mental Capacity Act Policy Safeguarding Adult Policy Safeguarding Children Policy Equality and Diversity Policy Incident Reporting, Analysing, Investigating and Learning Policy and Procedures Policy Legal Claims Policy (Northern Services) Claims Management Policy (Eastern Services) Violence and Aggression Policy (Northern Services) Violence Prevention and Reduction Policy (Eastern Services) Consent for Examination or Treatment Policy
Key Words	Complaints, early resolution, concerns, advocacy, PHSO, ombudsman, advocacy.

In consultation with and date:
Senior Patient Experience Team 01.04.2023
Patient Experience Operational Group 12.04.2023
Associate Director of Quality & Safety 12.04.2023
Quality Leads (Northern & Eastern) 12.04.2023
Divisional Governance Managers (Eastern Services) 12.04.2023
Divisional Governance Coordinators (Northern Services) 12.04.2023
Associate Directors of Nursing (Eastern & Northern Service) 12.04.2023
Lead Nurse for Safety & Quality 12.04.2023
Patient Experience Leads (Eastern Services) 12.04.2023
Patient Experience Support Officers (Northern Services) 12.04.2023
Director of Nursing - Northern Services 12.05.2023
Director of Nursing – Eastern Services 12.05.2023
Chief Nursing Officer – 12.05.2023

Contact for Review:	Patient Experience Matron rduh.patientexperience@nhs.net
Executive Lead Signature: (Carolyn Mills) *(Applicable only to Trust Strategies & Policies)*	**To be added by Policies Administrator when uploading to Intranet**

CONTENTS

This policy aims to provide information and confidence to the public and our staff that any concerns or complaints raised about services provided by Royal Devon University Healthcare NHS Foundation Trust (hereafter referred to as the Trust) will be taken seriously and are welcomed as an opportunity to repair relationships and learn from our mistakes. The Trust will apply this complaints policy in line with our Trust values as follows:

- Are compassionate
- Act with integrity
- Are inclusive
- Are empowered

The Trust has been selected by the Parliamentary Service Health Ombudsman (PHSO) to be an early adopter site for the Complaints Standards NHS pilot. The Standards aim to support organisations in providing a quicker, simpler and more streamlined complaint handling service, with a strong focus on early resolution.

It should be read in conjunction with the more detailed guidance modules available on the Parliamentary and Health Service Ombudsman website.

The Complaint Standards are based on My Expectations, which set out what patients expect to see when they make a complaint about health or social care services. The Standards and the guidance modules that we are testing as part of the pilot describe how staff can meet those expectations and can be found here.

Although the Trust encourages service users to raise any concerns they may have immediately and at the time they occur by speaking to a member of staff, this policy focuses specifically on those concerns or complaints that require management through the Patient Advice and Liaison Service (PALS) and the Patient Experience Team.

Anyone can raise a concern or make a complaint about their own care.

Anyone can raise a concern or make a complaint on behalf of a patient with their consent.

Special thanks also to Liverpool Women's NHS Foundation Trust and the Deputy Head of Patient Experience in supporting the Patient Experience Matron at RDUH with the development of this policy.

More information can be found on the Trust website, including in the patient information leaflet How to raise a concern or make a complaint'

1 INTRODUCTION

1.1 Complaints are part of everyday life and have an impact on our experience and interactions. At some point we all may find ourselves having to make a complaint or being complained about. Complaining and being complained about does raise challenges, concerns and opportunities in equal measure.

1.2 The Trust recognises the importance of having a systematic, accessible and impartial process for dealing efficiently and effectively with complaints from any area of service. The Trust promotes early intervention, informal problem solving and where appropriate conciliation and mediation. Not every complaint requires a formal investigation, and alternatives can provide many complainants with a speedier outcome. The Trust encourages staff to reflect on their own personal experience of complaint handling and to place themselves in the shoes of the patient at all times.

1.3 The Trust is committed to using feedback from complaints and concerns in a positive way by listening to our users and learning lessons from their experiences to improve the quality of services offered. Our complaint handling must be focused on people and their experiences, not unduly on statistical data however valuable that may be**.**

1.4 The Trust aims to provide a quality complaints service and this policy sets out the principles and processes for handling, responding to and learning from complaints that are received by the Patient Advice and Liaison Service (PALS) or Patient Experience Team.

1.5 This policy describes how the core expectations given in the NHS Complaint Standards: Model Complaint Handling Procedure for providers of NHS services in England (2022) will be put into practice by Royal Devon University Healthcare NHS Foundation Trust. The Model Complaint Handling Procedure is one of a number of supportive tools and guidance modules designed to assist NHS organisations (and independent organisations who provide NHS services) in England in embedding the NHS Complaint Standards in practice

1.6 This policy sets out the principles and processes involved when any person wishes to raise a concern or complaint. This includes the opportunity for the Trust to provide an apology and identify the learning when complaints are responded to, where this is relevant.

1.7 The Trust participated as an early adopter site working with the Parliamentary & Health Service Ombudsman (PHSO) and trial guidance modules as part of the new Complaints Standards project. This policy has been developed using information from the Model Complaint Handling Procedure. As with the Standards themselves, the model procedure puts existing good practice in one place, providing a more consistent approach to complaints handling across the NHS in England.

2 PURPOSE

2.1 The purpose of this policy is to provide clear guidance of the Trust complaints process for our staff so they are informed and aware of the action to be taken when a patient of other eligible person shares a concern or wishes to make a complaint concerning any aspect of the patient experience.

2.2 The policy outlines how the trust will manage complaints and the standards we will follow. It follows the relevant requirements as given in the Local Authority, Social Services and National Health Service Complaint Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2009 and 2014 Regulations).

2.3 The Trust aims to provide a quality complaints service and this policy sets out the principles and processes for handling, responding to and learning from complaints that are received by the Patient, Advice and Liaison Service (PALS) or Complaints Teams across the Trust.

2.4 Under the NHS Complaint Regulations, the way in which complainants would like their concerns and complaints to be handled, is reflected in the user-led vision found in the PHSO report My Expectations for Raising Concerns and Complaints. The Trust supports these principles and is committed to promoting best practice and encourage early resolution when complaints arise and promote their local and informal resolution wherever possible.

2.5 The aim of this policy is to provide a clear understanding of the Trust complaints process, and to describe the expectations of all staff involved in the complaints handling process. This includes setting out the expectations of how staff are expected to respond to patients and their families/relatives.

For those who raise a concern or complaint the Trust will:

• Comply with its legal obligations for complaint handling as set out in the relevant statutory regulations
• Promote best practice in complaint handling consistent with the national strategic objectives of ‘My Expectations’
• Treat the complainant fairly and objectively;
• Support staff involved when they are involved in a complaint investigation
• Ensure all correspondence is subject to a robust triage to ensure the best use of complaint handling resources.
• Encourage early resolution and mediation as an alternative to investigation
• Use information from complaints (‘lessons learnt’) to support and assist us to improve services and benefit other patients;
• Monitor concerns and complaints to identify opportunities for improvement;
• Ensure complainants are not treated unfairly or have their care compromised as a result of any concern or complaint raised;
• Ensure that information about concerns or complaints is not kept within patient records and remains confidential.

Following a complaint investigation, the Trust will:

• Provide a prompt and effective resolution;
• Make the process as easy and as clear as possible;
• Acknowledge, apologise and explain when things have gone wrong with your care;
• Provide a dedicated contact for all formal complaints to manage your case;
• Complete a fair, impartial investigation and share the findings with the complainant (if consent has been given appropriately);
• Provide a clear letter to complainants that explains the outcome (upheld or not) and action(s) being taken to address the identified failings.
• Ensure that any learning from complaint investigations improves our services;
• Ensure that all complainants are provided with signposting information about the PHSO in the event they consider that their complaint is not resolved;
• Provide appropriate signposting for advocacy services and additional support.

3 DEFINITIONS

3.1 The following definitions apply for terms used in this policy:

Patient: the person whose care and treatment are the subject of the complaint, concern or comment.

Carer: A carer is someone who provides unpaid help and support to another person who could not cope without their help. A carer may be a partner, child, relative, friend or neighbour.

Complainant: the person who is raising the complaint, concern or comment.

Patient Advice and Liaison Service (PALS). The PALS team provides an identifiable person for a patient or member of the public when they have a problem or need information while they are using hospital (including community hospitals) and other NHS services. PALS can also be accessed directly by staff on behalf of patients.

Complaint is defined as ‘an expression of dissatisfaction, either spoken or written, that requires a response. It can be about: an act, omission or decision made, and/or the standard of service provided’ (NHS Complaints Standards)

Patient Experience Officers / Leads (complaint handlers) manage a caseload of complaints, linked to a specific division, and acts on your behalf to assist in the co-ordination of your complaint, keeping you informed of progress and updating you on when to expect your response.

Patient Safety Incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

Litigant in Person is an individual, company or organisation that is not represented in court by a solicitor or barrister, but nevertheless has rights of audience (this is, the right to address the court in person).

Local Resolution Meeting: A meeting arranged with the complainant / advocate raising the concerns. This meeting has an agreed agenda and expectations for resolution. This can be formal or informal, virtual or face to face. Notes will be taken and shared following the meeting to record attendance, summary of the discussions, record outcome and agreed actions (where relevant).

Quality Assurance (QA)

Once your formal complaint response has been written, a QA process takes place which checks that the letter you are about to receive has met the required quality standard prior to being finalised. It is then read and signed by a member of the Executive Team. Where complaints have been resolved via early resolution, correspondence will be signed by a Divisional representative.

Parliamentary Health and Service Ombudsman (PHSO)

If the complainant remains dissatisfied with a complaint response following investigation and the Trust has considered all reasonable steps have been taken to resolve, the complainant will be advised to contact the PHSO. The PHSO is an independent complaint handling service set up by Parliament. The complainant can ask the PHSO to review their complaint. The PHSO is completely independent of the NHS. They will only consider complaints which have been through the NHS complaints procedure. Before the PHSO accepts a complaint for review, they will wish to be satisfied that all reasonable attempts have been made by the Trust to resolve the complaint.

DATIX is the information system which supports the reporting and management of concerns, complaints and incidents.

4 DUTIES AND RESPONSIBILITIES OF STAFF

The following describes the duties and responsibilities of key individuals in ensuring that the policy is correctly applied.

4.1 The **Chief Executive**

- Overall responsibility and accountability for ensuring compliance with the statutory requirements of the NHS complaints procedure and for making sure we comply with the 2009 and 2014 Regulations
- Has overall responsibility to make sure we take any necessary remedial action.
- Ensure we report annually on how we learn from complaints.
- Responsible for signing the final written response to the complaint (unless delegated to an authorised person(s)

- The Chief Executive will delegate the responsibility for the effective delivery of the Trust's Complaints Policy and Procedure to the Chief Medical Officer and Chief Nursing Officer.

4.2 The **Chief Medical Officer** and **Chief Nursing Officer**

- Responsible to ensure the fitness for purpose of the Trust's complaints procedure and have strategic responsibility for complaints performance.
- Senior level ownership for the quality of responses sent to complainants.
- Delegate to the Deputy Director of Nursing (Patient Experience) the responsibility for the operational management of the Trust's complaints handling in line with this policy.
- Deputising for the Responsible Person

4.3 The **Trust Directors**

- Senior level scrutiny and oversight of the quality of complaint investigations and responses as part of the quality assurance sign off process of draft letters.

4.4 The **Deputy Director of Nursing (Patient Experience)**

- Responsibility for the operational management of the Trust's complaints handling in line with this Policy.
- Performance of complaints handling in line with statutory requirements and KPIs
- Scrutiny of quality of investigations and draft response letters of adjudication (decision) to complainants (prior to review by a Trust Director).
- Ensure that staff have access to the policy and have the training and understanding for dealing with complaints.

4.5 The **Divisional Associate Directors, Associate Medical Directors, Associate Directors of Nursing, Divisional Nurses, Divisional Governance Managers / Coordinators / Operational Teams**

- Will be responsible for ensuring complaints and concerns are investigated and responded to in line with this Policy and for ensuring, where appropriate, lessons are learnt (actions) and remedial action is implemented and evaluated
- The division retain ownership and accountability for the management and reporting of complaints. They are responsible for preparing, quality assuring or reviewing the final written response as part of the QA process. They should be satisfied that the investigation has been carried out in accordance with this procedure and guidance, and that the response addresses all aspects of the complaint before it is sent to the Deputy Director of Nursing (patient experience) for approval.

- Provide necessary assistance to the divisional complaint case handler in all aspects of the operation and delivery of the Trust complaints procedure.
- Identify appropriate staff to undertake complaint investigations as required.
- Ensure the participation and cooperation of all staff with complaints enquiries.
- Monitor performance at Divisional level against KPIs and review the information gathered from complaints regularly (at least quarterly) and use this to consider how services could be improved, or how internal policies and procedures could be updated. They report on the outcomes of these reviews via the organisation's governance structure.
- They are also responsible for making sure complaints are central to the overall governance of the organisation. They make sure staff are supported both when handling complaints and when they are the subject of a complaint.
- Deputising for the Responsible Person, if authorised.

4.6 The **Patient Experience Manager** has a responsibility for adhering to this Policy and New NHS Complaints Standards (2022)

- The manager will also provide leadership to the PALS and Complaints Team in implementing this policy and support the requirements for governance and assurance arrangements.
- Working with senior manager(s) or external partner(s), they will be involved in a review of quarterly reports and annual reporting. They will review this information to identify areas of concern, agree remedial action and improve services.
- Is responsible for overall day-to-day management organisational reporting and oversight of procedures for handling complaints and support the teams that deliver those services.

4.7 **The Patient Experience Officers / Leads and the PALS Team are responsible for:**

- Ensuring the complaints processes are accessible, with support, to everyone who wishes to raise a concern or complaint.
- Ensuring everyone making a formal complaint is informed of local advocacy or support organisations.
- Ensuring that the complainant is contacted within the standard target of three working days after date of receipt as stipulated in the NHS Complaint Regulations.
- Ensuring that they are the named contact for complainants when managing a complaint, including providing contact details of telephone and email.
- Making initial contact by phone or email and maintaining contact with the complainant.
- Arranging LRMs when requested and support note taking.
- Ensuring that, where language or communication support is required, for example that access to interpreters is arranged.
- Making information available in a format that people understand.

- Obtaining feedback about the complaints handling process.
- Implementing and monitoring the Trust process for handling and resolving complaints in an effective and timely way.
- Ensure the complainant is updated on a regular basis as to the progress of the complaint investigation and any delays and issues experienced.
- Ensure that the information and responses they receive from the person making the complaint, and from staff being complained about, clearly addresses all the issues raised
- Ensuring that each complaint has adhered to the Quality Assurance process prior to Executive Sign off.
- Prepare performance reports for Divisional Governance meetings
- Liaising and co-operating with external organisations to provide a single unified response for mixed sector complaints.
- Accurate recording of progress of complaints on the DATIX database including the recording of actions.

4.8 **All staff** regardless of their role and seniority, are responsible for supporting complainants with help and information about our complaints procedure and trying to resolve complaints quickly and appropriately as they arise. This support will be offered in line with the Trust's values and with particular emphasis on treating complainants with respect and dignity and ensuring complainants, or the patients on whose behalf they are acting, are not discriminated against.

All staff must attend training as required and ensure they are familiar with and adherence with this policy at all times. We ask our staff to co-operate fully in complaint investigations and provide accurate statements when requested within the stated timescales.

We have processes in place to ensure that our senior managers regularly review complaints alongside other forms of feedback. They will make sure action is taken on all identified learning arising from complaints so that improvements are made to our service.

We expect all our staff who have contact with patients, service users, or those that support them, to deal with complaints in a sensitive and empathetic way. This includes making sure people are aware of our local independent advocacy provider and/or national sources of support and advice. Patient information leaflets, 'How to raise a concern or make a complaint' are available on the trust website.

We expect all staff to listen, provide an answer to the issues quickly, and capture and act on any learning identified.

5 IDENTIFYING A COMPLAINT

5.1 Everyday conversations with our users

Our staff speak to people who use our services every day. This can often raise issues that our staff can help with immediately. We encourage people to discuss any issues they have with our staff, as we may be able to sort the issue out to their satisfaction quickly and without the need for them to make a complaint.

Our staff are empowered to learn from insight that comes from complaints and encouraged to help resolves issues and support service users there and then if they need advice, an explanation to resolve any confusion regarding care and treatment or a concern about an error that may have been made.

Our staff ensure mistakes are reviewed through the organisation's Duty of candour processes. More detailed information on regulation 20 from the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 can be found in the PHSO guidance on promoting a just and learning culture.

5.2 Feedback and complaints

People may want to provide feedback instead of making a complaint. In line with DHSC's NHS Complaints Guidance people can provide feedback, make a complaint, or do both. For example, patients, families and carers can leave feedback on Care Opinion or the Friends and Family Test (FFT). Feedback can be an expression of dissatisfaction (as well as positive feedback) but is normally given without wanting to receive a response or make a complaint.

- People do not have to use the term 'complaint'. We will use the language chosen by the service user, or their representative, when they describe the issues they raise (for example, 'issue', 'concern', 'complaint', 'tell you about'). We will always speak to people to understand the issues they raise and how they would like us to consider them.
- Further explanation of what is and isn't a complaint can be found at the PHSO website
- For more information about the types of complaints that are and are not covered under the 2009 Regulations please see The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
- If we consider that a complaint (or any part of it) does not fall under this policy and procedure we will explain the reasons for this. We will do this in writing to the person raising the complaint and provide any relevant signposting information.
- The trust will send out complainant feedback forms to those who have used the complaints process. All feedback received will be included in the annual complaints report prepared by the Patient Experience Manager.

Our sites in North and East Devon have separate complaints teams. Complaints can be made to us as follows:

- In person: By visiting the PALS office located in the main entrance of North Devon District Hospital (NDDH) and Royal Devon & Exeter Hospital (RDE)
- By phone: PALS NDDH Tel: 01271 314090 or RDE Tel: 01392 402093
- In writing to: PALS, North Devon District Hospital, Raleigh Park, Barnstaple, EX31 4JB or PALS, Royal Devon & Exeter Hospital (Wonford), Barrack Road, Exeter, EX2 5DW
- By email: rduh.complaints-northern@nhs.net (NDDH) or if the complaint is regarding our Exeter sites please email rduh.complaints-eastern@nhs.net (RDE)

We will consider all accessibility and reasonable adjustment requirements of people who wish to make a complaint in an alternative way. We will record any reasonable adjustments we make.

6 WHO CAN MAKE A COMPLAINT?

6.1 Any person may make a complaint to us if they have received or are receiving care and services from our organisation. A person may also complain to us if they are affected or likely to be affected by any action, inaction or decision by our organisation.

6.2 If the person affected does not wish to deal with the complaint themselves, they can appoint a representative to raise the complaint on their behalf. There is no restriction on who may represent the person affected. However, the patient / service user will need to provide us with their consent for the representative to raise and discuss the complaint with us and to see their personal information. Advocacy organisations also provide a useful service in assisting service users, relatives and carers to make a complaint, especially where a complainant is unable to make, or is disadvantaged in being able to make a complaint personally. The Trust has a statutory obligation to inform the complainant of their right to information about other sources of support in making their complaint, including the Independent Health Complaints Advocacy (IHCA). This is a free, independent service providing information to anyone who wants to make a complaint. The IHCA has a statutory role in advising complainants and, where appropriate, assisting them in making complaints. They will, if required, deal with the complaint on behalf of the complainant and/or offer impartial information on how to make a complaint.

6.3 If the person affected has died, or is otherwise unable to complain because they are deemed to not have capacity (as defined by the Mental Capacity Act 2005), then the complaint may be made on their behalf by a representative. Where there is a registered Power of Attorney for Health and Welfare the named attorney/s are able to raise issues on behalf of the patient if they do not have capacity and it is in the patient's best interests. There is no restriction on who may act as representative but there may be restrictions on the type of information we may be able to share with them. We will explain this when we first look at the complaint. There may be occasions whereby complaints are raised relating to a safeguarding concern. In these circumstances, liaison must take place with the Safeguarding Lead, Deputy Director of Nursing (Patient Experience) and Patient Experience Manager. For further information see the Information Commissioner's guide : Who can access personal data

6.4 In the case of a child under 18, the representative making the complaint must be a person/s with parental responsibility or those deemed to be acting in the best interests of the child. If a complaint is brought on behalf of a child we will need to be satisfied that there are reasonable grounds for a representative bringing the complaint rather than the child. The patient experience team and Safeguarding team can review and advise on a case-by-case basis. If we are not satisfied we will share our reasons with the representative in writing. Where the child is in the care of a local authority or a voluntary organisation, the representative must be a person authorised by that authority or organisation.

6.5 If at any time we see that a representative is not acting in the best interests of the person affected we will assess whether we should stop our consideration of the complaint. If we do this, we will share our reasons with the representative in writing. In such circumstances we will advise the representative that they may complain to the Parliamentary and Health Service Ombudsman if they are unhappy with our decision.

6.6 The patient information leaflet entitled "Help us to get better at what we do' explains the process by which someone may raise any concerns they may have. All wards and departments stock supplies of these leaflets which are readily available for patients and the public if required.

6.7 In addition to the offer of assistance from the IHCA, other support, for example, provision of a registered interpreter and/or translator for patients whose first language is not English can be arranged. The support required will depend on the individual requirements of the complainant. For further information please contact Patient Advice and Liaison Service (PALS) at NDDH or RDE for advice.

6.8 If the person has died duty of confidentiality remains in place after death. Under the case law relating to Article 8 of the European Court of Human Rights, the personal representative of the deceased or the legal executor of their estate will control access to any personal information. This includes clinical records. However, anyone who may have a potential claim arising out of the death, such as family and friends named in the will, may also be entitled to access to the deceased person's personal information under the Access to Health Records Act 1990.

6.9 If a complaint is received that identifies a **patient safety incident** this will be escalated to the divisional governance team by the patient experience officer/lead.

6.10 If a complaint is received from **a Member of Parliament (MP)** representing a constituent or a constituent who is authorised to act on behalf of the patient, consent must be obtained (see consent forms in Appendix). Personal information must never be disclosed without consent.

6.11 If a complaint is received from a **Legal Representative** the Patient Experience Officer/Lead will ensure that the Trust has received written permission via our consent form from the person involved to release clinical information to the legal representative. The patient experience officer / lead will also ascertain whether the Trust should respond to the legal representative or their client.

6.12 Occasionally a complaint may be made after a patient's death has been referred to the **Coroner's Office** or during the course of a Coroner's Inquest. This should not prevent the Trust's investigation continuing but the Trust Solicitor should be informed that a complaint has been made. Information obtained during the investigation of the complaint must not be released to the complainant without knowledge of the Trust Solicitor as certain information could impact upon the outcome of the Inquest.

6.13 If a complaint is received from a **Transsexual Patient** under Section 22 of the Gender Recognition Act 2004, we risk legal action if we disclose, without the patient's consent, the past gender history of a patient who is living in a gender other than their birth gender. The risk applies whether or not the patient has a Gender Recognition Certificate, which is the official recognition of a gender transition.

6.14 The following complaints will not be dealt with under the Local Authority Social Services and National Health Service Complaints (England) Regulations (2009), regulation 8(1):

• A complaint made by any NHS organisation or private or independent provider or responsible body.
• A complaint made by an employee about any matter relating to their employment.
• A complaint, the subject matter of which has previously been investigated under these or previous NHS Regulations.
• A complaint arising out of an NHS body's alleged failure to comply with a request for information under the Freedom of Information Act 2000.
• A complaint that is made orally and resolved to the complainant's satisfaction in a timely manner of no later than 5 working days.
• A complaint that relates to any scheme established under section 10 (superannuation of persons engaged in health services) or section 24 (compensation for loss of office) of the Superannuation Act or to the administration of those schemes.

7 TIMESCALE FOR MAKING A COMPLAINT

7.1 Complaints must be made to us within 12 months of the date the incident being complained about happened or the date the person raising the complaint found out about it, whichever is the later date.

7.2 If a complaint is made to us after that 12-month deadline, we will consider it if:

- we believe there were good reasons for not making the complaint before the deadline, and
- it is still possible to properly consider the complaint.

7.3 If we do not see a good reason for the delay or we think it is not possible to properly consider the complaint (or any part of it) we will write to the person making the complaint to explain this. We will also explain that, if they are dissatisfied with that decision, they can complain to the Parliamentary and Health Service Ombudsman.

7.4 Matters referred to the Trust under this policy will be acknowledged within three working days of receipt, and a final response provided no longer than six months (or longer where agreed with the complainant). The Regulations enable the Trust to reach decisions about the timeframe for handling and responding to complaints on a case-by-case basis. The complexity of the complaint, the required depth of investigation, and the impact on Trust resources will inform decisions concerning the target timeframe for responding to the complainant.

7.5 An exception of this would be complaints made about the Trust First Steps Nursery service which must be responded to within 28 days of receipt, in accordance with OFSTED regulations.

8 COMPLAINTS AND OTHER PROCEDURES

8.1 We make sure our complaints staff are properly trained to identify when it may be not be possible to achieve a relevant outcome through the complaint process on its own. Where this happens, staff will inform the person making the complaint and give them information about any other process that may help to address the issues and has the potential to provide the outcomes sought.

8.2 This can happen at any stage in the complaint handling process and may include identifying issues that could or should:

- trigger a patient safety investigation
- involve a coroner investigation or inquest
- trigger a relevant regulatory process, such as fitness to practice investigations or referrals
- involve a relevant legal issue that requires specialist advice or guidance.

8.3 When another process may be better suited to cover other potential outcomes, our staff will seek advice and provide clear information to the individual raising the complaint. We will make sure the individual understands why this is relevant and the options available. We will also signpost the individual to sources of specialist independent advice. For further details see guidance.

8.4 This will not prevent us from continuing to investigate the complaint. We will make sure that the person raising the complaint gets a complete and holistic response to all the issues raised, which includes any relevant outcomes where appropriate. Our complaints staff will engage with other staff or organisations who can provide advice and support on the best way to do this.

8.5 If an individual is already taking part or chooses to take part in another process but wishes to continue with their complaint as well, this will not affect the investigation and response to the complaint. The only exceptions to this are if:

- the individual requests or agrees to a delay
- there is a formal request for a pause in the complaint process from the police, a coroner or a judge.

In such cases the complaint investigation will be put on hold until those processes conclude.

8.6 If we consider that a staff member should be subject to remedial or disciplinary procedures or referral to a health professional regulator, we will advise the person raising the complaint. We will share as much information with them as we can. Where the person raising the complaint chooses to refer the matter to a health professional regulator themselves or where they subsequently choose to, it will not affect the way that their complaint is investigated and responded to. We will also signpost to sources of independent advice on raising health professional fitness to practise concerns.

9 CONFIDENTIALITY OF COMPLAINTS

9.1 We commit to maintaining confidentiality and protecting privacy throughout the complaints process in accordance with UK General Protection Data Regulation and Data Protection Act 2018. We will only collect and disclose information to those staff who are involved in the consideration of the complaint. Documents relating to a complaint investigation are securely stored and kept separately from medical records or other patient records. They are only accessible to staff involved in the consideration of the complaint. Complaint outcomes may be anonymised and shared within our organisation and may be published on our website to promote service improvement.

9.2 Where the complaint is brought on behalf of the patient a decision should first be made as to whether the complainant is a suitable person to pursue the complaint. Consideration needs to be given to all relevant factors such as Power of Attorney (Health and Welfare), closeness of the complainant's involvement with the patient over the time they had known them, the nature and frequency of their contact and their beliefs about what the patient would have felt about the complainant making the complaint on their behalf. If the patient is alive and competent to give consent then this must be sought. All consent forms can be found in Appendix 2-6 and please refer to the PHSO guidance on consent and confidentiality.

9.3 If the person dealing with the complaint identifies at any time that anyone involved in the complaint may have experienced, or be at risk of experiencing, harm or abuse then they will discuss the matter with relevant colleagues and initiate as per the Trust's safeguarding policy and procedure.

10 HOW WE HANDLE COMPLAINTS

10.1 We publish clear information about our complaints process and how people can get advice and support with their complaint through their local independent NHS Complaints Advocacy service, which for this locality is the Devon Advocacy Consortium, email: devonadvocacy@livingoptions.org or Telephone: 01392 82237.There are other specialist independent advice services that operate nationally and further guidance can be found here.

10.2 We will make sure that everybody who uses our services (and those that support them) know how they can make a complaint by having our complaints policy and/or materials that promote our procedure visible in public areas and on our website. We will provide a range of ways to do this so that people can do this easily in a way that suits them. This includes providing access to our complaints process online.

10.3 We will make sure that our service users' ongoing or future care and treatment will not be affected because they have made a complaint.

11 HANDLING PERSISTANT AND UNREASONABLE COMPLAINTS

11.1 The trust is committed to treating all complainants equitably. On rare occasions, despite our best efforts to resolve a complaint, a complainant can behave in a way that could be considered unreasonable or the trust identifies a pattern of complaint making that is vexatious in nature (raising the same issue when it has already been investigated and responded to). In accordance with NHS England Complaints Policy and the Department for Health and Social Care, the Trust has adopted guidance. See Appendix 7 for details of the Trust's procedure for handling unreasonable and persistent complainants.

12 WHAT WE DO WHEN WE RECEIVE A COMPLAINT

12.1 We want all patients, their family members and carers to have a good experience while they use our services. If somebody feels that the service received has not met our standards, we encourage people to talk to staff in the first instance, or to our Patient Advice and Liaison Service to see if we can resolve the issue promptly.

12.2 We want to make sure we can resolve complaints quickly as often as possible. To do that, we train our staff to proactively respond to service users and their representatives and support them to deal with any complaints raised at first point of contact.

12.3 All of our staff who have contact with patients, service users (or those that support them) will handle complaints in a sensitive and empathetic way. Staff will make sure people are listened to, get an answer to the issues quickly wherever possible, and any learning is captured and acted on.

Our staff will:

- listen to make sure they understand the issue(s)
- ask how the complainant has been affected
- ask what the complainant would like to happen to put things right
- carry out these actions themselves if they can (or with the support of others)
- explain why, if they can't do this
- capture any learning if something has gone wrong on DATIX as actions, to share with colleagues and improve services for others.

13 COMPLAINTS THAT CAN BE RESOLVED QUICKLY

13.1 Our frontline staff often handle complaints that can be resolved quickly at the time they are raised, or very soon after. We encourage our staff to do this as much as possible so that people get a quick and effective answer to their issues. An example of this quick resolution would be an inpatient on the ward raising a concern and the staff resolving.

13.2 If a complaint is made verbally (in person or over the phone) and resolved within a few days, it does not need go through the remainder of this procedure. For this to happen, we will confirm with the person making the complaint that they are satisfied that we have resolved the issues for them.

13.3 If PALS cannot resolve the complaint, our dedicated complaints teams within the divisions will handle it in line with the rest of this procedure.

13.4 For all other complaints, our staff will acknowledge them (either verbally or in writing/email) within three working days. Staff will also discuss with the person making the complaint how we plan to respond to the complaint and agree an estimate of timeframe for response.

14 EARLY RESOLUTION

14.1 When we receive a complaint, we are committed to making sure it is addressed and resolved at the earliest opportunity. Our staff are trained to identify any complaint that may be resolved quickly. If staff consider that the issues cannot be resolved quickly, we will take a closer look into the issues.

14.2 When our staff believe that an early resolution may be possible, they are empowered to take action to address and resolve the issues raised, and put things right for the person raising them. This may mean giving a quick explanation or apology themselves or making sure a colleague who is more informed of the issues does. Our staff will resolve complaints in person or by telephone wherever possible. The PHSO guidance module on early resolution provides more detailed information.

14.3 If we think a complaint can be resolved quickly, we aim do this within 14 working days. However, this can take longer if the additional time means the complaint is more likely to be resolved for the individual. We will always discuss with those involved what we will do to resolve the complaint and how long that will take.

14.4 If we can answer or address the complaint, and the person making the complaint is satisfied that this resolves the issues, our staff at Divisional level have the authority to provide a response on our behalf. This will be confirmed in writing (by email or letter) in line with the individual circumstances.

14.5 We will capture a summary of the complaint and how we resolved it and we will share that with the person making a complaint. This will make sure we build up a detailed picture of how each of the services we provide is doing and what people experience when they use these services. We will use this data to help us improve our services for others.

14.6 If we are unable to find an appropriate way to resolve the complaint to the satisfaction of the person making it, we will look at whether we need to take a closer look into the issues.

14.7 Not every complaint can be resolved quickly (due to its complexity or seriousness). In these cases, we will ensure that the complaint is allocated to a patient experience officer/lead in the relevant Division, who will take a closer look into the issues raised. This will always involve taking a detailed triage and fair review of the issues to determine what happened and what should have happened.

14.8 We will make sure staff involved in providing a response are properly trained to do so. We will also make sure they have:

- the appropriate level of authority and autonomy to carry out a fair investigation
- the right resources, support and protected time in place to carry out the investigation, according to the complexity of each case.

14.9 Where possible, complaints will be looked at by someone not involved in the events complained about. If this is not possible, we will explain to the person making the complaint the reasons why it was assigned to that person. This should address any perceived conflict of interest.

14.10 The Patient Experience Lead/Officer / complaint investigator will:

- engage with the person raising the complaint (preferably by telephone) to make sure they fully understand the Trust procedure and agree:
    - the key issues to be looked at
    - how the person has been affected
    - the outcomes they seek
- signpost the person to support and advice services, including independent advocacy services, at an early stage
- make sure that any staff members subject to a complaint are made aware at the earliest opportunity (see ‘Support for staff’ below)
- agree a suitable timescale for how long the investigation will take with the person raising the complaint, depending on:
    - the complexity of the complaint
    - the work that is likely to be involved
- keep the person (and any staff subject to the complaint) regularly informed and engaged throughout
- explain how they will carry out the closer look into the complaint, including:
    - what evidence they will seek out and consider

- who they will speak to
- who will be responsible for the final response
- how the response will be communicated.

For further detail see the PHSO guidance.

14.11 Staff who carry out investigations will give a clear, balanced explanation of what happened and what should have happened. They will reference relevant standards, policies and guidance to clearly identify if something has gone wrong. For further information please see the PHSO guidance module, carrying out the investigation.

14.12 The Patient Experience Officer/Lead and complaint investigators will make sure the investigation clearly addresses all the issues raised. This includes obtaining evidence from the person raising the complaint and from any staff involved in the investigation. If the complaint raises clinical issues the Complaint Handler will obtain a clinical view from someone who is suitably qualified. Ideally, they should not have been directly involved in providing the care or service that has been complained about.

14.13 We will complete our investigation within the timescale set out at the start of the investigation. Should circumstances change the Patient Experience officer/lead will:

- notify the person raising the complaint immediately
- explain the reasons for the delay
- provide a new target timescale for completion.

14.14 In accordance with the NHS complaints (England) regulations 2009, if we cannot conclude the investigation and issue a final response within 6 months (unless we have agreed a longer timescale with the person raising the complaint within the first 6 months) the Responsible Person or a Senior Manager will inform the person in writing to explain the reasons for the delay and the likely timescale for completion. They will then maintain oversight of the case until it is completed and a final written response issued.

14.15 We acknowledge that before sending out a final written response to a complainant it is best practice to share and discuss (by telephone, in a meeting or in writing) the outcome of our investigation. However, this may not always be possible and will be decided on a case-by-case basis.

15 PROVIDING A REMEDY

15.1 At the start of an investigation, it is important for us to understand the impact of events and the outcome the person is looking for. If, following the investigation it is identified that something has gone wrong we will seek to establish what impact the failing has had on the individual concerned. Where possible the trust will put that right. If it is not possible to put the matter right will decide, in discussion with the individual concerned and relevant staff, what action can be taken to remedy the impact.

15.2 Further information from the PHSO can be found here on providing remedy. The following remedies may be appropriate:

- an acknowledgement and a meaningful apology for the error
- reconsideration of a previous decision
- expediting an action
- waiving a fee or penalty
- issuing a payment or refund
- changing policies and procedures to prevent the same mistake(s) happening again and to improve our service for others.

16 THE FINAL WRITTEN RESPONSE

16.1 As soon as practical after the investigation is finished, the patient experience officer/lead will co-ordinate a written response, signed by our Responsible Person (or their delegate). They will send this to the person raising the complaint and any other interested parties. The response will include:

- a reminder of the issues investigated and the outcome sought
- an explanation of how we investigated the complaint. We will provide the information in a language and format to the preference of the complainant.
- the relevant evidence we considered
- what the outcome is
- an explanation of whether or not something went wrong that sets out what happened compared to what should have happened, with reference to relevant standards, policies and guidance
- if something did go wrong, an explanation of the impact it had
- an explanation of how that impact will be remedied for the individual
- a meaningful apology for any failings
- an explanation of any wider learning we have acted on/will act on to improve our service for other users.
- The relevant clinical / service manager / investigator will agree actions to be taken as a result of the investigation and a SMART action developed and recorded onto DATIX. Open actions will be monitored at Divisional Governance and evidence of completion must be updated and added to DATIX.
- confirmation that we have reached the end of our complaint procedure

- details of how to contact the Parliamentary and Health Service Ombudsman if the individual is not satisfied with our final response
- a reminder of where to obtain independent advice or advocacy.
- The PHSO guidance module on writing and communicating final responses can be found here

17 SUPPORT FOR STAFF

17.1 We will make sure all staff who look at complaints have the appropriate: training, resources, support and protected time to respond to and investigate complaints effectively.

17.2 We will make sure staff being complained about are made aware and will give them advice on how they can get support from within our organisation, and external representation if required.

17.3 We will make sure staff who are complained about have the opportunity to give their views on the events and respond to emerging information. Our staff will act openly and transparently and with empathy when discussing these issues.

17.4 The complaint handler will keep any staff involved in complaint updated. These staff will also have an opportunity to see how their comments are used before the final response is issued.

18 REFERRAL TO THE OMBUDSMAN

18.1 In our response on every complaint we will clearly inform the person raising the complaint that if they are not happy with the outcome of our investigation, they can take their complaint to the Parliamentary and Health Service Ombudsman.

18.2 If the complaint is about detention under the Mental Health Act, or a Community Treatment Order or Guardianship we will inform the person making the complaint that if they are not happy with the outcome, they can take their complaint to the Care Quality Commission.

19 COMPLAINTS INVOLVING MULTIPLE ORGANISATIONS

19.1 If we receive a complaint that involves other organisation(s) (including cases that cover health and social care issues) we will make sure that we investigate in collaboration with those organisations. Complaint Handlers for each organisation will agree who will be the ‘lead organisation’ responsible for overseeing and coordinating consideration of the complaint.

19.2 The Complaint Handler for the lead organisation will be responsible for making sure the person who raised the complaint is kept involved and updated throughout. They will also make sure that the individual receives a single, joint response. For further information see guidance.

20 MONITORING, DEMONSTRATING LEARNING AND DATA RECORDING

20.1 We expect all staff to identify what learning can be taken from complaints, regardless of whether mistakes are found or not.

20.2 Our Senior Managers take an active interest and involvement in all sources of feedback and complaints, identifying what insight and learning will help improve our services for other users.

20.3 We maintain a record of:

- each complaint we receive
- the subject matter and outcome
- whether we sent our final written response to the person who raised the complaint within the timescale agreed at the beginning of our investigation.

20.4 We monitor all feedback and complaints over time, looking for trends and risks that may need to be addresses. We also seek feedback from:

- People who have made a complaint
- Staff who have been specifically involved in a complaint
- Staff who carried out the investigation

20.5 In keeping with the Regulations section 18, as soon as practical after the end of the financial year, we will produce and publish a report on our complaints handling. This will include how complaints have led to a change and improvement in our services, policies or procedures.

21 COMPLAINTS ABOUT A PRIVATE PROVIDER OF OUR NHS SERVICES

21.1 This complaint handling procedure applies to all NHS Services we provide.

21.2 Where we outsource the provision of NHS Services to a private provider we will ensure that they follow these same complaint handling procedures.

22 COMPLAINING TO THE COMMISIONER OF OUR SERVICE

22.1 Under section 7 of the Regulations, the person raising the complaint has a choice of complaining to us, as the provider of the service, or to the commissioner, Devon Integrated Care Board. If a complaint is made to our commissioner, they will determine how to handle the complaint in discussion with the person raising the complaint.

22.2 In some cases, it may be agreed between the person raising the complaint and the commissioner that we, as the provider of the service, are best placed to deal with the complaint. If so, they will seek consent from the person raising the complaint. If that consent is given they will forward the complaint to us and we will treat the complaint as if it had been made to us in the first place.

22.3 In other cases, the commissioner of our services may decide that it is best placed to handle the complaint itself. It will do so following the expectations set out in the Complaint Standards and in a way that is compatible with this procedure. We will co-operate fully in the investigation.

23 ARCHIVING ARRANGEMENTS

23.1 The original of this policy will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

24 PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECIVENESS OF THE POLICY

24.1 To evidence compliance with this policy, the following elements will be monitored and reported at Patient Experience Operational Group (PEOG) and the annual report.

Area of Review	Monitoring Process
Straightforward/single issue complaint	Monitor percentage of complaints dealt with as early resolution
Complex/multiple issue or multiple organisations complaint	Monitor Percentage of complaints completed within 6 months
Actions for all complaints	100% completed within timeframe and monitored at divisional level performance reports
Reopened rate	Monitor the number of complaints reopened
PHSO early resolution referrals	Monitor the number of primary investigations that are resolved by early resolution with actions for learning.
PHSO detailed Investigation referrals	Monitor the number of detailed investigations that are upheld and partly upheld.

Annual Policy Compliance audit (completed by Complaints Manager)	Monitor compliance of the policy across the Trust. 20 complaints records (East), 20 complaints records (North). Completed in April/May for the previous financial year, presented to PEOG/PEC and annual report.

24.2 A quarterly report, as part of the Integrated Performance Review, outlining the total number of complaints and concerns received Trust-wide, top themes and number of cases referred to the PHSO will be submitted to the Board of Directors. This report enables the Board to monitor the effectiveness of the complaint's procedure. It will also identify trends and service changes that have been made in response to complaints.

24.3 The Board of Directors will receive an annual report on the Trust's complaint activity for the financial year, including any matters of general importance arising out of the complaints or the way they were handled, cases referred to the PHSO, lessons learned and resultant improvements in care. This report includes data to allow the Trust to benchmark the effectiveness of its procedures against other organisations.

24.4 Complaints activity will be monitored monthly with each Division as part of the Trust's Performance Assurance Framework.

24.5 The Patient Experience Committee (PEC) will review a copy of the Patient Experience quarterly report of all complaints and concerns and their trends and analyse sources of patient feedback, identify emergent themes, triangulate with intelligence about and from Members and the wider community and prepare reports for the Governance Committee

24.6 The Trust's Governance Committee will receive a report following each meeting of the Patient Experience Committee to provide assurance and provide an action plan to cover any gaps in assurance.

25 REFERENCES

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
NHS England Complaints Policy Updated 2021
The Department of Health & Social Care, NHS Complaints Guidance Updated 2021
The Parliamentary and Health Service Ombudsman (PHSO) NHS Complaint Standards, Summary of Expectations, December 2022
The Parliamentary and Health Service Ombudsman (PHSO) Easy Read NHS Complaint Standards Spring 2021 Update
The Parliamentary and Health Service Ombudsman - Model Complaint Handling Procedure for providers of NHS Services in England, December 2022

Parliamentary and Health Service Ombudsman – My expectations for raising concerns and complaints 2014
The Parliamentary and Health Service Ombudsman Complaint handling guidance modules 2022
Access to Health Records Act 1990
NHS England Records Management Code of Practice 2021
Data Protection Act, 1998
Data Protection Act 2018
Information Commissioners Office – Right of Access
The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
European Court Of Human Rights - Guide on Article 8 of the European Convention on Human Rights : Right to respect for private and family life, home and correspondence, August 2022
Gender Recognition Act 2004
Mental Capacity Act 2005

1 APPENDIX: COMPLAINTS LEAFLET

Royal Devon University Healthcare NHS Foundation Trust

Help us to get better at what we do

Royal Devon University Healthcare NHS Foundation Trust

How to raise a concern or make a complaint

Other formats

If you need this information in another format such as audio CD, Braille, large print, high contrast, British Sign Language or translated into another language, please contact the PALS desk on 01392 402093 or at rduh.pals-eastern@nhs.net (for Mid Devon, East Devon and Exeter services) or on 01271 314090 or at rduh.pals-northern@nhs.net (for North Devon services)

Help us improve

We know sometimes we don't get things right. That is why we take complaints very seriously and welcome feedback in all forms to help us improve our services. We will make time to listen to you and act on what you say.
It is absolutely fine for you to ask us a question, raise an issue or ask us for something at any time. We will do our best to answer you. Talk to a member of staff that is caring for you or your loved one.

Resolving issues as soon as we can

If we cannot answer your questions and/or you would like to make a complaint or give us feedback, please speak to the ward manager or team manager of the service in the first instance. If you are unable to resolve your concern, you can contact the Patient Advice and Liaison Service (PALS) team:

- Northern services – on 01271 314090 or at rduh.pals-northern@nhs.net
- Eastern services – on 01392 402093 or at rduh.pals-eastern@nhs.net

for advice and signposting. If they are unable to resolve your concern, they will also be able to direct you to a member of the Patient Experience team to make a formal complaint.

You should do this as soon as possible after a problem or issue arises. Speaking up will not affect the care you receive from us.
If it is not possible to raise your complaint immediately, please do so as soon as you can. This should be within 12 months of when you became aware of the problem. We may not be able to help you after that.

We will acknowledge your complaint within three working days. If your complaint is straightforward and easy to resolve, we will try to do that as quickly as possible, however complex cases may take longer to investigate.

If we need to take a closer look

If your complaint is more complex, we will need time to take a closer look at it and carry out an investigation. We will arrange a time to speak to you to make sure we understand your issues and the outcome you would like.

We will explain how we will investigate your complaint and tell you how long that is likely to take. We will agree with you how and when you will be involved and kept updated as we carry out this work.

During our investigation we will:

- keep you updated on our progress
- gather and consider any relevant evidence from you and anyone else involved - this may include looking at any records about the care or service provided to you
- make sure we have your permission to look at any personal information
- compare what happened to you with what should have happened - using the right standards, policies and guidance
- give you an open and honest answer and make impartial decisions based on the facts
- write and tell you what we have found
- apologise if something has gone wrong and put things right for you as soon as we can
- make sure we learn from what you have told us, particularly if it could affect other patients or service users.

Making sure you have help and support

If you would like help making your complaint, then you should contact our local NHS advocacy provider. Their service is free. They are independent and they are there to help you every step of the way. If you would like to talk to the Devon Advocacy Consortium about helping with your complaint, you can contact them by emailing devonadvocacy@livingoptions.org or calling 01392 822377.

Complaining on behalf of someone else

You can complain on behalf of somebody else. We will need their consent so we can look at their personal records and share what we find with you. A member of the Patient Experience team can post or email a consent form to you for you to complete and return. In some cases, the person may not be able to provide their consent, for example if they are a young child. If that is the case and you are not legally allowed to see their personal information, we may still be able to look into the matter for you. We may be able to give you a response but we will not be able to share any of their personal information with you.

If you need help with this issue, please speak to our local NHS advocacy provider, Devon Advocacy Consortium or email the Patient Experience team.

Northern services

Email: rduh.complaints-northern@nhs.net
Tel: 01271 335760 / 01271 314185

Eastern services
Email: rduh.complaints-eastern@nhs.net
Tel: 01392 402093

Taking your complaint further

Once we have sent you our final response, if you're not happy with how we've dealt with your complaint and would like to take the matter further, you can contact the Parliamentary and Health Service Ombudsman.
The Ombudsman makes final decisions on complaints that have not been resolved by the NHS. The service is free for everyone. To take a complaint to the Ombudsman or to find out more, go to www.ombudsman.org.uk or call 0345 015 4033.

This leaflet was adopted from Parliamentary and Health Service Ombudsman (PHSO) resources.

PALS

The Patient Advice and Liaison Service (PALS) ensures that the NHS listens to patients, relatives, carers and friends, answers question and resolves concerns as quickly as possible. If you have a query or concern, please contact:

PALS Mid Devon, East Devon and Exeter

- call 01392 402093 or email rduh.pals-eastern@nhs.net. You can also visit the PALS and Information Centre in person at the Royal Devon and Exeter Hospital in Wonford, Exeter.

PALS North Devon

- call 01271 314090 or email rduh.pals-northern@nhs.net. You can also visit the PALS and Information Centre in person at the North Devon District Hospital in Barnstaple.

Have your say

Royal Devon University Healthcare NHS Foundation Trust aims to provide high quality services. However, please tell us when something could be improved. If you have a comment or compliment about a service or treatment, please raise your comments with a member of staff or the PALS team in the first instance.
Tell us about your experience of our services. Share your feedback on the Care Opinion website www.careopinion.org.uk.

Royal Devon University Healthcare NHS Foundation Trust
Raleigh Park, Barnstaple
Devon EX31 4JB
Tel. 01271 322577
www.royaldevon.nhs.uk

2 APPENDIX: CONSENT FORM FOR PATIENT OR SERVICE USER MAKING THEIR OWN COMPLAINT

CONSENT FORM for patient or service user making their own complaint

I ……. give permission to Royal Devon University Healthcare NHS Trust to investigate my complaint.

I understand that access to my personal information and/or relevant medical records will be required to investigate and respond to my complaint and may be seen by the people involved in investigating and responding to my complaint.

I agree that relevant personal information about me may be shared with and gathered from the following organisation(s) and agencies to help investigate and respond to my complaint:

- (Add organisations if relevant)

My details:

My Name	
NHS Number (if known)	
Address	
Post Code	
Telephone contact No(s)	
Email	
Date of birth	
Date	
Signature	

I understand that my data will be processed in line with General Data Protection Regulations (GDPR) 2018.

My consent to share personal information is entirely voluntary and I understand that I may withdraw my consent at any time.

Should you have any questions about this form or the process, please contact us.

Please return this form as soon as possible so there is no delay in the handling of this complaint.

By email - please return a clear signed copy to:
Northern services - rduh.complaints-northern@nhs.net
Eastern services – rduh.complaints-eastern@nhs.net

Or by Post to:

Northern Services
Patient Advice & Liaison (PALS)
North Devon District Hospital (Wonford)
Raleigh Park
Barnstaple
Devon
EX31 4JB

Eastern Services
Patient Advice & Liaison (PALS)
Royal Devon & Exeter Hospital
Barrack Road
Exeter
Devon
EX2 5DW

3 APPENDIX: CONSENT FORM FOR REPRESENTATIVE TO ACT ON BEHALF OF THE PERSON AFFECTED (INCLUDING ADVOCATE AND MP)

CONSENT FORM for someone to act as my representative for the consideration of my complaint (including MP's and advocacy services)

Patient to complete:

I ……. (insert person affected) understand that

…….... (insert complainant/MP/advocacy service) has made

a complaint on my behalf to Royal Devon University Healthcare NHS Trust

I confirm that:

- I support the complaint and I am aware of the issues that have been raised
- I understand that access to my personal information and/or my medical records will be required in order to investigate and respond to the complaint and may be seen by the people involved in investigating and responding to my complaint
- I agree that relevant personal information about me may be shared and gathered from the following organisation(s) and agencies to help them investigate and respond to my complaint:
    - (Add organisations if relevant)

I understand that my data will be processed in line with General Data Protection Regulations (GDPR) 2018.My consent to share personal information is entirely voluntary and I understand that I may withdraw my consent at any time.

Please complete the section overleaf.

My details:

My Name	
NHS Number (if known)	
Address	
Post Code	
Telephone contact No(s)	
Email	
Date of birth	
Name of the person making the complaint on behalf of me	
Relationship to the person making the complaint on behalf of me	Include relationship or if they are an MP/advocacy service
Date	
Signature	

If you have any questions about this form or the process or wish to withdraw your consent, please contact us – see details below
Please return this form as soon as possible so there is no delay in the handling of this complaint.

By email - please return a clear signed copy to:
Northern services - rduh.complaints-northern@nhs.net
Eastern services – rduh.complaints-eastern@nhs.net

Or by Post to:

Northern Services
Patient Advice & Liaison (PALS)
North Devon District Hospital (Wonford)
Raleigh Park
Barnstaple
Devon
EX31 4JB

Eastern Services
Patient Advice & Liaison (PALS)
Royal Devon & Exeter Hospital
Barrack Road
Exeter
Devon
EX2 5DW

4 APPENDIX: CONSENT FORM FOR SHARING PERSONAL INFORMATION WITH OTHER ORGANISATION(S) THAT ARE BEING COMPLAINED ABOUT

CONSENT FORM for sharing my personal information with other organisation(s) I am complaining about

I …….. (insert person affected) hereby give my permission for Royal Devon University Healthcare NHS Trust to share any relevant personal information they hold about me with the other organisations and service providers that are involved in the care/service I have complained about.

I also give my permission for the organisations listed below to share any relevant personal information they hold about me for the purpose of investigating and responding to my complaint.

I understand that this may include relevant extracts from my medical records.

I understand that my rights under the Data Protection Act will not be affected

Statement of consent:

- I understand that personal information is held about me.
- I have had the opportunity to discuss the implications of sharing or not sharing information about me.
- I agree that relevant personal information about me may be shared and gathered from and between the following organisations(s) and agencies to help them investigate and respond to my complaint:
    - (Add organisations if relevant)

Are there any organisations that you do not want us to share or gather information from? Please list them here:

My details:

My Name	
NHS Number (if known)	
Address	
Post Code	
Telephone contact No(s)	
Email	
Date of birth	
Relationship to the person making the complaint on behalf of me	
Date	
Signature	

I understand that my data will be processed in line with General Data Protection Regulations (GDPR) 2018.

My consent to share personal information is entirely voluntary and you may withdraw your consent at any time.

****

If you have any questions about this form or the process or wish to withdraw your consent, please contact us – see details below

Please return this form as soon as possible so there is no delay in the handling of this complaint.

By email - please return a clear signed copy to:
Northern services - rduh.complaints-northern@nhs.net
Eastern services – rduh.complaints-eastern@nhs.net

Or by Post to:

Northern Services
Patient Advice & Liaison (PALS)
North Devon District Hospital (Wonford)
Raleigh Park
Barnstaple
Devon
EX31 4JB

Eastern Services
Patient Advice & Liaison (PALS)
Royal Devon & Exeter Hospital
Barrack Road
Exeter
Devon
EX2 5DW

5 APPENDIX: CONSENT FORM EASY READ VERSION

CONSENT FORM – EASY READ

Use this form if you want to make an NHS complaint for someone else. That person has to give you permission to make the complaint for them. You should send a copy of this form with your complaint.

SECTION A – About you		
	Your name:	
	Your address:	
	Your telephone number:	
	Your mobile telephone number:	
	Your email address:	

<table>
<tr><td colspan="5">SECTION B - About the patient</td></tr>
<tr><td> 
</td><td>Name of the patient:</td><td colspan="3"></td></tr>
<tr><td rowspan="2">  </td><td rowspan="2">When was the patient born?</td><td>Day
 
</td><td>Month
 
</td><td>Year
 
</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>  </td><td>Patients address:</td><td colspan="3">(if this is a different address from yours)</td></tr>
<tr><td>  </td><td>How does the patient know you?</td><td colspan="3"></td></tr>
</table>

SECTION C - Consent

Has the patient agreed to this complaint? Circle your answer	Yes	No	They have died
			

If the patient can agree to you making the complaint, ask them to sign below

I am the patient

gree that the person named in this form can ke a complaint for me.

gree they can see information about me. This cludes my medical records and any other formation that they need to make the complaint.

Patient's signature:

_____

Today's date:

	_____ _

If the patient is younger than 16, their parent or guardian must fill in this section:

	My name is:	
	I am:	Name of patient's parent or guardian
	I agree that:	Name of person making a complaint
	Can make a complaint about:	Name of patient

 	I agree that they can see any information that could help them make a complaint. This includes medical records.	
	Your signature: _____	
	Today's date: _____	
	**If the patient has died**, their nearest family member or legal representative must fill in this section:	
	My name is:	
	I am:	Patient's nearest family member or legal representative
	I agree that:	Name of person making a complaint

	Can make a complaint :	Name of patient
 	I agree that they can see any information that could help them make a complaint. This includes medical records. By law I am allowed to give my permission.	
	Your signature: _____	
	Today's date: _____	
If the patient cannot give their consent, fill in this section. You need to say why they are not able to agree to you making the complaint.		
	I am the patient's representative	
	Your signature: _____	

	Today's date: _____
The patient is not able to give their direct consent because: Insert full details above.	

Content and pictures shared from the Parliamentary and Health Service Ombudsman website

6 APPENDIX: CONSENT FORM FOR USE WHEN THE PERSON AFFECTED CANNOT PROVIDE CONSENT

CONSENT FORM for use where the person affected cannot provide consent

I ……. am making a complaint to Royal Devon University Healthcare NHS Trust on behalf of

…… (insert service user) who is unable to make the complaint because:

☐ They are a child (You must have parental responsibility)

☐ They lack capacity
- Please provide evidence of LPA for Health and Welfare, Court Appointed Deputy for Personal Welfare, or explain why it is in their best interests for the complaint to be made on their behalf

☐ They have died

☐ Other
- Please explain fully why the person cannot make the complaint themselves or provide consent for you to act as their representative

Person affected/patient details:

Name of child/person affected	
NHS number (if known)	
Address	
Postcode	
Date of birth	
Relationship to person making the complaint	

I understand that the organisation I am complaining about has a duty of confidentiality to its patients and service users. (That duty remains in place after death).

I understand that access to the personal information and/or medical records of the person I am complaining on behalf of will be required to investigate and respond to my complaint and that I may only see that information if I have a right of access to that information.

I believe I have a right of access to that personal information because:

_____
_____
(please explain why you believe you have a right of access and provide any evidence you might have in support of that).

I understand that, if I do not have a right of access to the relevant personal information, the organisation can still respond to my complaint but will be unable to release any personal information in its response, which may leave some of my questions unanswered.

I have considered if someone who has a right of access to the relevant personal information would be better placed to make the complaint.

Person making complaint details:

Name	
Address	
Postcode	
Telephone number	
Email	
Date	
Signature	

Please return this form as soon as possible so there is no delay in dealing with this complaint.

Should you have any question about this form, please contact us – see details below.

By email - please return a clear signed copy to:
Northern services - rduh.complaints-northern@nhs.net
Eastern services – rduh.complaints-eastern@nhs.net

Or by Post to:

Northern Services
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Royal Devon & Exeter Hospital
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Devon
EX2 5DW

7 APPENDIX: PROCEEDURE FOR HANDLING PERSISTANT AND/OR UNREASONABLE COMPLAINTS

APPENDIX 1: PROCEDURE FOR HANDLING PERSISTENT AND/OR UNREASONABLE COMPLAINANTS

1. INTRODUCTION

1.1 Persistent and/or unreasonable/vexatious complainants are becoming an increasing problem for NHS staff. The difficulty in handling such complaints is placing a strain on time and resources and is causing undue stress for staff that may need support in difficult situations. NHS staff are trained to respond with patience and sympathy to the needs of all complainants but there are times when there is nothing further which can reasonably be done to assist them or to rectify a real or perceived problem.

1.2 In determining arrangements for handling such complaints, staff are presented with two key considerations:

- The first is to ensure that the complaints procedure has been correctly implemented so far as possible and that no material element of a complaint is overlooked or inadequately addressed and to appreciate that even repeated complaints may have aspects which contain some genuine substance. The need to ensure an equitable approach is crucial.

- The second is to be able to identify the stage at which a complaint has become unreasonable. One approach to the situation is to develop an approved policy, which is formally incorporated into the complaints procedure. Implementation of such a policy would only occur in exceptional circumstances. Information on the handling of unusual or unreasonable complaints could also be made available to the public as part of the material on the complaints process as a whole.

2. PURPOSE OF THIS PROCEDURE

2.1 The aim of this procedure document is to identify situations where the complainant might be considered to be unreasonable and to suggest ways of responding to these situations**.**

2.2 The procedure should only be implemented following careful consideration by, and with the `authorisation of, the Chief Executive of the Trust or their deputies in their absence.

3. DEFINITION OF AN UNREASONABLE COMPLAINANT

3.1 Complainants (and/or anyone acting on their behalf) may be deemed as “unreasonable complainant behaviour” or be raising “unreasonable persistent complaints” where previous or current contact with them shows that they meet **TWO** of the following criteria:

- Persist in pursuing a complaint where the NHS complaints procedure has been fully and properly implemented and exhausted (e.g. where investigation

has been denied as "out of time", where the Care Quality Commission has declined a request for Independent Review).

- Adopts an excessively ‘scattergun’ approach, for instance, in pursuing a complaint with multi organisations / individuals.

- Refuses to co-operate with the complaint investigation process, whilst still wishing their complaint to be resolved and adhere to our code of conduct

- Makes the same complaint repeatedly, perhaps with minor differences, after the complaint has been investigated. This would include where people insist that the minor difference constitute new complaints

- Has insufficient, or no grounds for their complaint and are making it for reasons that thy do not admit or make obvious.

- Insists their complaint is dealt with in ways that are incompatible with NHS procedure or are disproportionate to the complaint.

- Change the substance of a complaint or continually raise new issues or seek to prolong contact by continually raising further concerns or questions **upon receipt** of a response whilst the complaint is being addressed. Care must be taken not to discard new issues which are significantly different from the original complaint. These might need to be addressed as separate complaints**.**

- Are unwilling to accept documented evidence of treatment given as being factual, e.g. drug records, General Practitioner records, nursing records or deny receipt of an adequate response in spite of correspondence specifically answering their questions or do not accept that facts can sometimes be difficult to verify when a long period of time has elapsed.

- Do not clearly identify the precise issues which they wish to be investigated, despite reasonable efforts of the Trust’s staff and, where appropriate, the Independent Complaints Advocacy Service, to help them specify their concerns, and/or where the concerns identified are not within the remit of the Trust to investigate.

- Focus on a peripheral matter to an extent, which is out of proportion to its significance and continue to focus on this point. (It is recognised that determining what is a ‘peripheral' matter can be subjective and careful judgement must be used in applying this criteria).

- Have threatened or used actual physical violence towards staff or their families or associates at any time – this will in itself cause personal contact with the complainant and/or their representatives to be discontinued and the complaint will, thereafter, only be pursued through written communication. All such incidents should be documented and the incident reporting system Datix

and to the police after consultation with the local security management specialist, health &safety officer and other senior staff.

- Have in the course of addressing a registered complaint, had an excessive number of contacts with the Trust placing unreasonable demands on staff.

(A contact may be in person or by telephone, letter or email. Discretion must be used in determining the precise number of 'excessive contacts' applicable under this section, using judgement based on the specific circumstances of each individual case).

- Have harassed or been personally abusive or verbally aggressive on more than one occasion towards staff dealing with their complaint or their families or associates. (Staff must recognise that complainants may sometimes act out of character at times of stress, anxiety, or distress and should make reasonable allowances for this. They should document all incidents of harassment on DATIX).
- Are known to have recorded meetings or face-to-face/telephone conversations without the prior knowledge and consent of other parties involved.
- Display unreasonable demands or patient/complainant expectations and fail to accept that these may be unreasonable (e.g. insist on responses to complaints or enquiries being provided more urgently than is reasonable or normal recognised practice).

4. OPTIONS FOR DEALING WITH UNREASONABLE COMPLAINANTS

4.1 Where complainants have been identified as unreasonable in accordance with the above criteria, the Patient Experience Manager will advise the Chief Executive (or appropriate deputy in their absence) what action to take. The Chief Executive (or deputy) will implement such action and will notify complainants in writing of the reasons why they have been classified as unreasonable and the action to be taken. This notification may be copied for the information of others already involved in the complaint, e.g. conciliator, Care Quality Commission, Independent Health Complaints Advocacy (IHCA), Member of Parliament.

4.2 A record must be kept for future reference of the reasons why a complainant has been classified as unreasonable. The Chief Executive (or deputy) may decide to deal with complaints in one or more of the following ways:

- Try to resolve matters, before invoking this procedure, by drawing up a signed 'agreement' with the complainant (and if appropriate involving the relevant practitioner in a two-way agreement) which sets out a code of conduct for the parties involved if the Trust is to continue processing the complaint. If these terms are contravened consideration would then be given to implementing other action as indicated in this section.

- Once it is clear that complainants meet any one of the criteria above, it may be appropriate to inform them in writing that they may be classified as an unreasonable complainant, copy this procedure to them, and advise them to take account of the criteria in any further dealings with the Trust. In some cases it may be appropriate, at this point, to suggest that complainants seek advice in processing their complaint, e.g. through the ICHA.
- Decline contact with the complainants either in person, by telephone, or email, by letter or any combination of these, provided that one form of contact is maintained or alternatively to restrict contact to liaison through a third party
- Notify the complainants in writing that the Chief Executive has responded fully to the points raised and has tried to resolve the complaint but there is nothing more to add and continuing contact on the matter will serve no useful purpose. The complainants should be notified that correspondence is at an end and that further letters received will not be acknowledged; however, they will be held on file.
- Inform the complainants that in extreme circumstances the Trust reserves the right to pass unreasonable complaints to the Trust's solicitors.
- Temporarily suspend all contact with the complainants or investigation of a complaint whilst seeking legal advice or guidance from the Regional Office, National Health Service Executive, or other relevant agencies.

5.0 WITHDRAWING 'UNREASONABLE' STATUS

5.1 Once complainants have been determined as 'unreasonable' there needs to be a mechanism for withdrawing this status at a later date if, for example, complainants subsequently demonstrate a more reasonable approach or if they submit a further complaint for which normal complaints procedures would appear appropriate. Staff should previously have used discretion in recommending 'unreasonable' status at the outset and discretion should similarly be used in recommending that this status be withdrawn when appropriate. Where this appears to be the case, discussion will be held with the Chief Executive (or their deputy). Subject to their approval, normal contact with the complainants and application of NHS complaints procedures will then be resumed.

8 APPENDIX: COMMUNICATION PLAN

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the strategy/policy	***Divisional Governance Leads/coordinators, Patient Experience Leads, Patient Experience operational group members.***
The key changes if a revised policy/strategy	***This integrated Policy reflects the new national complaints standards. The KPI's have altered to align with the standards.***
The key objectives	***To align the complaints handling policy and procedure across both sites pre-integration. To align to the new national standards of which the Trust is an early adopter site.***
How new staff will be made aware of the policy and manager action	***There is very little procedural change that would require wide scale communications, due to the trusts work as an early adopter site, the complaints handling process is aligned and embedded across the sites. New staff will be informed at Trust induction and manager awareness.***
Specific Issues to be raised with staff	***Staff should be made aware of the policy, with particular attention drawn to the importance of early resolution and a change in the Trust wide KPI's top reflect the new standards.***
Training available to staff	***Training is being tested as part of the Pilot with staff from RDUH, once training has been finalised this be accessible for all staff via Learn+***
Any other requirements	***Nil***
Issues following Equality Impact Assessment (if any)	*e.g. no negative impacts, 2 positive impacts for ….* *Use information on Equality Impact Assessment to complete this section.*
Location of hard / electronic copy of the document etc.	***Policy will be available on the Trust intranet "HUB".***

9 APPENDIX: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Management of Complaints Policy
Division/Directorate and service area	Corporate Nursing-Patient Experience
Name, job title and contact details of person completing the assessment	[redacted] Deputy Director of Nursing (Patient Experience)
Date completed:	

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

The purpose of this policy is to provide clear guidance of the Trust complaints process for our staff so they are informed and aware of the action to be taken when a patient of other eligible person shares a concern or wishes to make a complaint concerning any aspect of the patient experience.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☐ Staff ☒ Patients ☒ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	☐	☒
Disability	☐	☒
Sex - including: *Transgender, and Pregnancy / Maternity*	☐	☒
Race	☐	☒
Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. **Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to…** (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

No Groups identified

5. **Do you think the document meets our human rights obligations?** ☒

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
• ***Fairness*** *– how have you made sure it treats everyone justly?* • ***Respect*** *– how have you made sure it respects everyone as a person?* • ***Equality*** *– how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity*** *– have you made sure it treats everyone with dignity?* • ***Autonomy*** *– Does it enable people to make decisions for themselves?*

6. **Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?**

In development of the national standards the Ombudsman held a consultation with the public and third sector and advocacy organisations.

Data Protection Policy

Post holder responsible for Procedural Document	[redacted] Data Protection Officer
Author of Policy	[redacted] Data Protection Officer
Division/ Department responsible for Procedural Document	Information Management and Technology Directorate / Health Records Department
Contact details	[redacted] (external) X[redacted] (internal)
Date of original document	21/11/18
Impact Assessment performed	**Yes**/No
Ratifying body and date ratified	Information Governance Steering Group—18th March 2019
Review date (and frequency of further reviews)	December 2020
Expiry date	March 2022
Date document becomes live	21 May 2019

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience	✓	Maintain Operational Service Delivery	
Assurance Framework	✓	Integrated Community Pathways	
Monitor/Finance/Performance	✓	Develop Acute services	
CQC Regulations/Outcomes	N/A	Infection Control	
Other (please specify):			
Note: This document has been assessed for any equality, diversity or human rights implications ✓			

Controlled document

This document has been created following the Royal Devon and Exeter NHS Foundation Trust Policy for Procedural Documents. It should not be altered in any way without the express permission of the author or their representative.

Royal Devon and Exeter NHS
NHS Foundation Trust

Full History		Status: Final	
Version	Date	Author	Reason
1.0	05/02/19	Data Protection Officer	Drafting of policy
1.0	15/03/19	Data Protection Officer	Outcome of consultation
1.0	18/03/2019	Data Protection Officer	IGSG Approval

Associated Trust Policies/ Procedural documents:	• Information Security Policy, • Subject Access Policy, • Health Records Policy, • The Data Security and Protection Toolkit, • Data Protection Impact Assessment Policy, • Information Governance Policy, • Data Quality policy
Key Words:	Data Protection, Subject Access Requests, General Data Protection Regulation
In consultation with and date: 27/02/19 Members of the Safety & Risk Committee, Information Governance Steering Group and Records Management Groups Quality Assurance-21/03/2019 Information Governance Steering Group-18/03/2019	
Contact for Review:	Head of Information Governance
Executive Lead Signature:	[redacted] Adrian Harris

CONTENTS

KEY POINTS OF THIS POLICY

- This policy has been created in order to ensure that there is compliance with the General Data Protection Legislation (GDPR) 2016 and Data Protection Act 2018.

- The policy outlines the Trusts responsibility in ensuring that it conforms to all the requirements of the legislation.

- The new seven data protection principles are outlined as well as how they are adapted in practice through areas such as privacy notices.

- It gives key definitions as well as outlining a responsibilities regarding application of the legislation

- It encompasses both the EU Law and Data Protection Act 2018

1. INTRODUCTION

1.1 The Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as 'the Trust') has a legal obligation to comply with all appropriate legislation in respect of Data, Information and IT Security. It also has a duty to comply with guidance issued by the Department of Health, the Information Commissioner, other advisory groups to the NHS and guidance issued by professional bodies.

1.2 This policy covers all aspects of information within the Trust and is not solely patient/service user related. Information produced, handled and held by the Trust includes, but is not limited to:

- patient/client/service user information;
- staff/personnel information;
- corporate/business information.

1.3. This policy covers all methods of holding information and in all media, including, but not limited to:

- Systems purchased/developed/managed by, or on behalf of, the Trust;
- Manually stored data in paper format;
- Tapes and other data from CCTV systems;
- Data held in offsite archive storage;
- Data held on cds/dvds, memory sticks, laptops, ipads, iphones, and all other types of mobile media;
- Structured and unstructured record systems – paper and electronic;
- Transmission of information – email, post, fax and telephone.

1.4 Failure to comply with this policy could result in disciplinary action.

2. PURPOSE

2.1 This policy outlines how the Trust will meet its legal obligations in respect of data protection particularly with reference to the Data Protection Act 2018, to the residual powers of the Access to Health Records Act 1990 and other appropriate legislation such as the Human Rights Act 1998. It is also written to encompass the General Data Protection Regulations which took effect from May 2018

2.2 All individuals at all levels within the Trust are expected to comply with this policy, including: individuals directly employed by the Trust (substantive/ permanent, fixed-term, bank/locum, etc); and individuals working within but not directly employed by the Trust (volunteers, students, agency, secondees, etc); hereafter referred to collectively as "staff".

2.3 This policy applies equally to personal information, and sensitive personal information, that may be used to provide healthcare, to inform research or to manage and administer the Trust workforce, and all other business functions of the Trust.

3. DEFINITIONS

Data Protection Legislation refers to both the General Data Protection Regulations (2016) and the Data Protection Act 2018 where the following definitions apply.

3.1 **Personal Data** means 'any information relating to an identifiable person who can be directly or indirectly identified in particular by reference to an identifier'.

3.2 **Special Category Data** consists of personal data relating to: - ethnic origin, - physical and mental health (including, for example, details of the reasons for an individual's sick leave), - sex life, - genetics - biometrics (where used for ID purposes) - religion or belief, - political opinion - Trade Union membership greater protections are required when processing this data.

3.3 **Processing** means obtaining, recording, holding or adding to the information or data or carrying out any operation or set of operations on the information or data.

3.4 **Data Subject** means an individual who is the subject of the personal data.

3.5 **Data Controller** means a person who or organisations which (either alone or jointly or in common with other persons/organisations) determines the purposes for which, and the manner in which, any personal data is processed. In this case, this means the Trust or nominated individuals acting on behalf of and with the authority of the Trust.

3.6 **Data Processor** means any person (other than a member of staff) or organisation that processes data on behalf of the Trust.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 The **Chief Executive** and the **Board** supports the seven Data Protection Principles and endorses this Data Protection Policy. The Chief Executive has overall accountability for data protection within the Trust and for ensuring that the Trust has a named and trained Data Protection Officer.

4.2 The **Senior Information Risk Owner (SIRO)** is responsible for managing information risk within the Trust and for acting as an advocate for information risk at Board level.

4.3 The **Data Protection Officer** will actively promote best practice throughout the Trust and act as the point of contact for advice and data protection queries. In addition the Data Protection Officer will also maintain the data protection registration with the Information Commissioner by ensuring that all databases that require registration are registered in accordance with the Act"s requirements and these registrations are reviewed on a regular basis.

4.4 Nominated **Information Asset Owners** are responsible for the assets that contain personal information under their control. This includes ensuring the provision of adequate access control and system security documentation, periodic risk assessments and annual reports to the SIRO.

4.5 The **Caldicott Guardian** is responsible for championing the principles of Data Protection and Confidentiality across the Trust.

4.6 **All managers** will ensure that staff understand and adhere to the principles of the Data Protection Act and associated legislation, and that annual Information Governance training is completed by all staff.

4.7 **All staff** will be expected to have knowledge of this policy and adhere to the Data Protection and Caldicott Principles. In addition, all risks or incidents involving personal information must be reported to managers.

4.8 The **Information Governance Lead** is responsible for ensuring that training modules are up to date and that the Trust has a robust Subject Access Request procedure.

5. DATA PROTECTION PRINCIPLES

5.1 The GDPR sets out the main principles (these are highlighted below in bold) for organisations when processing data. In accordance with Article 5 of the GDPR, the Trust must ensure that personal data is:

5.2 Processed lawfully, fairly and in a transparent manner in relation to the data subject ("lawfulness, fairness and transparency"). To process personal data and special category data lawfully, the Trust must identify a legal basis for each data processing activity.

5.3 An annual data mapping exercise is undertaken across the Trust which identifies all inbound and outbound flows of information and an appropriate condition under Article 6 and Article 9 is identified and documented.

5.4 General information about how we process personal data as a regulator (referred to as "fair processing information") will be available on our website through privacy notices and other public-facing material.

5.5 Fair Processing Notices are included in starter packs which staff receive when they first start with the Trust and on our public facing website for our patients.

5.6 Collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes; ("Purpose Limitation"). The Trust has clearly identified and documented the purposes for processing and included details of these purposes in our privacy information which we make available to both patients and our staff. All purposes are reviewed on an annual basis.

5.7 Adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed ("Data Minimisation"). The Trust will only collect personal data required for specified purposes and ensure information we hold is periodically reviewed and deleted when it is no longer required.

5.8 Accurate and, where necessary, kept up to date; every reasonable step must be taken to ensure that personal data that are inaccurate, having regard to the purposes for which they are processed, are erased or rectified without delay ("Accuracy"). The Trust will take reasonable steps to ensure the accuracy of personal data and will carefully consider any challenges to the accuracy of information. This will be achieved by ensuring:

- appropriate processes are in place to check the accuracy of data;
- any mistakes are clearly identified as a mistake;
- all records will identify any matters of opinion, and where appropriate whose opinion it is and any relevant changes to the underlying facts;
- any challenges to the accuracy of personal data will be carefully considered when complying with an individual's right to rectification;

5.9 Kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed ("Storage limitation"). We will ensure that personal data is not kept in an identifiable form for longer than is necessary. Because of our functions as a public authority, the Trust retains some personal data for long periods of time.

Details of all of our retention and disposal periods are set out in our Records Retention Policy.

5.10 Processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures ("Confidentiality, Integrity and Availability"). A key principle of the GDPR and DPA18 is that personal data must be processed securely by means of 'appropriate technical and organisational measures' – this is the 'security principle'. This will be achieved by ensuring:

- An information security policy is in place and implemented across the Trust.
- Additional policies and controls are in place to enforce them.
- Information security risk shall be adequately managed and risk assessments on IT systems and business processes shall be performed where appropriate.
- The requirements for confidentiality, integrity and availability for the personal data we process are understood.
- Appropriate information security controls are implemented to protect all IT facilities, technologies and services used to access, process and store the Trust information.
- Encryption and/or pseudonymisation are in place where it is appropriate to do so.
- Access to personal data can be restored in the event of any incidents, such as by establishing an appropriate backup process.
- Regular testing is conducted and reviews of the Trusts measures to ensure they remain effective, and act on the results of those tests where they highlight areas for improvement.
- Measures are implemented that adhere to an approved code of conduct or certification mechanism when necessary.
- All relevant information security requirements of the Trust shall be covered in agreements with any data processors, third-party partners or suppliers, and compliance against these is monitored.

6. ACCOUNTABILITY

6.1 The Trust is **responsible** for complying with the GDPR and DPA18 and must be able to **demonstrate** compliance by evidencing the steps taken to comply. This will be achieved by ensuring:

6.1.1 We take responsibility for complying with the GDPR, at the highest management level and throughout our organisation;

6.1.2 we keep evidence of the steps we take to comply with the GDPR;

6.1.3 Appropriate technical and organisational measures are in place, which will be achieved by;

- adopting and implementing data protection policies;

- taking a 'data protection by design and default' approach - putting appropriate data protection measures in place throughout the entire lifecycle of the processing operations;
- putting written contracts in place with organisations that process personal data on the Trusts behalf;
- maintaining documentation of processing activities;
- implementing appropriate security measures;
- recording and, where necessary, reporting personal data breaches;
- carrying out Data Protection Impact Assessments (DPIA) for uses of Personal Data that are likely to result in high risk to individuals' interests;
- appointing a data protection officer;
- adhering to relevant codes of conduct and signing up to certification schemes (where possible);
- The Trust reviews and updates its accountability measures at appropriate intervals.

7. LAWFUL BASIS FOR PROCESSING

7.1 The Trust must determine the lawful basis for processing before starting any collection of personal data. The lawful basis for processing are set out in Article 6 of the GDPR and at least one of these must apply whenever Personal Data is processed:

7.1.1 **Consent**: the individual has given clear consent to process their Personal Data for a specific purpose.

7.1.2 **Contract**: the processing is necessary for a contract with the individual, or because they have asked the Trust to take specific steps before entering into a contract.

7.1.3 **Legal obligation**: the processing is necessary to comply with the law (not including contractual obligations).

7.1.4 **Vital interests**: the processing is necessary to protect someone's life.

7.1.5 **Public task**: the processing is necessary to perform a task in the public interest or for your official functions, and the task or function has a clear basis in law.

7.1.6 **Legitimate interests**: the processing is necessary for the Trust's legitimate interests or the legitimate interests of a third party unless there is a good reason to protect the individual's personal data which overrides those legitimate interests. (This cannot apply when the Trust is processing data to perform its official tasks).

7.2 In order to process **Special Categories Data**, the Trust must also ensure that one of the following applies:

7.2.1 The data subject has given explicit consent to the processing of those personal data for one or more specified purposes;

7.2.2 Processing is necessary for the purposes of carrying out the obligations and exercising specific rights of the controller or of the data subject in the field of employment and social security and social protection;

7.2.3 Processing is necessary to protect the vital interests of the data subject or of another natural person where the data subject is physically or legally incapable of giving consent;

7.2.4 Processing relates to personal data which are manifestly made public by the data subject;

7.2.5 Processing is necessary for the establishment, exercise or defence of legal claims or whenever courts are acting in their judicial capacity;

7.2.6 Processing is necessary for reasons of substantial public interest, on the basis of EU or UK law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject;

7.2.7 Necessary for the purposes of preventative or occupational medicine, for assessing the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or management of health or social care systems and services on the basis of Union or Member State law or a contract with a health professional

7.2.8 Necessary for reasons of public interest in the area of public health, such as protecting against serious crossborder threats to health or ensuring high standards of healthcare and of medicinal products or medical devices

7.3 These conditions must be read alongside the Data Protection Act 2018, which adds more specific conditions and safeguards:

- Schedule 1 Part 1 contains specific conditions for the various employment, health and research purposes under Articles 9(2)(b), (g), (i) and (j).
- Schedule 1 Part 2 contains specific 'substantial public interest' conditions for Article 9(2)(h).

7.4 The Trust annually reviews the purposes of our processing activities, and selects and documents the most appropriate lawful basis for each activity to demonstrate compliance. This information is included in our privacy notices for both staff and patients.

8. CONSENT

8.1 Where relying on consent as the legal basis for lawful sharing of personal information, ensure the quality of consent meets new requirements and that:

- consent is active, and does not rely on silence, inactivity or pre-ticked boxes;
- consent to processing is distinguishable, clear, and is not "bundled" with other written agreements or declarations;
- data subjects are informed that they have the right to withdraw
- there are simple methods for withdrawing consent, including methods using the same medium used to obtain consent in the first place;
- separate consents are obtained for distinct processing operations; and
- consent is not relied on where there is a clear imbalance between the data subject and the controller (especially if the controller is a public authority).

9. INDIVIDUALS RIGHTS

9.1 The Trust will respect individuals' rights when processing personal data. These are enshrined in the legislation as follows:

- The right to be informed
- The right of access – see subject access requests
- The right to rectification
- The right to erasure
- The right to restrict processing
- The right to data portability
- The right to object
- Rights in relation to automated decision making and profiling.

9.2 The rights above depend upon the lawful basis for processing. For example, the right to erasure only applies where the lawful basis for processing is consent. Where public task, legitimate interests, contractual basis or a legal requirement are used as the basis for processing, the right of rectification, restriction and the right to object are also limited to ensuring that the data is accurate before it can be processed.

9.3 The right to be informed is, however, a key right and applies in all circumstances (see Transparency above).

10. DATA PROCESSORS AND CONTRACTS

10.1 Where it uses a data processor, the Trust is still responsible for data protection and liable for any data transferred.

10.2 The Trust is also liable for the Data Processor's compliance with the legislation and must only appoint processors who can provide sufficient guarantees that the requirements of the legislation will be met and the rights of data subjects protected. It must, therefore, ensure that there is an appropriate written contract with the data processor. The contract is important so that both parties understand their responsibilities and liabilities.

10.3 Contracts will set out the subject matter and duration of the processing, the nature and purpose of the processing, the type of personal data and categories of data subject, and the obligations and rights of the controller and which must, as a minimum set out the following:

- only act on the written instructions of the Trust;
- ensure that people processing the data are subject to a duty of confidence;
- take appropriate measures to ensure the security of processing;
- only engage sub-processors with the prior consent of the Trust and under a written contract;
- assist the Trust in providing subject access and allowing data subjects to exercise their rights under the GDPR;
- assist the Trust in meeting its GDPR obligations in relation to the security of processing, the notification of personal data breaches and data protection impact assessments;
- delete or return all personal data to the controller as requested at the end of the contract;

- submit to audits and inspections, provide the controller with whatever information it needs to ensure that they are both meeting their Article 28 obligations, and tell the controller immediately if it is asked to do something infringing the GDPR or other data protection law of the EU or a Member State.

10.4 The Trust will apply the approach set out in the Procurement Policy Note (PPN03/17) Changes to Data Protection Legislation & General Data Protection Regulation, published by Crown Commercial Service.

11. DOCUMENTATION

11.1 The Trust is required to maintain a record of its processing activities, covering areas such as processing purposes, data sharing and retention.

11.2 A Data mapping review of all data processing activities across the Trust will be undertaken on an annual basis coordinated by the Information Governance team. The review will identify all inbound and outbound flows of personal identifiable information from each department and clinical area, the purposes of the flow, what type of personal data is involved, who it is shared with, the lawful basis and whether an information sharing agreement has been established.

12. DATA PROTECTION BY DESIGN AND DEFAULT

12.1 The Trust will ensure that privacy and data protection issues are considered at the design phase of any new system, service, product or process and that appropriate technical and organisational measures to implement the data protection principles and safeguard individual rights are in place. This will involve but is not limited to;

- Only using Data Processors that provide sufficient guarantees of their technical and organisational measures for data protection by design.
- Anticipating risks and privacy-invasive events before they occur, and take steps to prevent harm to individuals
- Making data protection an essential component of the core functionality of our processing systems and services.

13. DATA PRIVACY IMPACT ASSESSMENT (DPIA)

13.1 The GDPR introduces a new obligation to carry out a DPIA before carrying out types of processing likely to result in high risk to individuals' interests.

13.2 The Trust will consider if a full DPIA is necessary if the processing of personal data involves:

- evaluation or scoring (including profiling and predicting)
- automated decision making
- systematic monitoring of data subjects, including in a publicly accessible area
- sensitive data (special categories of data as defined in Article 9 and data regarding criminal offences)
- data being processed on a large scale
- matched or combined datasets
- vulnerable individuals

- transferring data outside the European Union
- Innovative technological or organisational solutions
- preventing data subjects from exercising a right or using a service or a contract

An effective DPIA allows the organisation to identify and resolve any such problems at an early stage, minimising costs and reputational damage which might otherwise occur.

13.3 For further procedural detail see the Data Protection Impact Assessment Procedure document.

14. SUBJECT ACCESS REQUESTS

14.1 Section seven (7) of the Act allows an individual, or a person that the data subject has authorised, to be informed by any data controller whether person identifiable data of which that individual is the data subject are being processed by or on behalf of that data controller.

14.2 And if it is the case, to be given by the data controller a description of:

- The person identifiable data of which that individual is the data subject
- The purposes for which they are being or are to be processed and the recipients or classes of recipients to whom they are or may be disclosed
- To have communicated to him in an intelligible form, the information constituting any person identifiable data of which that individual is the data subject; and any information available to the data controller as to the sources of those data.

14.3 The Service User can obtain this information from the Trust by making a written request. This is known as a "Subject Access Request".

14.4 The Trust's approach to dealing with Subject Access Requests by service users, or members of the public, is detailed in the Subject Access Request Policy.

14.5 Staff requests should apply in writing to the Human Resources department.

14.6 All requests must be acted upon immediately as the Trust has 30 days to complete disclosure.

15. DATA PROTECTION OFFICER

15.1 The GDPR introduces a duty to appoint a Data Protection Officer (DPO) if you are a public authority or body, or if you carry out certain types of processing activities.

15.2 The Trust's DPO is Kelly Prince, Head of Information Governance who can be contacted via email:

rde-tr.dataprotectionofficer@nhs.net
Or at the following address:
Information Governance
Q Corridor
Wonford Hospital

Barrack Road
Exeter
EX2 2DW

16. PERSONAL DATA BREACHES

16.1 It is a legal obligation to notify personal data breaches of the GDPR under Article 33 within 72 hours, to the ICO, unless it is unlikely to result in a risk to the rights and freedoms of individuals. Article 34 also makes it a legal obligation to communicate the breach to those affected without undue delay when it is likely to result in a high risk to individual's rights and freedoms. It is also a contractual requirement of the standard NHS contract to notify incidents in accordance with this guidance. By notification, this may be an initial summary with very little detail known at the outset but a fuller report that might follow. There is no expectation that a full investigation will be carried out within 72 hours.

16.2 The Trusts documents all data breaches even if they don't need to be reported to the Information Commissioner.

16.3 The *'Guide to the Notification of Data Security and Protection Incidents'* must be followed when a data breach has been detected. The guidance applies to all organisations operating in the health and social care sector.

17. INTERNATIONAL TRANSFERS

17.1 Personal data, even if it would otherwise constitute fair processing, must not, unless certain exemptions apply or protective measures taken exemptions apply or protective measures taken, be disclosed or transferred outside the European Economic Area to a country or territory which does not ensure an adequate level of protection for the right and freedoms of data subjects.

17.2 In the event that any member of staff wishes to process personal information outside of the United Kingdom, the Trust Information Governance and Data Protection Officer must be consulted prior to any agreement to transfer or process information.

17.3 All information flows are mapped and reviewed periodically to identify any overseas transfers.

18. DATA SECURITY AWARENESS TRAINING

18.1 The Trust will provide appropriate training and awareness programmes to ensure staff are aware of their responsibilities for data protection, confidentiality and information security via NHS Digital's mandated training requirements.

18.2 All staff are required to complete and pass the data security and protection training module allocated to them, and the annual refresher module as a minimum.

18.3 Additional specialist training is compulsory for staff in specialist roles, such as the Caldicott Guardian, Senior Information Risk Owner (SIRO), information governance staff, health & social care records staff, information asset owners and administrators.

19. ANONYMISATION / DE-IDENTIFICATION

19.1 Secondary use business processes should be initially documented and then reviewed regularly to assess any requirement to use de-identified data. Following assessment any processes that require de-identified data must be modified in line with this policy.

19.2 All onward disclosure should be limited to pseudonymised or anonymised/de-Identified data.

19.3 Staff only have access to the data that is necessary for the completion of the business activity which they are involved in. This is reflected in Caldicott Principles; access should be on a need to know basis. This principle applies to the use of PID for secondary or non-direct care purposes. By de-identification users are able to make use of patient level clinical data for a range of secondary purposes without having to access the identifiable data items.

19.4 The aim of de-identification is to obscure the identifiable data items within the persons records sufficiently that the risk of potential identification of the subject or a person's record is minimised to acceptable levels, this will provide effective anonymisation. Although the risk of identification cannot be fully removed this can be minimised with the use of multiple pseudonyms.

19.5 De-identified data should still be used within a secure environment with staff access on a need to know basis.

19.6 De-identification can be achieved by:

- Removing direct patient identifiers;
- The use of identifier ranges, for example; value ranges instead of age;
- By using a pseudonym.
- If patient data is required the NHS Number is the most secure form of identifiable data. The NHS Number should be included within all patient records and documentation in line with the current Connecting for Health NHS Number Campaign.

19.7 Pseudonymisation

19.7.1 When pseudonymisation techniques are consistently applied, the same pseudonym is provided for individual patients across different data sets and over time. This allows the linking of data sets and other information which is not available if the PID is removed completely.

19.7.2 To effectively pseudonymise data the following actions must be taken:

- Each identifying field of PID must have a unique pseudonym;
- Pseudonyms to be used in place of NHS Numbers and other fields must be of the same length and formatted on output to ensure readability. For example, in order to replace NHS Numbers in existing report formats, then the output pseudonym should generally be of the same field length, but not of the same characters; i.e. 5L7 TWX 619Z. Letters should be used within the pseudonym for an NHS number to avoid confusion with original NHS numbers;
- Consideration needs to be given to the impact on existing systems both in terms of the maintenance of internal values and the formatting of reports;

- Where used pseudonyms for external use must be generated to give different pseudonym values in order that internal pseudonyms are not compromised;
- The secondary use output must, where pseudonyms used, only display the pseudonymised data items that are required. This is in accordance with the Caldicott Guidelines;
- Pseudonymised data should have the same security as PID.

20. MONITORING

The Information Governance Manager is responsible for monitoring compliance with this policy and ensuring its effectiveness. This will be achieved by an annual review of all inbound and outbound data transfers across the Trust. Each data flow will be documented and risk assessed to ensure appropriate safeguards have been implemented to protect information.

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards.

All organisations that have access to NHS patient data and systems must use this toolkit to provide assurance that they are practising good security and that personal information is handled correctly.

21. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

22. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

22.1 To evidence compliance with this policy, the following elements will be monitored:

What areas need to be monitored?	How will this be evidenced?	Where will this be reported and by whom?
Compliance with relevant Data Protection Legislation	KPI's	Information Governance Steering Group
Data Security and Protection Toolkit	Data Security and Protection Toolkit action plan and Internal Audit Report	Information Governance Steering Group
Monitoring of Data Security Incidents and assurance of action	Incident Reports	Information Security Forum and Information Governance Steering Group

Identification and management of Information Governance risks	Risk Register and Actions	IM&T Divisional Group and Information Governance Steering Group
Maintenance of Documents by Information Asset Owners	System Level Security Policies, Risk assessments and Business Continuity Plans	Divisional Groups and Information Governance Steering group

23. REFERENCES

Crown Commercial Service – Action PPN 03/17
Procurement Policy Note – Changes to Data Protection Legislation & General Data Protection Regulation

Data Protection & Security Toolkit
https://uat.igt.hscic.gov.uk/CCA/

The Cyber Essential Scheme
https://www.cyberessentials.ncsc.gov.uk/

APPENDIX 1: TOP TIPS
KEEPING PERSONAL DATA SECURE

DO

✔ Maintain confidentiality at all times and keep personal information secure

✔ Always keep personal identifiable information accurate and up to date

✔ Be aware of the Trust's Senior Information Risk Owner (Adrian Harris) and Caldicott Guardian

(John Rennison)

✔ Always lock your computer when leaving your desk

✔ Ensure you are familiar with Trust Information Governance Policies (these can be found on HUB)

✔ Always dispose of handover sheets in the appropriate confidential waste bins

✔ Ensure that personal data is sent and received safely and securely

✔ Ensure that you are up to date with your mandatory Information Governance Training

✔ Only store personal information on encrypted media such as a memory stick

✔ Only access information about individuals where you have a justified work-related reason to do so

DON'T

✘ Share your passwords or smartcards with anyone

✘ Take confidential information outside of the Trust unless absolutely necessary

✘ Discuss patient or staff details outside of the work environment e.g. Park and Ride/Oasis

✘ Disclose personal information without appropriate consent from the individual

✘ Send sensitive information without the appropriate security measures

✘ Keep personal information on your desk in a public area

✘ Disclose more information than is necessary

✘ Share personal data without going through the necessary Information Governance process

APPENDIX 2: COMMUNICATION PLAN

Royal Devon and Exeter NHS
NHS Foundation Trust

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the policy	All staff that may acquire or commission information systems
The key changes if a revised policy	Reviewed and amended to include the new Data Protection Act 2018/GDPR and the new updated forms. New Policy
The key objectives	To ensure personal identifiable information is processed according to the relevant privacy legislation and regulation.
How new staff will be made aware of the policy and manager action	Notification on HUB, cascade by email from manager, induction process
Specific Issues to be raised with staff	This applies to all new information systems, whether electronic or paper based.
Training available to staff	On an individual basis available from the Information Governance Team.
Any other requirements	None
Issues following Equality Impact Assessment (if any)	No negative impacts.
Location of hard / electronic copy of the document etc.	Department shared drive (Information Governance). The original of this standard operating procedure will remain with the Head of Information Governance in the Health Records Department of the Information Governance Department, IMT services, Medical Directorate. An electronic copy will be maintained on the Trust intranet (Hub), Archived copies will be stored on the Trust's “archived policies” shared drive and will be held indefinitely,

APPENDIX 3: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Data Protection Policy
Division/Directorate and service area	Information Governance, IM&T
Name, job title and contact details of person completing the assessment	[redacted] Head of Information Governance
Date completed:	05/02/2019
The purpose of this tool is to: • **Identify** the equality issues related to a policy, procedure or strategy • **Summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit • **Highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.	

1. What is the main purpose of this document?

This document sets out the appropriate actions and procedures, which must be followed to comply with the Data Protection Act and other associated requirements in respect of data protection impact assessments by the Royal Devon and Exeter NHS Foundation Trust.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☐ Staff ☒ Patients x☐ Other (please specify) ☐

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	☐	☒
Disability	☒	☐
Sex - including: Transgender, and Pregnancy / Maternity	☐	☒
Race	☐	☒
Religion / belief	☐	☒

Sexual orientation – including: Marriage / Civil Partnership	☐	☒

4. **Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to** *(e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)*?

None

☒

5. **Do you think the document meets our human rights obligations?**
Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
• ***Fairness*** *– how have you made sure it treat everyone justly?* • ***Respect*** *– how have you made sure it respects everyone as a person?* • ***Equality*** *– how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity*** *– have you made sure it treats everyone with dignity?* • ***Autonomy*** *– Does it enable people to make decisions for themselves?*

6. **Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?**

7. **If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact** please note this below and how this will be monitored/addressed.

"Protected characteristic":	Not applicable
Issue:	Not applicable
How is this going to be monitored/ addressed in the future:	Not applicable
Group that will be responsible for ensuring this carried out:	Not applicable