Freedom of Information Request

Reference Number:  EPUT.FOI.18.781
Date Received:  Legal Team

Information Requested:

1. Are Service Users or the general public allowed to audio-visually record meeting and calls with your staff?

   Please note: all answers given are quotes from EPUT Use of Mobile Phones Policy CP54 and Procedure CP54

   **Procedure CP54**

   **6.1 Overt patient recordings**
   Although we cannot place restrictions on a patient wishing to record notes of a consultation or conversation with a health professional, where it is felt absolutely necessary by the patient to do so, staff should ensure that:

   - Any recording is done openly and honestly.
   - The recording process itself does not interfere with the consultation process or the treatment or care being administered.
   - The patient understands that a note will be made in their health record stating that they have recorded the consultation or care being provided.
   - The patient is reminded of the private and confidential nature of the recording and that it is their responsibility to keep it safe and secure.
   - Any recording is only made for personal use.

2. If so, do they require permission or are they permitted to do so covertly?

   **Procedure CP54**

   **6.2 Covert patient recordings**
   Although we cannot place restrictions on a patient wishing to covertly record a consultation or conversation with a health professional, where staff are aware that covert recording has occurred they should ensure that:

   - The issue is discussed with the patient as per 6.1 above.
   - Relevant staff should consider providing patients with a written record summary, and or a verbatim record (if practical) of their consultation for their own personal use
   - Patients are advised that they are entitled to see their notes, if they so wish, by informally asking the healthcare professional in charge of the consultation, or to request a paper copy of their medical notes formally through a Subject Access Request (SAR) made under the Data Protection Act 2018
   - Patients are given information on how they can complain if they have an issue with their treatment and care, and their attention is drawn to the relevant guidance from the Care Quality Commission (see below) and Information Commissioner’s Office.
3. Do you have any guidance or policy for the public or service users to record calls when they speak to your staff?

Procedure CPG54
3.2.6 Patients and Visitors will be made aware of the Trust procedures concerning the use of mobile phones within the patient areas through information leaflets and local posters.

4.1.1 Secure services have their own mobile phone operational protocols therefore staff, patients and visitors in these services must refer to Use of Mobile Telephone within Secure Services Protocols SSOP35 and SSOP40 which are on intranet.

4. What is your organisation's protocol on service users recording calls when they speak to your staff? Please provide a copy of your policy, procedure and guideline notes on this issue.

Procedure CPG54
1.1 Mobile phones may have extended functions which include camera, audio and video recording capability, music players, email and internet functions. There is a potential for patients and visitors to use this functionality to take inappropriate photographs, videos or recordings that present potential to interfere with patient dignity and privacy.

1.2 NHS Protect has produced the good practice advice in their “Patients Recording NHS staff in Health and Social Care Settings” May 2016 document for use in health and social care settings. The document provides clarification to NHS clinical and non-clinical staff working within health and social care settings on dealing with situations where patients might record their treatment and care. This advice covers both covert and overt recording of consultations. However, it predominantly concerns overt recording as the patient will generally ask NHS staff for permission for recording to take place.

Procedure CPG54
6.2 Covert patient recordings
Although we cannot place restrictions on a patient wishing to covertly record a consultation or conversation with a health professional, where staff are aware that covert recording has occurred they should ensure that:
• The issue is discussed with the patient as per 6.1 above.
• Relevant staff should consider providing patients with a written record summary, and or a verbatim record (if practical) of their consultation for their own personal use.

5. Call centres - do you inform users they can record? If the answer is no what is the reason for this please? If yes, do send me a copy.

All calls into the contact centre are recorded for monitoring and training purposes, Callers are informed that calls are recorded. We do not as standard practice advise our callers that they can record the message.

6. Are service users made aware of their right to record the encounter, if they choose to do so? Is this reflected in your policy document on the matter?

Procedure CPG54
6.2 Covert patient recordings
Patients are advised that they are entitled to see their notes, if they so wish, by informally asking the healthcare professional in charge of the consultation, or to request a paper copy of their medical notes formally through a Subject Access Request (SAR) made under the Data Protection Act 2018

Patients are given information on how they can complain if they have an issue with their treatment and care, and their attention is drawn to the relevant guidance from the Care Quality Commission (see below) and Information Commissioner’s Office.

7. Does your organisation have an “Unacceptable Behaviour” policy? If so, please can you provide me with a copy?
   Please see attached

8. If such a policy contains points of objectionable behaviour such as telephones calls being recorded by the caller due to them being not necessary or unwanted or needed and furthermore the staff members may feel threatened or apprehensive, are you aware that denying users the right to record calls goes against the current UK laws.

   Policy CP22
   3.3 Antisocial and nuisance behaviour
   Among others, examples of antisocial and nuisance behaviour included are:
   • Obscene/nuisance/offensive telephone calls, texts, fax or email messages
   • Taking photos/videos or making sound recordings without permission

9. Are your policies and procedures compliant with the public right to audio-visually record encounters with your staff, without their consent? If not, will you provide appropriate training for your staff so they are fully informed of the Public right to record?

   Policy CP54
   4.1 Patient Privacy and Dignity
   Cameras and voice recording facilities should not be used in any way that could cause harm or offence to an individual (member of staff or client) or bring the Trust into disrepute.
   Under no circumstances should photos or voice recordings be taken without the prior consent of those involved. Such misuse may be subject to the Trust’s disciplinary procedures and could also be subject to civil and criminal proceedings.

   2.3 The use of camera phones within patient areas or patient’s own home risks infringing patient confidentiality. Given the difficulty in detecting usage, the consent for taking photographs on a mobile phone of either patients or their confidential information is prohibited. The only exception to this is for staff where a job role or function demands this use for example in community health services staff take wound photographs for monitoring healing.

   3.1 All staff are responsible for adhering to this policy and associated procedural guidelines and for reporting any breaches on Datix reporting incident system.

10. What is your organisations current charging policy for Freedom of Information requests (FOI) or Subject Access Requests (SAR)? If charges are applied are concessions available for those on low income or students?
   The Trust adheres to guidance set the ICO:


11. What is your organisations complaints policy? Please can you forward me a copy. Does your complaints procedure permit service users evidence such as covert call recordings to form part of the investigation.
The complaints policy and procedure is on our Trust website https://eput.nhs.uk/contact-us/complaints/

At present the Trust does not permit service users covert call recordings to form part of a complaints investigation. However, this is being considered in our review of the current complaints policy.
# COMPLAINTS PROCEDURAL GUIDELINES

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## PROCEDURE SUMMARY

The purpose of this procedural document is to ensure that complaints about services provided by the Trust are dealt with in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and in a speedy and efficient manner, that is open, accessible, fair, flexible, conciliatory and without blame.

The Trust monitors the implementation of and compliance with this procedure in the following ways:

- Executive Directors/Service Directors receive weekly open complaints situation report, and fortnightly complaints overview identifying any areas of concern.

- Regular assurance and exception reports to the Clinical Commissioning Groups (CCG’s) and Quality Meetings. Quarterly Thematic Report and quarterly lessons learned update.

- Internal audits to monitor and check key areas of complaints process. Non-Executive Directors (NEDs) review and monitor complaints monthly as an independent quality assurance check.
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The Director responsible for monitoring and reviewing this policy is
Executive Director of Corporate Governance & Strategy
COMPLAINTS PROCEDURE – CPG2

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

COMPLAINTS PROCEDURAL GUIDELINES

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST
COMPLAINTS PROCEDURAL GUIDELINES

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APPENDIX 4 – PALS OPERATIONAL PROCEDURES

APPENDIX 5 – PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN’S PRINCIPLE FOR REMEDY
The purpose of this procedural document is to ensure that complaints about services provided by the Trust are dealt with in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and in a speedy and efficient manner, that is open, accessible, fair, flexible, conciliatory and without blame. This Policy ensures the Trust incorporates into our practice the Risk Management Standards (NHSLA), CQC Registration Requirements, Making Experiences Count (DH, June 2007), NHS Constitution (2009) and Principles of Good Complaint Handling (Parliamentary and Health Service Ombudsman 2009).

1.0 INTRODUCTION

1.1 A complaint is an oral or written expression of dissatisfaction about any matter reasonably connected with services supplied by this Trust. This includes NHS services and Local Authority services delegated to the Trust under its partnership agreements.

The Trust proactively seeks feedback from our patients/residents and their families/carers in the following ways;

- A complaint may be made orally or in writing (including email and through the Trust website). The Trust website provides contact details of the Complaints and Patient Experience Teams.

- Every public area within the Trust will display posters and information leaflets that inform patients/residents, carers and visitors about the Trust’s complaints procedure.

- This procedure should be read in conjunction with the Complaints Policy.

1.2 The aim of the Trust’s Complaints Policy and Procedural Guidelines is to encourage communication on all sides to resolve the complaint satisfactorily, and for the Trust to learn from complaints. The Trust will proactively consider and manage all complaints raised by patients/residents or their families/carers. The Complaints Procedure will attempt to involve the complainant from the outset and determine what they are hoping to achieve from the process. The complainant should be given the opportunity to understand all possible options for pursuing the complaint and what these options mean.
1.3  This procedure sets out how issues are to be handled in an appropriate and proportionate manner. The Trust recognises that there are times when the complainant is satisfied with the outcome but there is still a need for the Trust to further investigate a matter. Some complainants will ask for a very thorough investigation of their issues, the Trust will determine what a proportionate response to the matter, including any investigation, actually is.

1.4  Council of Governors and members of the Foundation Trust do not have any role in the complaints procedure. Governors and members however should refer, or ask the Trust Secretary to refer, any complaints that they receive to the Complaints Department or the Patient Advice and Liaison Service (Appendix 5).

1.5  “Working days” will in this procedure mean Mondays to Fridays, excluding Bank Holidays.

1.6  Inadequate complaints handling can itself be grounds for complaint.

1.7  The rules about patient/resident confidentiality must be adhered to throughout this procedure and consent from complainants (and any patient/resident where the complainant is not the patient or resident) sought when required. Consent will be valid for a period of 6 months, when this has expired; the Trust will require further written consent. If the patient/resident does not have capacity other alternatives of consent will be sought.

1.8  Complaints records will be kept separately from health records. Subject to the need to record information which is strictly relevant to the patient’s/residents health, no references to the complaint shall be made in the health records.

1.9  Under the NHS Constitution (2013) all patients/residents and their families have the right to have any complaint they make about the NHS dealt with efficiently and for it to be properly investigated. They also have the right to be kept informed of progress and to know the outcome of any investigation undertaken. In the event of a member of staff being investigated through the Conduct and Capability policy as a result of a complaint, the Trust has a duty of confidentiality to the employee not to disclose this to the complainant.

1.10  Complaints will be handled in the strictest confidence in accordance with the NHS Confidentiality Policy. Care will be taken that information is only disclosed to those who have a demonstrable need to have access.

1.11  Anyone disclosing information to others who are not directly involved in the complaint will be dealt with under conduct procedures.

1.12  Any complaints against a person working with children must reflect the Safeguarding Children Procedures CLPG37 and the appendix on Safer Working Practices with children and Managing Allegations. In such cases the Head of Safeguarding Team should be contacted to discuss the complaint and a decision
made to report to the Local Authority Designated Officer (LADO) as per national guidance, Working Together to Safeguard Children 2015.

2.0 WHAT IS A COMPLAINT? WHO CAN COMPLAIN AND HOW TO COMPLAIN?

2.1 Complainants will generally be existing or former patients/residents of the Trust’s services, or people who are affected by the action, omission or decision of the Trust. A patient/resident must give their written consent for someone to act on their behalf.

2.2 A complaint may be made by a person (in regulations referred to as a representative acting on behalf of a person, but not acting on behalf of themselves without the complainant’s knowledge) who has:

- Requested a representative to act on their behalf.
- Delegated authority to do so, for example in the form of Power of Attorney.
- Is an MP acting on behalf of and by instruction from a constituent.
- Has died;
- Is a child;
- Is unable to make the complaint themselves because of
  (i) Physical incapacity; or
  (ii) Lack of capacity within the meaning of the Mental Capacity Act 2005.

2.3 Where a representative makes a complaint on behalf of a child, the Trust will consider the complaint, if it is satisfied that there are reasonable grounds for the complaint being made by a representative instead of the child; and if it is not satisfied, must notify the representative in writing, and state the reason for its decision. The Trust must be satisfied that the representative is conducting the complaint in the best interests of the child on whose behalf the complaint is made.

2.4 Where a representative makes a complaint on behalf of a person who lacks capacity within the meaning of the Mental Capacity Act 2005. The Trust must be satisfied that the representative is conducting the complaint in the best interests of the person on whose behalf the complaint is made. If it is not satisfied the complaint must not be considered and the Trust must notify the representative in writing, and state the reason for its decision.

2.5 Carers have a right to complain about issues that affect them in their role as carers. Where it is necessary to share information which relates to a patient’s care, the patient’s consent will be sought in writing.

2.6 Persons wishing to make a complaint can contact the Complaints Team at epunft.complaints@nhs.net or by telephone on 01268 407817 or by writing to the Chief Executive. Leaflets are available at all Trust sites and details on the Trust website: www.eput.nhs.uk Details are attached as Appendix 2.
3.0 TIME LIMITS FOR MAKING A COMPLAINT

3.1 A complaint should be made as soon as possible after the action giving rise to it, to enable a full investigation whilst all the facts regarding the complaint are still readily available. The time limit for making a complaint is within 12 months of the event.

3.2 There is discretion to extend this time limit where it would be unreasonable in the circumstances of a particular case for the complaint to have been made earlier. Therefore, all complaints made outside of the above time limits will be referred to the Head of Complaints for guidance. The time limit in paragraph 3.1 (above) will not apply if the Trust is satisfied that the complainant had good reasons for not making the complaint within that time limit; and despite the delay, it is still possible to investigate the complaint effectively and fairly.

3.3 In any case where the Head of Complaints has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Parliamentary and Health Service Ombudsman (PHSO) to consider it.

4.0 ROLES AND RESPONSIBILITIES

4.1 All Trust staff are expected to:

- Take any concerns raised by a patient/resident or their family/carer seriously, to act compassionately, listen and to view it as an opportunity to learn and improve the services provided for current and future patients.

- Make every effort to resolve concerns and complaints when they are raised within their ward/work area and know who to escalate the issue to if they are unable to resolve the concerns personally.

- Follow the Trust’s Complaints Policy and Procedure and know where and how to find the information about the Patient Experience and Complaints Teams for patients/residents and relatives should they request it.

- Forward any written complaints received immediately to the Complaints Team for action.

- Assure complainants that the Trust will not recriminate or discriminate against any person who makes a complaint.
4.2 Chief Executive

- Is the accountable and responsible person who will ensure that the Trust’s complaints handling processes comply with the National Regulations.

- Will ensure that no patient/resident is discriminated against or their care adversely affected following a complaint.

- Will personally respond to all formal complaints, if, for any reason this is not possible, an Executive Director will have delegated responsibility.

- Will ensure that a customer service culture that always puts the patient/residents first is actively promoted.

4.3 Executive Director of Corporate Governance

- Has overarching responsibility for the complaints process.

- Is a designated signatory for the Chief Executive.

4.4 Executive Directors/Service Directors

- Appoints an investigator.

- Agrees if a complaint meets complex criteria.

- Approves extension timescales.

- Reviews and amends as appropriate draft complaint responses

- Approves complaints Investigation Report and identified lessons learned.

- Ensures the lessons learned are embedded in their relevant service area and arrange local events for their services to learn from complaints.

4.5 Non-Executive Directors

- The Non-Executive Directors (NEDs) of the Trust will review and monitor four complaints monthly; these will be selected randomly from the list of closed complaints during the relevant period and will consist of two Mental Health and two Community Health Service complaints.

- The NEDs will refer to the Investigation Report and the response letter and consider if the complaint was investigated robustly, the quality and openness of the response, reflect the Trust’s customer service standards and the likely satisfaction of the complainant with the response.
- The NEDs will also satisfy themselves that deadlines were adhered to and any learning is identified. They can make further suggestions for learning for the Trust if appropriate.

- These reviews shall be sent to the Chair for sign off and a copy will be kept in the complainant’s file.

- If the Non-Executive Director believes the case was deficient in identified ways, they will discuss their findings with the relevant Director.

4.6 Investigating Officers – Clinical and Non Clinical

Department of Health guidance on investigating complaints can be found on the Trust’s intranet under the Executive Director of Corporate Governance/Complaints.

The Complainant can request that their complaint is investigated by someone from a different Service/Directorate if appropriate.

Investigating Officers;

- Will be appointed by the Executive Director/Service Director.

- Are responsible for contacting the complainant immediately to introduce themselves either by telephone or letter to:
  - Clarify their issues
  - Identify the outcome the complainant is seeking
  - Agree a Complaints Handling Plan
  - Extend the timescale if the complaint meets the identified complex complaint criteria, or other appropriate reasons, as approved by the Executive Director.

- Are responsible for keeping the complainant informed as reasonably practicable, as to the progress of the investigation and the reasons for any delay. Any required extension to the timescale should be approved by the Executive Director and should be discussed with the complainant. Such agreement can be indicated in a telephone call.

- Will conduct a thorough investigation in a timely manner into all concerns raised by the complainant through examination of relevant documentation, and by conducting staff interviews, whilst ensuring that the investigation is conducted in a manner that is supportive to those involved and takes place in a blame free atmosphere.

- Will base their decisions on available facts and evidence, acting fairly and objectively.
• Will complete the Complaints Investigation Report, including identified lessons learned.

• Will draft a written response, ensuring PHSO’s principles are reflected and send to the relevant Director with the completed Investigation Report for approval. Once this is approved by the Director, the draft response and the Investigation Report, together with documented lessons learned and accompanying statements, records etc., should be sent to the Complaints Team Mailbox (epunft.complaints@nhs.net). All records relating to the investigation may be required by the Non-Executive Directors when they review a complaint and by the Ombudsman at later stages of the complaints procedure.

4.7 Complaints Team Roles

• **Head of Complaints and Customer Service** will act as the Trust’s Senior Manager and lead for the management and handling of complaints.

• This post will oversee the complaints team and:

  • Ensure any learning from complaints is triangulated with all other forms of patient/resident feedback, through the Lessons Learned Group, to ensure it informs on-going work to improve the patient/resident experience.

  • Provide complaint and compliment data for the monthly quality report and include information on lessons learned on a quarterly basis.

  • Provide a quarterly Thematic Report, highlighting any trends and emerging themes, to the Integrated Governance and Quality Steering Committee.

  • Will ensure the complaints annual report is published on the Trust website and a copy sent to the appropriate Clinical Commissioning Groups, which arrange for the provision of the services by the Trust.

  • Is responsible for ensuring that regular assurance reports are developed which will include aggregated information about complaints, qualitative and quantitative analysis of information, action plans to deal with the management of risks identified and information about lessons learnt and compliments received by the Trust. These reports will be presented as required by;
    - Department of Health (annually)
    - Trust Board
    - Trust Executive Team
    - Clinical Commissioning Groups (CCGs)
    - Integrated Quality and Governance Steering Committee
    - Performance and Finance Scrutiny Committee
4.8 Complaints Manager

- Reports to Head of Complaints.
- Will have day to day responsibility for handling complaints.
- Will ensure that best practice is followed by staff in the handling and management of complaints and provide support and help with the complaints procedures.
- Will manage all Ombudsman’s reviews and requests as well as concerns raised by Parliamentary MPs.
- Will be the first point of contact for any Clinical Commissioning Group (CCG) to liaise with on any issues about the Trust that complainants choose to take to the CCG.
- Will be responsible for liaising with other NHS and Social Care Organisations about who takes the lead when a complaint covers more than one organisation.
- Ensure all complaints are documented on the Datix system.
- With the agreement of the complainant, the Complaints Manager or the Investigating Officer will make arrangements for conciliation, mediation or other assistance for the purpose of resolving the complaint. The Trust will ensure that appropriate conciliation and mediation services are available.
- Will stop the formal complaints process if a complainant decides to withdraw their complaint. The complainant’s request will be acknowledged by the Complaints Manager, who will consider with the relevant Director whether to continue with the investigation for the Trust’s purposes of identifying if there are lessons to be learned.
- Will ensure that the complainant is kept informed in writing of any decision to discontinue or put on hold a complaint investigation stating the reason for the decision.
5.0 COMPLAINTS HANDLING PROCESS

5.1 Local Resolution

- A complaint can be made orally or in writing to any member of Trust staff (any complaints received in writing must be passed to the Complaints Team). The Trust expects all staff to attempt to resolve issues on the front line speedily and effectively and to the complainant’s satisfaction. This is a fundamental requirement of the Trust’s customer service standards.

- If a patient/resident, relative or visitor approaches a member of staff with a concern, the staff member is expected to resolve this immediately with the assistance of a more senior member of staff when necessary. They should ensure that they obtain appropriate consent from the patient/resident, where possible. The most satisfactory outcome to complaints often comes when complaints are dealt with fully and effectively within the service. The details of the concern and the outcome should be documented on the Complaint Monitoring Form located on the Trust intranet, under Forms on the home page and sent to the Patient Experience Team.

- Reassurance should be given to the complainant that their concern is being taken seriously, that it will be dealt with confidentially and will not in any way adversely affect their or their relative’s treatment.

- If front line staff cannot resolve a concern within 24 hours they should advise the complainant of the role of the PALS team who may be able to assist in the first instance, a copy of the Complaints, Comments, Compliments and Concerns leaflet should be provided to ensure they have the relevant contact numbers and options to take their concern forward.

- The first responsibility of the recipient of a complaint is to ensure that the patient/s/residents immediate healthcare needs are being met. This may require urgent action before any matters relating to the complaint are tackled.

- Where the issue raised is about a member of staff, another member of staff should be appointed by the local manager to seek to resolve the matter speedily. The complainant should be approached in a non-defensive manner to ascertain their concerns. Complainants will be listened to and treated courteously with dignity and respect.

- The complainant can have a friend, advocate or representative present in any meetings with staff (and staff should record if this is offered and/or declined). If appropriate, the staff member should respond with an apology, explanation of the circumstances that gave rise to the complaint, and provide a suitable explanation/remedy if possible.
A summary of the Local Resolution meeting will be sent to the Patient Experience Team outlining any action that will be taken in response to the complaint: in order to prevent the same thing happening again.

5.2 Formal Complaints  (Low/Medium risk)

- When a complaint is received by the Complaints Department a decision will be made as to whether it can be dealt with by the Patient Experience Team, locally (local resolution) or formally (complaint). If the complainant specifically asks for it to be formally investigated this will be respected and acted upon accordingly.

- Where a complaint is made orally, the Complaints Team must make a written record of the complaint which includes the name of the complainant, the subject matter of the complaint and the date on which it was made with a copy of the record sent to the complainant with the acknowledgement letter, inviting the complainant to check for accuracy, then sign and return it.

- Oral complaints can also be received by the Patient Experience Team who will escalate to the Complaints Team as appropriate.

- All complaints received by the Complaints Team will be risk rated according to a system based on consequences. The purpose of this risk rating is to decide what level of intervention is appropriate to the risk to patients/other patients, residents or other residents and the Trust (e.g. where there is media interest, and to decide if any immediate remedial action is needed).

- All formal complaints will be acknowledged within 3 working days of the date on which the complaint was received in the Complaints Department.

- The acknowledgement letter advises the complainant of independent Advocacy Services and encloses an ethnicity form and information of the complaints process. The appointed Investigating Officer will make contact with the complainant immediately either by telephone or letter to:
  - Clarify their issues
  - Identify the outcome the complainant is seeking
  - Agree a Complaints Handling Plan
  - Extend the timescale if the complaint meets the identified complex complaint criteria or more time is needed to complete the investigation.

- Complaints should be reviewed by the relevant Service Manager to consider if there is a safeguarding concern so as to comply with guidance. (Clinical Governance and Adult Safeguarding - An Integrated Process (DoH February 2010).

- Complainants can request or be offered a meeting at any point during the complaints process.
• Where staff, have been mentioned in a complaint, the acknowledgement letter will advise complainants that the details/summary of their complaint will be shared with the staff involved in order for internal investigation to take place. The complainant will be given the opportunity to “opt out” of their complaint if they do not want their information shared.

• Confidentiality will be maintained in such a way that only managers and staff who are leading the investigation know the content of the complaint. Anyone disclosing information to others who are not directly involved in the complaint should be dealt with under disciplinary procedures.

• Putting things right is about the remedy offered. Remedies include:
  • apologies
  • explanations
  • changes to prevent a recurrence (and will consider if the complainant can be involved in some way)
  • financial remedies where they are justified and appropriate
  • all payments shall be in line with the procedure in Appendix 3.

• Financial remedies can involve:
  • financial recompense for direct or indirect financial loss, loss of opportunity, inconvenience, distress, or any combination of these.
  • time and trouble payments. (Please see the NHS Finance Manual and the Local Government Ombudsman’s good practice guide on remedies).
  • returning complainants who have suffered injustice or hardship as a result of maladministration or poor service, to the position they were in before this took place. If that is not possible, it means compensating complainants appropriately.
  • Appendix 2, Guidance for the payment of financial remedy, sets out the procedure to be followed when a financial payment is considered to be a remedy.

5.3 Formal Complaints (Major and Catastrophic Risk)

• “Major risk” and “Catastrophic Risk” means a more thorough investigation and response is needed and an independent investigation of the issues is required. Where the complaint is rated “major (or catastrophic) risk” a full investigation into the concerns raised will be instigated by the Director of the service concerned. It is imperative that a record of the investigation, including statements made by witnesses, is made. This is important as any independent review will consider how robust the process was. The Director will appoint the Investigator and will decide on issues of independence from the area complained about, and whether any other arrangements will be made, according to the circumstances of the case, so that issues are investigated thoroughly and independently.
For major (and catastrophic) risk rated complaints, the Director of the service will delegate responsibility for carrying out an investigation to a member of their team or an external investigator (the Investigating Officer), but will be responsible for drafting a full and detailed response to the issues raised, based on the Investigation Report, and on behalf of the Chief Executive. Investigators will produce an Investigation Report and present this to the Director. The Investigator will seek clinical help if appropriate, and extend the response timescale, if required. They will also decide if the complaint is upheld or not.

The Director will approve the investigation’s conclusions and also decide if the matter should be further reviewed by another independent person about the conclusions reached and whether they are in line with a reasonable interpretation of policy and good clinical practice. This should be recorded in the Complaints Investigation Report.

The Investigation Report (and relevant statements, records, and notes etc.) must accompany the response letter prepared by the Director to the Complaints Manager, who will maintain a record of complaints handling. Investigating officers should make a written record of all interviews to ensure that information is relayed correctly. These records may be required by the Ombudsman at later stages of the complaints procedure.

5.4 Complaint Response Letter/Complaints Investigation Report

Investigators will draft a response letter and send (together with the Complaints Investigation Report and supporting documentation) to their Director at least a week before the due date, for quality checking. The Director should complete the check within 48 hours so as not to delay the sign off process.

The response letter should;
• Summarise the nature and substance of the complaint
• Be comprehensive, fair and timely and not proportion blame.
• Contain language that is easy to understand and avoiding jargon and acronyms (as per the Trust’s Customer Service standards).
• Reflect the Ombudsman’s principles
• Answer all of the points raised as they appear, putting in numerical order if appropriate.
• Aim to satisfy the complainant that their complaint has been fully and fairly investigated.
• Acknowledge mistakes and offer apologies where appropriate.
• Advise of any lessons learned from the complaint and identify any recommendations/changes to current practice or policy
5.5 When the draft response has been approved by the relevant Director it should be sent (password protected), to the Complaints Manager who will carry out a check to ensure that all issues identified within the original complaint have been responded to, and that adequate records of the investigation are evident with lessons for the Trust identified. The letter will then be sent to the Chief Executive (or delegated person) for signing.

5.6 The final response letter must notify the complainant of their right to refer the complaint for Independent Review by the Ombudsman and also advise what they can do if they disagree with the response received or would like further explanation.

5.7 All correspondence relating to complaints shall be in 12 point, Arial type-size, shall be sent by first class post and marked “Private and Confidential” and/or “Personal”.

5.8 In line with Department of Health guidelines, the Complaints Team will send a questionnaire approximately six weeks after the response has been received, to ask whether the complainant was satisfied with the outcome of the investigation and the way the matter was handled.

6.0 ACTION PLANNING AND LEARNING LESSONS FROM COMPLAINTS

- The Trust is determined to learn from complaints as part of good customer service and as a means of helping to improve Trust services.

- Following the investigation of all concerns/complaints raised, identified lessons learned will be recorded in the Complaints Investigation Report.

- Executive Directors/Service Directors will provide the Complaints Team with completed action plans of lessons learned from complaints, including supporting evidence as appropriate, and ensure lessons learned are embedded in their relevant service area.

- Executive Directors will also arrange local events for their services to share learning from complaints.

- The Complaints Team will use the service action plans provided in Trust reporting mechanisms.

- The Complaints Team will share lessons learned with all staff in the Trust via the Trust Intranet.

- Lessons learned will also be published in the Complaints Annual Report.
7.0 INDEPENDENT REVIEW (PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN)

Complainants may refer their case to the Parliamentary and Health Service Ombudsman for review where:

- The complainant is not satisfied with the result of the Trust’s investigation
- The complaint has not been resolved within six months (or such longer period as may be agreed before the expiry of that period with the complainant)
- The Trust has decided not to investigate the complaint on the grounds that it was not made within the time limits.

7.1 A complainant can approach the Health Service Ombudsman with his/her complaint. It is unlikely that the Ombudsman will take up the complaint prior to the completion of the Trust’s Health Service Complaints Procedure. However, the Ombudsman does have the power to consider complaints that have not been put to the Trust and/or where the stages of the complaints procedure have not been exhausted.

7.2 The Trust will make these arrangements for Ombudsman review known to all complainants at the end of the process and will include the Parliamentary Health Service Ombudsman’s contact details in the final response letter.

7.3 Any reports from independent reviews conducted by the Ombudsman will be used as valuable sources of feedback for the Trust to learn from.

8.0 COMPLAINTS ABOUT SERVICES CONTRACTED TO OR BY THE TRUST

8.1 Where the Trust makes arrangements for the provision of services through an NHS contract or with an independent provider, it will ensure that the NHS Contract and/or independent provider has in place arrangements for the handling and consideration of complaints about any matter connected with its provision of services which shall be in line with this policy and procedure and passed to the Trust.

8.2 When the Trust undertakes to provide a service through a commercial arrangement with another organisation, the contract shall also state how complaints under that arrangement will be managed (which will usually be by the Trust) and this procedure will be used, unless the contractual arrangements provide otherwise.
9.0 MIXED SECTOR COMPLAINTS

9.1 Where a complaint involves more than one NHS provider, or one or more other bodies such as a Local Authority or a purchaser, there should be full cooperation and coordination in seeking to resolve the complaint through each body’s local complaints procedure. NHS bodies and Local Authorities will need to ensure that, between them, they address all matters of concern to the complainant. Whichever body the majority of the complaint relates to will take the lead in this matter and will write to the complainant explaining this and asking for their permission to pass the relevant parts of the complaint onto the pertinent bodies.

9.2 If a complaint is a joint NHS/Social care complaint (requiring a Trust and Local Authority Social Care response), such complaints will be rated at least as ‘moderate risk’ and the Complaints Manager will agree with the relevant Social Care provider who will lead on the matter and how to coordinate the response. The issues raised about the Trust will be investigated according to this procedure.

9.3 If the complaint comes from a Clinical Commission Group (CCG), on behalf of a complainant, the CCG will decide, with the Trust, how to handle the issue and will discuss this with the Complaints Manager. When a CCG decides, with the complainant’s consent, that the Trust is the appropriate body to deal with the complaint, the complaint will be handled as if the complainant had complained directly to the Trust from that date.

9.4 If the Trust receives a complaint that is solely concerned with services provided by another organisation, the Complaints Manager will seek the complainant’s permission to pass the complaint to the other organisation’s Complaints Manager. The Complaints Manager will be responsible for liaising with the person making the complaint and if the complainant agrees, will forward it to the correct body. Any doubts over which body is responsible for handling the complaint should be resolved before the complaint is dispatched. This should then be recorded in writing.

10.0 COMPLAINTS MADE FOLLOWING SERIOUS INCIDENTS (SIs)

10.1 All complaints will be checked to see if it is part of a Serious Incident (SI).

10.2 Any complaint received by the Complaints Department that could be connected to an Adverse Incident or Serious Incident will be identified and sent to the Risk Management Team and Head of Serious Incidents and Quality for cross referencing.

10.3 These issues will be included in the Terms of Reference of the SI Investigation (Full Internal Investigation Report).
10.4 If a complaint arises as part of the Serious Incident process, the appointed Complaint Investigator will liaise with the investigator of the Serious Incident as the Serious Incident Report must be used as the basis of the response to the complainant. All complaint responses must be checked to ensure that there is no contradiction. The complainant will be kept informed of progress by the appointed Complaint Investigator.

10.5 Where the Trust accepts that there has been negligence, a speedy resolution should be sought.

11.0 SUPPORTING STAFF

11.1 The purpose of the complaints procedure is not to apportion blame amongst staff but to investigate complaints with the aim of satisfying complainants whilst being fair to staff.

11.2 It will be the decision of the relevant Operational Manager, with advice from Human Resources, whether or not to investigate under the Conduct and Capability Policy.

11.3 When a disciplinary warning or other action is imposed on an individual member of staff as a result of a complaint, the Line Manager is responsible for investigating and informing the individual concerned if any information will be provided to the complainant about the action to be taken by the Trust.

11.4 Any information collected in the complaints procedure can be used in the Conduct and Capability procedures, but the two procedures must remain separate, and confidentiality maintained at all times.

11.5 The Trust has a policy and procedure in place for Workforce Wellbeing and Stress Management (HR26).

11.6 The Workforce Well-being and Stress Management Policy provides a personal support line service to staff. Should it be identified that a staff member involved needs additional support, the manager must make the staff member aware of the service and how to access it. It is essential that line managers provide immediate and ongoing support. Support offered must be recorded in the staff member’s personal file.

11.7 The contact Freephone number is: 0800 731 8627. Further assistance for staff is available via www.eput.helpeap.com using the organisational code ‘EPUT1’. To use the EAP services click ‘Register’ and enter the code ‘EPUT1’. This will prompt you to set up an account, which will generate log-in details.

11.8 If there is any staff member at serious risk of personal criminal proceedings or action by any regulatory body, they will be advised to contact their trade union or professional representative for support.
11.9 The Complaints Team will advise the member of staff’s Line Manager, in writing, that the Trust has received a complaint about a member of staff that they manage. The Line Manager is advised a copy of the complaint has been sent to the Director of the Service to arrange for the complaint to be investigated. The appointed Investigating Officer will be able to provide the Line Manager with details of the complaint. The Line Manager is asked to arrange to meet with the staff member to discuss the complaint and offer any support he/she may need. The Line Manager is asked to advise the staff member about expert counselling and support services available to them if required (email and telephone details provided).

11.10 Any staff members who are asked to act as witnesses in any complaints interventions or investigations will be given support by their Line Manager. The Line Manager will discuss any issues with the staff member and make suggestions of further support where this is necessary. The Complaints Team will provide advice to any staff member involved in a complaint.

### 12.0 MATTERS EXCLUDED FROM CONSIDERATION UNDER THIS POLICY

12.1 The following are outside of the Trust Complaints procedure.

12.2 Complaints made by an NHS body which relates to the services provided by another NHS body, except where a joint response is required under this procedure.

12.3 Complaints made by an independent provider about any matter relating to arrangements made by an NHS body with that independent provider unless otherwise stated in the contractual arrangements.

12.4 A complaint made by an employee about any matter relating to their contract of employment. Separate mechanisms exist under the Trust’s ‘Grievance Policy Procedure’.

12.5 A complaint which has already been investigated by the Trust or is being or has been investigated by the Ombudsman except where they have referred an issue back to the Trust for further investigation.

12.6 A complaint arising out of the Trust’s alleged failure to comply with a data request under the General Data Protection Regulation 2016 or a request for information under the Freedom of Information Act 2000. The Trust Information Governance Manager should be consulted with regard to complaints arising out of data subject requests under the General Data Protection Regulation 2016

12.7 A complaint by non-patient/non-resident third parties who are not complaining, who have not been affected by an action, omission or decision of the Trust.
13.0 LEGAL CASES AND POTENTIAL LITIGATION

13.1 It should not be assumed that a complainant who has used a solicitor to lodge a complaint has decided to take formal action. However, the Complaints Manager should be notified of any such complaint.

13.2 Where there is a prima facie case of clinical error, the person dealing with the complaint should immediately inform the Complaints Manager. The Complaints Manager will seek advice from the Trust’s Legal Advisor who will implement the Trust’s Corporate Procedural Guidelines for Negligence and Insurance Claims.

13.3 In all prima facie cases of clinical error, there should be a full and fair investigation regardless of whether the complainant has indicated that they propose to start legal proceedings. The principles of good claims management and risk management should be applied.

13.4 A complaint can only be suspended if the Trust has legal advice that it would prejudice a legal process. (Department of Health Guidance).

14.0 PERSISTENT AND UNREASONABLE COMPLAINANTS

14.1 It is the Trust’s intention to capture the spirit of the complaints regulations by creating and using an open, fair, flexible and conciliatory approach to all complaints, viewing them as opportunities to address concerns rather than as criticisms which need to be defended. However, it is recognised that in a minority of cases complainants become persistent and unreasonable in their pursuit of a complaint and that this in turn has a detrimental effect on staff and services.

14.2 A persistent and unreasonable complainant may include one or more of the following criteria:

- Has been personally abusive or aggressive towards staff dealing with the complaint.

- Is unreasonably unwilling to accept documented evidence of treatment given as being factual; e.g. medication charts, nursing records.

- Unreasonably insists that he/she has not had an adequate response, in spite of a large volume of correspondence specifically answering their questions.

- Focuses on a small matter which is out of all proportion to its significance, and keeps returning to this at meetings.

- Constantly and unreasonably raises new concerns, which did not appear in the original complaint in an apparent attempt to keep the correspondence going.
Unreasonably changes the complaint/story as time goes on, telling ‘horror stories’ about their experiences.

Is a relative, carer or friend, complaining on behalf of a patient/resident who has confirmed that they do not have a personal complaint against the Trust.

14.3 When faced with a persistent and unreasonable complainant the following action will be taken:

- The complaint will be reviewed, as even a persistent and unreasonable complainant may have a complaint which contains some substance.

- Inform and pass details of the complaint and the complainant to the Head of Complaints and request the persistent and unreasonable procedure is implemented.

- The Head of Complaints will refer all alleged persistent and unreasonable complaint and details of the complainant to the Executive Team who will review, make recommendations to manage persistent and unreasonable clients or residents and agree on a course of action.

14.4 If the Executive Team decides a complainant is persistent and unreasonable, the Chief Executive will write to the complainant informing them of any restriction put in place; what it means for their future contact with the Trust; how long those restrictions will remain in place; and what they can do to have their position reviewed and provide the client or resident with a copy of the policy. It can also include that:

"The Chief Executive has responded fully to all the points raised, and has tried to resolve the complaint; however there is nothing more that can be added. Therefore, from this point the Trust will acknowledge any letters but not respond to them unless new issues are raised."

14.5 Following this action any further attempt by a persistent and unreasonable complainant to raise the issue directly with staff can be refused. Staff will be supported not to enter into dialogue with the complainant but to request them to address their complaint to the Complaints Manager in writing.

14.6 The Trust will make it clear that while it welcomes complaints and takes them seriously, unreasonable or persistent and unreasonable complainants may be referred to the Trust’s Head of Legal Services/Solicitor.
15.0 ANONYMOUS COMPLAINTS

15.1 Where a service user/resident or carer or other concerned individual wishes to make an anonymous complaint the Trust will review it, but outside of the complaints process. If a complaint is received totally anonymously the Complaints Manager will pass it to the relevant Director for their consideration.

15.2 Whilst the Trust will act on anonymous information where it has concerns (in line with the intentions behind the Trust Whistle Blowing Policy, or the Child and Vulnerable Adult Policy, the Trust will not bring any complaints about an individual or team to the attention of anyone mentioned or to the Team Manager unless it is a general issue.

15.3 The Trust’s policy about raising a concern about practice, (Human Resources Policy, Whistle Blowing) offers staff a process to raise issues/concerns. This process recognises that staff may wish to remain anonymous when raising concerns. This does not preclude staff from using the complaints policy where they are considered to have sufficient interest in the patient’s/residents welfare.

16.0 TRAINING

16.1 All staff shall be responsible for knowing and understanding the Trust policy and procedure on complaints.

16.2 All new Trust staff will be made familiar with the Complaints Policy and Procedures at the staff induction (including e-learning).

16.3 Complaints Investigators will be provided with appropriate training to enable them to investigate and complete complaint documentation.

16.4 The Head of Complaints or the Complaints Manager will provide training as and when required for Investigators.

17.0 MONITORING OF IMPLEMENTATION AND REVIEW OF EFFECTIVENESS

17.1 The Complaints Team will provide the Executive Team with:

- Weekly complaints situation report to Executive Directors/Service Directors highlighting open complaints and completion dates.
- Fortnightly complaints overview identifying any areas of concern.
- Monthly complaints information for the Quality Report.
- Quarterly Thematic Reports providing trends analysis and highlighting any trends/themes.
• Quarterly lessons learned update.

17.2 The Complaints Team will provide the Clinical Commissioning Groups (CCGs) regular assurance and exception reports.

17.3 The Complaints Team will carry out internal audits to monitor and check the following key areas:
• Process for listening and responding to concerns/complaints i.e. was the complaint handled in line with procedural guidelines?
• Was the response open and honest?
• How front line resolution was carried out.
• How investigations were carried out including looking at appropriate severity and following up of action plans.
• Support given to staff members involved in complaints.
• Duties as outlined in the procedural guideline.
• How the complainant was treated following complaint.
• Lessons learnt/ and any improvements made to services.
• Completion of action plans.
• Process for handling joint complaints between organisations.

17.4 The Non-Executive Directors (NEDs) of the Trust will review and monitor complaints monthly as an independent quality assurance check. This process is highlighted in 4.5 of this document.

END
CRIMINAL BEHAVIOUR WITHIN A HEALTH ENVIRONMENT (ZERO TOLERANCE) POLICY

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<td>AUTHOR:</td>
<td>Local Security Management Specialist</td>
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<td>CONSULTATION GROUPS:</td>
<td>Police Liaison Committee, Clinical Service Boards, Health, Safety &amp; Security Committee</td>
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POLICY SUMMARY

This policy sets out the Trust’s commitment and arrangements for the management of any alleged criminal or abusive behaviour from persons against Trust staff, property and assets, and must be used in conjunction with CPG22 guidelines Criminal Behaviour within a Health Environment (Zero Tolerance) Procedure and RM05 Restrictive Practice Policy and Procedures.

The Trust monitors the implementation of and compliance with this policy in the following ways:

Implementation will be monitored by review of incidents and policy audit. This policy will be available to all staff on the Trust Intranet in the policy library. All new Trust staff will be advised of this policy and associated Procedural Guidelines (CPG22) via Trust Induction training, e-News and Briefings. This policy will be reviewed every three years and additionally when there is new relevant national guidance.

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The Director responsible for monitoring and reviewing this policy is
The Executive Director of Corporate Governance and Strategy
CRIMINAL BEHAVIOUR WITHIN A HEALTH ENVIRONMENT (ZERO TOLERANCE) POLICY - CP22

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CRIMINAL BEHAVIOUR WITHIN A HEALTH ENVIRONMENT (ZERO TOLERANCE) POLICY

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3.0 DEFINITIONS

4.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

5.0 POLICY REFERENCE AND ADDITIONAL GUIDANCE

6.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES
1.0 INTRODUCTION

1.1 This policy sets out the Trust’s commitment and arrangements for the management of any alleged criminal or abusive behaviour from persons against Trust staff, property and assets, and must be used in conjunction with CPG22 Guidelines Criminal Behaviour within a Health Environment (Zero Tolerance) Procedure and RM05 Restrictive Practice Policy and Procedures.

1.2 This policy sets out the process of dealing with incidents involving challenging behaviour, violence and aggression which results in criminal acts like assault, threats to kill, anti-social behaviour, racial abuse and criminal damage and a zero tolerance approach to unacceptable behaviour, especially bullying and harassment, etc.

1.3 The philosophy of the Trust, reflected in this policy is that patients will be treated with compassionate care and dignity and staff will be supported if they are a victim of crime. Criminal acts and abusive behaviour (verbal and non-verbal) committed by others will not be tolerated and prosecution will be pursued where appropriate.

1.4 In Mental Health and Learning Disability Services the expectation will always be that challenging or threatening behaviour by patients will be managed in the first instance through the clinical risk management process involving the Multi-Disciplinary Team (MDT) and that care plans and risk assessments are in place and reviewed appropriately following changes in behaviour.

1.5 In Mental Health and Learning Disability services, where an incident is beyond the bounds of safe management of care planning and staff skills, (for example, an assault), not necessarily related to the patients diagnosis or condition, flow charts are provided to inform a course of action to be agreed by the clinical team.

1.6 Further advice is available, such as the Trust Search Policy and Procedure and local operational protocols which provide an effective tool to reduce some of the causes of challenging and violent and aggressive behaviours, where appropriate.

1.7 On occasion aggressive behavior, verbal abuse and other abusive behavior may be experienced from visitors and relatives. This Policy makes provision for the management of these incidents. The Zero Tolerance Procedure CPG22 directs staff in how to deal with these situations.

2.0 Responsibilities

2.1 Chief Executive

- The Chief Executive is ultimately responsible for implementing the requirements of this Policy and complying with the NHS Security Management Standards.
2.2 Security Management Director (SMD) will:

- Ensure there is adequate security management provision made in the Trust to prevent and manage challenging behaviour, violence and aggression as specified in the NHS Security Management Standards.
- Ensure the emphasis on the security management needs of the Trust at Executive Board level.

2.3 Non-Executive Director lead for security management will:

- Promote and champion the security management agenda at Board level.

2.4 Executive Directors/Clinical Directors/Service Directors will:

- Ensure compliance with this Policy, Procedural Guidelines and associated policies throughout their areas of responsibility.
- Ensure that CLP30 CPA & NON CPA Policy / CG28 Clinical Risk Assessment & Management are included within their directorates risk assessment processes.
- Ensure the appropriate provision of resources and training is made available to address the outcomes of assessments or incident investigations. The Trust will attach a high priority to supporting investments put forward as a result of the risk assessment process whilst recognising the financial constraints of the organisation.

2.5 Associate Director of Risk and Compliance will:

- Monitor that all incidents of criminal activity are reported and that investigations into incidents are undertaken in accordance with this Policy and Procedural Guidelines in relation to the severity of the incident and its possible implications. The investigations will be in line with the Adverse Incident/SUI Policy and Procedure CP3.
- Collaborate with Workforce Development Team in ensuring there is a comprehensive package of training on prevention and management of challenging behaviour and violence and aggression issues, for all identified Trust employees.
- Monitor incidents of criminal activity and report to the Health, Safety & Security Committee and local H & S Directorate Sub-Groups.
- Identify hotspots and areas of good practice and feedback to the appropriate service Director.
- Ensure that Lessons Learnt or Service Changes made following investigations and incident trend analysis are shared with those involved in the incident and staff members via the Trust Intranet and Trust publications and will be shared externally.
- Ensure that where a risk has been identified either following an investigation or from incident analysis that cannot be mitigated against within reasonable timescales, that the risk will be added to the appropriate risk register. This will then be monitored by the appropriate service Management Team.
2.6 Local Security Management Specialist will:

- Ensure the Associate Director or Risk and Compliance and the SMD are kept fully informed on issues relating to incidents of criminal activity and security breach which may affect the Trust, its staff, patients or the levels of service which it offers.
- Analyse statistics and trends identifying areas of good practice and hot spots using the information taken from incident reports.
- Ensure investigations are comprehensive and action is taken to learn lessons and implement improvements to minimise the risk of recurrence.
- Provide a regular report on security issues including assaults against staff to the Trust Health Safety & Security Committee.
- Advise staff on how to report a crime or security incident via Datix if and when they occur, so accurate information can be recorded on the Trust incident recording system.
- Provide support, advice and guidance to all staff on measures to deal with incidents.
- Act as the EPUT central point of contact for the Police and other external agencies in respect of criminal investigations and security management, to ensure that relevant information is communicated and effective action is taken in the detection and prevention of crime and disorder.
- Monitor effectiveness of any local physical security arrangements in collaboration with the Physical Security Manager.
- Have an overview of security surveys and risk assessments (undertaken by the Physical Security Manager) as is necessary to protect staff, service users, visitors and property.
- Work collaboratively with the Workforce Development Team to ensure that effective training in the prevention and management of violence and aggression is available to all staff and non-executives who require it.

2.7 Departmental Managers/Team Leaders and other Persons in Charge will:

- Ensure that local security protocols and prevention and management of violence and aggression contribute to a safe and secure environment. This will include all staff attending mandatory, core training and other relevant training as prescribed by the Trust.
- Ensure that suitable and sufficient workplace risk assessments regarding challenging behaviour and violence and aggression are carried out within their ward/department.
- Ensure that local security procedures are in place in regards to work activities and type of environment.
- Ensure that all staff adhere to Trust policies, procedures and guidelines.
- Ensure that all staff adhere to the Trust incident reporting policy and procedures.
- Ensure that all staff are made aware of adverse incident analysis reports.
- Ensure that they carry out investigations in regards to all incidents and recommend and co-ordinate appropriate corrective action.
- Complete appropriate Risk Assessments for staff where necessary.
- Complete work place Risk Assessments for security in their locations (Appendix 2, Trust Risk Assessment Policy (RM11)).
• Ensure location security devices are monitored on a monthly basis at a local level by the manager or nominated deputy.
• Ensure criminal incidents are reported via Datix and investigated initially at local level by the manager.
• Ensure recommendations from the investigation will have completion dates and the names of the people responsible completion of any identified actions.
• Liaise with the Trust Local Security Management Specialist to ensure all criminal incidents are investigated and appropriate action arising from the investigations is taken.
• Ensure staff are complying with Trust Policy in regards to all risk management issues.

2.8 Workforce Development & Training team will:

• Ensure suitable and sufficient PMVA training is provided by the Trust Workforce Development and Training Department.
• Ensure conflict resolution/avoidance training is provided to all front line staff in accordance with the Security Management Standards regarding violence against NHS staff.
• Work with Risk Management Department in periodically undertaking a training needs analysis of staff within EPUT in relation to security incidents.

2.9 All staff will:

• Ensure they comply with all principles contained within this policy and associated guidelines.
• Report all incidents of abusive behaviour, acts of violence and other inappropriate acts.
• Assist managers and the Police as required in any investigations with regards to this policy.

3.0 DEFINITIONS

Definitions of types of behaviour

3.1 Non - physical assaults
The NHS defines a non – physical assault as:

‘The use of inappropriate words or behaviour causing distress and/or constituting harassment.’

Examples of such behaviour are:
• Offensive language, verbal abuse, swearing
• Unwanted or abusive remarks of a sexual nature
• Racist, sexist, homophobic or other discriminatory remarks
• Offensive gestures
• Threats, whether verbal or physical
• Bullying or intimidating behaviour
3.2 Physical assaults
The NHS defines a physical assault as:

‘The intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort.’

All physical assaults are investigated by the Trust LSMS and where appropriate (non-clinical assault) where the perpetrator knew what they were doing at the time of the assault; the assault must be reported to the police for prosecution.

A ‘clinical assault’ or ‘assault resulting from clinical factors’ is an assault that is directly caused by the patient’s clinical condition. Management of this kind of assault will generally be via clinical risk review and management plan in conjunction with support provided for staff victims. However, where there is a history of violence or the severity and impact of the assault is high and prosecution is in the public interest, the assault must be reported to the police.

Examples of this type of behaviour would be:

- Punching
- Kicking
- Head butting
- Striking with an object or weapon
- Throwing an object or weapon where contact is made
- Spitting where a person or their clothing is struck
- Strangulation
- Bear hugs
- Slapping
- Pinching
- Scratching

3.3 Antisocial and nuisance behaviour (ASB)
The statutory definition of ASB is:

‘Acting in a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household’ (Crime & Disorder Act 1998).

Behaviour that causes a nuisance or otherwise interferes with the safe and effective provision of health services could be termed ASB. ASB acts may be criminal offences in their own right and the Trust LSMS can advise you.
Examples of antisocial and nuisance behaviour include:

- Abandoned cars
- Climbing on buildings
- Damage to EPUT staff, patient or visitors property
- Dealing or misusing substances or alcohol on EPUT premises
- Discarding needles/drug paraphernalia
- Disregard for visiting times
- Dropping litter/dumping rubbish
- Hoax/prank/inappropriate calls to emergency services
- Fly posting/Fly tipping
- Following people
- Trespass
- Inconvenient or illegal parking
- Inappropriate sexual contact or indecent exposure
- Letting down tyres
- Other vehicle related nuisance or damage
- Loud music or excessive noise
- Misuse of air guns
- Obscene/nuisance/offensive telephone calls, texts, fax or email messages
- Pestering people
- Refusal to leave premise/grounds when asked
- Smoking in NHS buildings or external restricted areas
- Spitting or vomiting in public
- Taking photos/videos or making sound recordings without permission
- Uncontrolled animals
- Voyeurism
- Urinating in public

3.4 Theft

See also Trust Policy for Counter Fraud CP11, Trust Security Policy RM09 and Patient/Client Property & Money Procedure FP09/02, FP09-12 Procedure on Clients Money Held on Wards (South Essex) and FP11-01 - Safekeeping of Patients Belongings Policy (North Essex).

The legal definition of theft is:

‘A person is guilty of theft, if he dishonestly appropriates property belonging to another with the intention of permanently depriving the other of it’

All incidents or suspected incidents of any kind of theft must be reported via Datix and the LSMS will investigate and where appropriate report the incident to the police for criminal investigation and prosecution of offenders. Staff can raise concerns directly with the Trust LSMS on 01268 739728 ext. 1128

EPUT will always pursue prosecution where theft is identified and will seek to hold perpetrators to account and recover any losses.
3.5 Criminal Damage

The legal definition of criminal damage is:

‘Without lawful excuse, intentionally or recklessly to cause damage to another's property’

As with assaults, clinical assessment of a patient who has caused damage to ascertain whether or not they had capacity to know what they were doing at the time of the incident is essential. All incidents of damage must be reported on Datix and the LSMS will report to the police for criminal investigation and prosecution if appropriate.

4.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

4.1 Policy implementation

- Successful implementation of this policy and its associated Procedural Guidelines (CPG22) is dependent on all Trust staff meeting their responsibilities.
- Implementation will be monitored by review of incidents and policy audit.

4.2 Dissemination

- This policy will be available to all staff on the Trust Intranet in the policy library.
- All new Trust staff will be advised of this policy and associated Procedural Guidelines (CPG22) via Trust Induction training, e-News and Briefings.

4.3 Review of this policy

- This policy will be reviewed every three years and additionally when there is new relevant national guidance.

5.0 POLICY REFERENCES AND ADDITIONAL GUIDANCE

- NICE Guidelines NG10 Violence and Aggression: Short term management in mental health, health & community settings 2015
  http://www.cfsms.nhs.uk/pubs/sms_gen_pubs.html
- The Management of Health and Safety at Work Regulations (1999)
  ISBN0110856252.
CRIMINAL BEHAVIOUR WITHIN A HEALTH ENVIRONMENT (ZERO TOLERANCE) POLICY - CP22

- The Health and Safety at Work Act (1974)
  http://www.hse.gov.uk/legislation/hswa.htm

- Prevention & management of violence when withdrawal of treatment is not an option

6.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

- Non-Clinical Risk Assessment Policy and Procedure RM11
- Adverse Incident and Serious Untoward Incident Policy and Procedure CP3
- Security Policy and Procedure RM09
- Lone Worker Policy and Procedure RM17
- Restrictive Practice Policy and Procedure RM05
- Information Security Policy and Procedure CP50
- CCTV Policy and Procedure CP28
- CPA & Non CPA Policy and Procedure CLP30
- Clinical Risk Assessment & Management Policy and Procedure CG28

END
USE OF MOBILE PHONES POLICY

POLICY REFERENCE NUMBER: CP54
VERSION NUMBER: 6
REPLACES SEPT DOCUMENT CP54 Use of Mobile Phones Policy
REPLACES NEP DOCUMENT IT3 ICT Mobile Computing Device Policy
KEY CHANGES FROM PREVIOUS VERSION N/A
AUTHOR: Lucia Vambe
Practice Development Lead Nurse
CONSULTATION GROUPS: Practice Development
IMPLEMENTATION DATE: 01 April 2017
AMENDMENT DATE(S): 13 March 2017; May 2018
LAST REVIEW DATE: March 2017
NEXT REVIEW DATE: March 2020
APPROVAL BY CLINICAL GOVERNANCE COMMITTEE: Chairs Action following August 2017 meeting
RATIFICATION BY FINANCE AND PERFORMANCE COMMITTEE: 21st September 2017
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POLICY SUMMARY
The purpose of this policy and accompanying procedural guidelines is to set out working arrangements for the use of Mobile Phones within all areas of Trust premises for Staff, Patients and Visitors.

The use of Mobile Phones within patient settings must include a local individual risk assessment which considers whether use would represent a threat to patients’, staff and/or visitors safety or that of others. Risk Assessments must include the consideration of the operation of individual phones together with any surrounding electrically sensitive medical devices in critical care situations and privacy and dignity. ‘Patient’ will be the terminology used throughout this document and will refer to a patient, resident or service user.

The Trust monitors the implementation of and compliance with this policy in the following ways:
This policy and procedural guideline will be reviewed and monitored for compliance initially for a minimum of 1 year and thereafter 3 yearly or as required by legislation/best practice guidelines. Auditing for compliance will be undertaken a minimum of 3 yearly by operational managers/leads and the results presented to the appropriate Trust committee for consideration.

Following an incident where a mobile phone interferes with medical equipment this must be reported on an Incident Reporting Form and returned to the Integrated Risk Team. The Integrated Risk Team will then be responsible for reporting this to the MHRA and NPSA as required.

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The Director responsible for monitoring and reviewing this policy is
Executive Director of Nursing
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

USE OF MOBILE PHONES POLICY

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1.0 INTRODUCTION

1.1 Communication with family and friends is an essential element of support and comfort for patients either in hospital or whilst receiving care as an outpatient. Modern technology has made communication relatively easy particularly with the widespread use of mobile phones, text messaging and email. The use of mobile phones by staff, patients and visitors presents an increasing challenge due to new and continually developing technologies, potential connection and interaction to other hardware devices and portability. (DOH January 2009)

1.2 Mobile Phones commonly have extended functionality which can include email, internet, camera, audio or video recording capability and music players. Therefore, there is a potential for patients and visitors to use these functions to take inappropriate photographs, recordings or videos. This has a potential to present the greatest interference with patient dignity and privacy.

1.3 NHS Protect has produced the good practice advice in the May 2016 Patients Recording NHS staff in Health and Social Care Settings document which covers both covert and overt recording of consultations. Clarification of this document is cited in the Trust Mobile Phone Procedure CPG54.

1.4 Ring tones or music played via mobile phones could disturb others who are trying to recuperate and constant ‘chatter’ of staff, other patients or visitors on mobile phones would be equally disruptive.

1.5 Mobile phones could equally interfere with medical equipment and affect their use.

1.6 In addition charging mobile phones requires the use of a length of electrical wire which may provide ligature risks.

1.7 Consideration of these issues is essential in regards to where mobile phones should and should not be used on Trust premises.

2.0 SCOPE

2.1 This Policy and associated procedural guidelines applies to all staff, patients and visitors in all Trust areas, including in community residential areas, day hospitals, resource centers and inpatient settings.

2.2. The possession or use of mobile phones is strictly prohibited to all staff, patients, contractors and visitors entering clinical areas at Edward House, Christopher Unit, Larkwood Unit, Hadleigh Unit, Brockfield House, Robin Pinto Unit, Woodlea Clinic. When entering patient areas in these units, mobile phones should either be left in staff vehicle, at home or placed in the lockers.
within the reception area. However where someone needs use of a mobile phone for work related tasks then permission must be requested via security or in their absence one of the integrated clinical leads/unit coordinator for their authority. Those not working in any clinical areas of the secure wards at Edward House, Christopher Unit, Larkwood Unit, Hadleigh Unit, Brockfield, Robin Pinto and Wood Lea are able to take their mobile phone into non patient areas only. Staff in Larkwood Unit and on Poplar Ward in Rochford must read this policy in conjunction with the Unit's protocols on the use of Mobile phones.

2.3 The use of camera phones within patient areas or patient’s own home risks infringing patient confidentiality. Given the difficulty in detecting usage, the consent for taking photographs on a mobile phone of either patients or their confidential information is prohibited. The only exception to this is for staff where a job role or function demands this use for example in community health services staff take wound photographs for monitoring healing.

3.0 RESPONSIBILITIES

3.1 All staff are responsible for adhering to this policy and associated procedural guidelines and for reporting any breaches on Datix reporting incident system. (please see Corporate Policy CP3 for further details)

3.2 All Managers have a responsibility to ensure that standards are maintained as set out in this policy and accompanying procedural guidelines.

3.3 All Managers are responsible for ensuring that information about this policy and procedure is available in their areas to staff, patients and visitors.

3.4 The responsibility for using a mobile device remains with the authorised user.

3.5 All operational support issues must be reported to the ITT Service Desk for resolution.

3.6 All mobile ITT equipment must be approved by ITT Services and will only be issued for the sole use of the recipient individual.

3.7 Mobile devices must be returned to ITT Services when their intended use by the recipient individual no longer applies. Devices must not be passed on to other members of staff.

4.0 LEGAL CONSIDERATIONS

4.1 Patient Privacy and Dignity

There is a legal duty to respect a patient’s private life. The Human Rights Act 1998 (HRA) enshrines the right to respect for private and family life and states “there shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interest of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for
the protection of health or morals or for the protection of the rights and freedoms of others.”

The European Commission has found that the collection of medical data and maintenance of medical records fall within the sphere protected by the HRA. This would, therefore, apply to personal medical information including information which identified a patient such as a photograph.

Permitting the use of mobile phones with cameras in hospitals may not sufficiently ensure medical confidentiality or protect an individual’s right to respect for their private life.

Cameras and voice recording facilities should not be used in any way that could cause harm or offence to an individual (member of staff or client) or bring the Trust into disrepute. Under no circumstances should photos or voice recordings be taken without the prior consent of those involved. Such misuse may be subject to the Trust’s disciplinary procedures and could also be subject to civil and criminal proceedings.

The risk of breaching confidentiality and dignity must be assessed against patients' rights to communicate with the outside world whilst in hospital, including access to alternative forms of communication where the use of mobile phones is not allowed.

4.2 Patient Confidentiality

The Information Commissioner’s Office states that all public and private organisations are legally obliged to protect any personal information that they hold. In relation to this, any individual who takes a photograph of another individual will be processing personal data and must comply with the General Data Protection Regulation 2016.

The use of mobile phones can result in the creation of sensitive personal data and therefore consideration must be given to how effective confidentiality is by monitoring.

4.3 Child Protection

The Children Act 2004 places a duty on the Trust for ensuring the need to safeguard and promote the welfare of children. As such it must be taken into account that mobile phones are a potential risk in that inappropriate photographs/information could be taken, including confidential information pertaining to the child.

4.4 Health and Safety

Mobile phones need to be charged via the mains power supply. Only approved chargers compatible with the make and model of the phone may be used when charging mobile phones on Trust premises. Whether Trust or personal property, the charger must be up to date in relation to Portable appliance testing (PAT) before permitted for use. Failure to observe this
requirement will contravene Health and Safety Regulations and could place individuals at risk.

5.0 MONITORING OF IMPLEMENTATION AND COMPLIANCE

5.1 This policy and procedural guideline will be reviewed and monitored for compliance initially for a minimum of 1 year and thereafter 3 yearly or as required by legislation/best practice guidelines.

5.2 Auditing for compliance will be undertaken a minimum of 3 yearly by operational managers/leads and the results presented to the appropriate Trust committee for consideration.

5.3 Following an incident where a mobile phone interferes with medical equipment this must be reported on an Incident Reporting Form and returned to the Integrated Risk Team. The Integrated Risk Team will then be responsible for reporting this to the MHRA and NPSA as required.

6.0 REFERENCES

6.1 The Medicines and Healthcare products Regulatory Agency (MHRA) advises that in certain circumstances the electromagnetic interference from mobile phones can interfere with some devices, particularly if used within 2 meters of such devices. It has issued a number of reference documents relating to this;

- DB 1999(02) Emergency service radios and mobile data terminals: compatibility problems with medical devices. This document covers the impact of radio communications on the safe use of medical devices.
- DB 9702 Electromagnetic Compatibility of Medical Devices with Mobile Communications. This device bulletin includes the findings of a study conducted into the effects of mobile communications.
- Safety Notice 2001(06) - Update on Electromagnetic Compatibility of Medical Devices with Mobile Communications: TETRA (Terrestrial Trunked Radio Systems) and Outside media broadcasts from hospital premises.

6.2 Using Mobile Phones in NHS Hospitals (DOH January 2009).

Further references:

- NHS Protect, Patients recording NHS staff in health and social care settings (March 2016) Policy@nhsprotect.gsi.gov.uk.
- NHS Protect – Misuse of Social Media to Harass, Intimidate or Threaten NHS Staff May 2016 (Policy@nhsprotect.gsi.gov.uk).

7.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES

- Adverse Incident Serious Incidents Policy CP3 and CPG3
- Security Policy and Procedural Guidelines RM09 and RMPG09
- Purchase and Use of Mobile Phones and Pagers CP7 and CPG7
- Records Management Policy and Procedures CP9
- IT & T (Information Technology and Telecommunications) Security Policy and Procedural Guidelines CP37
- Patient/Client Property and Money Procedure FP09/02

END
USE OF MOBILE PHONES PROCEDURE

PROCEDURE REFERENCE NUMBER: CPG54
VERSION NUMBER: 6
REPLACES SEPT DOCUMENT: CP54 Use of Mobile Phones Policy
REPLACES NEP DOCUMENT: IT3 ICT Mobile Computing Device Policy
KEY CHANGES FROM PREVIOUS VERSION: EPUT Format
AUTHOR: Lucia Vambe
Practice Development Lead Nurse
CONSULTATION GROUPS: Trust wide:
Operational Services including Medical
Estates & Facilities
Purchasing Department
Communications & Engagement
Compliance
IT & Telecoms
Patient Experience Dept.
Risk Management
Safeguarding
Training & Development
Contact Centre
Pharmacy & Medicines
Quality & Practice
IMPLEMENTATION DATE: April 2017
AMENDMENT DATE(S): March 2013, May 2014, March 2016,
October 2016 and November 2016
LAST REVIEW DATE: March 2017
NEXT REVIEW DATE: March 2020
APPROVAL BY CLINICAL GOVERNANCE COMMITTEE: Chairs Action following August 2017 meeting
RATIFICATION BY FINANCE AND PERFORMANCE COMMITTEE: 21st September 2017
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PROCEDURE SUMMARY

The purpose of this procedure is to identify working arrangements for the use of Mobile Phones within all areas of the Trust for Staff, Patients and Visitors. The widest possible use of mobile phones for Staff, Patients and Visitors will be considered within patient areas: where local risk assessments indicate that such use would not represent a threat to patients’ or others own safety and security. Risk Assessments must include use of the operation of electronically sensitive medical devices in critical care situations or where levels of privacy and dignity may be affected. ‘Patient’ will be the terminology used throughout this document and will refer to a patient, resident or service user.

The Trust monitors the implementation of and compliance with this procedure in the following ways;

- Auditing for compliance will be undertaken a minimum of 3 yearly by operational managers/leads and the results presented to the appropriate Trust committee for consideration.

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The Director responsible for monitoring and reviewing this procedure is
Executive Director of Nursing
PROCEDURAL GUIDELINES ON THE USE OF MOBILE PHONES

1.0 INTRODUCTION

1.1 Whenever anyone is in hospital/Nursing Home or within a residential community, day or resource centre setting, communication with family and friends may become an essential element of support and comfort, the widespread use of mobile phones and their integrated functionality such as texting and e-mailing may provide a positive aspect of support.

1.2 Mobile phones may have extended functions which include camera, audio and video recording capability, music players, email and internet functions. There is a potential for patients and visitors to use this functionality to take inappropriate photographs, videos or recordings that present potential to interfere with patient dignity and privacy.

1.3 NHS Protect has produced the good practice advice in their “Patients Recording NHS staff in Health and Social Care Settings” May 2016 document for use in health and social care settings. The document provides clarification to NHS clinical and non-clinical staff working within health and social care settings on dealing with situations where patients might record their treatment and care. This advice covers both covert and overt recording of consultations. However, it predominantly concerns overt recording as the patient will generally ask NHS staff for permission for recording to take place.

1.4 There are no specific legal requirements that govern an individual making a personal recording of their medical consultation or treatment, either overtly or covertly, for their private use. The position may, however, change once a recording is no longer used as a record of the consultation, for example where the recording is disclosed or publicised in a modified way which is not connected to the consultation. This could include an instance where it is designed to cause detriment to or harass another individual captured in the recording. Any such disclosure or publication, depending on the nature and context, may attract a civil action for damages and may also be a criminal offence which could include an offence contrary to section 1 of the Protection From Harassment Act 1997, an offence contrary to section 4, 4A or 5 of the Public Order Act 1986, an offence contrary to section 1 of the Malicious Communications Act 1988 or an offence contrary to section 127 of the Communications Act 2003.

1.5 In addition, ring tones or music played via mobile phones could disturb others who are trying to recuperate and constant ‘chatter’ of other patients, visitors or staff on mobile phones may be equally disruptive to those patients wishing to rest. Mobile phones could also potentially interfere with medical equipment and affect their use.

1.6 The Trust has designated mobile phone use areas, these are the only areas in which the use of mobile phones is permitted without a risk assessment being completed.
2.0 SCOPE

2.1 This procedure applies to all Staff, Patients and Visitors in all areas of the Trust.

3.0 DESIGNATED MOBILE PHONE USE AREAS

3.1 Designated Areas

3.1.1 Non patient areas are defined as those areas where there is no patient access.

3.1.2 Non patient areas and Trust reception areas are designated as acceptable for mobile phone use, where issues of privacy and dignity and interference with medical equipment can be kept to a minimum.

3.1.3 Reception areas are defined as areas where patients and visitors have unlimited access and which are staffed at all times (this does not include ward reception areas).

3.1.4 For all other areas, risk assessments must be undertaken to assess whether the use of mobile phones is appropriate. In these areas a sign should be displayed at the area entrance which directs staff, patients and visitors to contact the unit/department/home manager to confirm whether or not mobile phone use is allowed.

3.1.5 The possession or use of mobile phones is strictly prohibited to all staff, patients, contractors and visitors entering clinical areas at Brockfield House, Robin Pinto Unit, Woodlea Clinic, Hadleigh Unit, Edward House, Christopher Unit, Larkwood Unit. When entering patient areas in these units mobile phones should either be left in staff vehicle, at home or placed in the lockers within the reception area. However where someone needs use of a mobile phone for work related tasks then permission must be requested via security or in their absence one of the integrated clinical leads/unit coordinator for their authority. For all other not working on any of the secure wards at Brockfield, Robin Pinto, Woodlea Clinic, Hadleigh Unit, Edward House, Christopher Unit and Larkwood Unit will now be able to bring their mobile phone into non patient areas only. Staff in Larkwood Unit and on Poplar Ward in Rochford must read this procedure in conjunction with the Unit’s protocols on the use of Mobile phones.

3.2 Risk Assessments

3.2.1 Some patient areas can also be designated as a mobile phone use area. Local Risk Assessments must be undertaken to determine if a patient area is to be designated as a mobile phone use area, using the Trust Risk Assessment Form (RM11 Appendix 1) which is on intranet.

3.2.2 Any local area designated as a mobile phone use area must be outlined in local Operational Policies.
3.2.3 Camera functions, audio or video record functions may not be used in any Trust area. The only exception to this is for staff and teams where a job role or function demands this use and they must seek permission from a senior manager.

3.2.4 Any staff member who witnesses the use of such functions must ask the offender to stop, inform a senior manager, complete a Datix incident form and if the offender is a patient, inform their care coordinator or named nurse (where appropriate).

3.2.5 The use of camera phones within patient areas or patient’s own home risks breaching patient confidentiality. The only exception to this is for staff where a job role or function demands this use for example in community health services staff take photographs of wounds to monitor healing.

3.2.6 Patients and Visitors will be made aware of the Trust procedures concerning the use of mobile phones within the patient areas through information leaflets and local posters.

4.0 STAFF USE OF MOBILE PHONES

4.1 General Use

4.1.1 Secure services have their own mobile phone operational protocols therefore staff, patients and visitors in these services must refer to Use of Mobile Telephone within Secure Services Protocols SSOP35 and SSOP40 which are on intranet.

4.1.2 For all other services staff on duty may use mobile phones for work related issues within mobile phone use designated areas. Staff may also use mobile phones within patient areas, where a local risk assessment has been undertaken, however consideration must be given to patients who are resting and only in emergency circumstances should a mobile phone be used within earshot of a patient. Staff can use mobile phones for personal use only when on designated breaks except for emergency use as detailed in section 4.1.4 below.

4.1.3 All Trust employees must adhere to the law in relation to the use of mobile telephones whilst driving. With effect from December 2003 the hand-held use by a driver of a mobile phone in a car is in direct breach of road traffic regulations. In no circumstances must a mobile phone be used when driving, unless using ‘hands-free’ equipment. In such circumstances, it is the driver’s responsibility to ensure it is safe to make or receive calls, given the driving conditions at the time. They must:

- Keep calls as short as possible,
- Avoid complex or emotionally sensitive calls,
- Never hold the phone or send or read a text message.

In general, drivers must endeavour to stop in a safe place to make or receive calls, as per Trust policy CP7.
4.1.4 Staff may not use the camera function, any of the recording functions, or play music within patient areas, unless this falls within their job role to do so.

4.1.5 Staff are reminded that the use of mobile phones must be kept to a minimum and for emergency use only. Whilst it is appreciated that family and friends may need to contact you, or you them, under special circumstances (e.g. illness) the use of mobile phones must not in any way impact on the workplace (e.g. workload, distraction to team members, putting private calls before business calls).

4.1.6 Where special circumstances occur members of staff must liaise with their line management to apprise them of the situation.

4.1.7 If a staff member uses their phone inappropriately this will be addressed by their manager through the Conduct & Capability Policy and Procedure HRPG27a.

4.1.8 If a mobile phone is lost or stolen the phone user will complete a Datix incident reporting form and advise IT and Purchasing department so the phone can be barred. (Guidance on completing this form can be found in the Trust’s Adverse Incident Procedural Guidelines CPG3).

4.2 Clinical Use

4.2.1 Secure services have their own mobile phone operational protocols therefore staff in these services must refer to secure services mobile phone protocols which are on intranet.

4.2.2 Where possible staff are encouraged not to give out individual telephone numbers.

4.2.3 If in any circumstances, it is felt necessary for staff to provide a patient or carer with their mobile phone number, they must undertake a risk assessment. The assessment must take into consideration how the staff member will ensure that this number is not used in place of an emergency number and how the staff member will ensure that it is answered even when not on duty.

4.2.4 Both the staff member and the patient or carer must agree the conditions for use of their mobile phone number using the contract for providing a staff mobile phone number to a patient / carers (Appendix 1).

4.2.5 If it is necessary to provide a contact number the contact centre number must be used or a locally agreed out of hours number. Hours of contact must be made clear to patients/carers and staff as well as any alternative arrangements and any specific agreements documented in their care plan. The contact centre number is 0300 123 0808. They provide a messaging service within agreed working hours and will hold all teams contact numbers that connect patients to staff.

4.3 Text Messaging
4.3.1 Any text message sent to or received from a patient, carer or colleague is classified as patient information and must be treated with the same rules around confidentiality as any other patient information / record.

4.3.2 All text messages sent to or received from patient or carers must be recorded in the patient notes.

4.3.3 The use of text messaging must be risk assessed before being undertaken.

5.0 PATIENT USE IN INPATIENT / NURSING HOME, DAY AND RESOURCE CENTRE AREAS

5.1 Secure services have their own mobile phone operational protocols therefore staff in these services must refer to secure services mobile phone protocols which are on intranet.

5.2 On admission to inpatient ward, Day Treatment services and Resource centers patients must be made aware of the Precautionary Measures in 6.0 on page 8 of this document.

5.3 Any mobile phone retained for use by the patient must be used in a designated Trust or locally risk assessed area under agreed conditions.

5.4 A copy of the Risk Assessment and the Contract for Patient Use of a Mobile Phone (appendix 2) must be completed and signed by the patient and a member of the Multi-Disciplinary Team (MDT)/Clinical team. Both must be kept within the patients notes.

5.5 Risk Assessments for patient use of a mobile phone must include an assessment of the following for individual patient use:
- Whether the mobile phone is a camera phone
- Whether the mobile phone has email or internet functionality
- If the mobile phone is capable of audio / video recording
- The management and use of charging leads/wires
- Whether use would represent a threat to patients' own safety or that of others
- Whether the operation of electrically sensitive medical devices in critical care situations would be affected
- Whether levels of privacy and dignity would be potentially affected

5.6 Extended functions, on any mobile phone cannot be used on Trust premises. Please see below

5.7 If it is assessed that a person continually abuses a mobile phone the issue will be re-assessed by the MDT/Clinical team regarding individual use and potentially removed. In any situation where the staff member in charge considers a breach of confidentiality or potential breach of confidentiality mobile phone use must be reassessed as soon as possible. Any breach of confidentiality must be reported using guidelines as set out in Adverse Incident and Serious Untoward Incidents Policy CP3
5.8 Any mobile phone brought in to the inpatient area which is assessed and not agreed for the patient to use will be retained by staff for safekeeping using Trust Policy regarding property (Patient/Client Property and Money Procedure FP09 02) or will be returned home with agreement from the Patient to a relative or friend.

6.0 Precautionary Measures

6.1 Overt patient recordings
Although we cannot place restrictions on a patient wishing to record notes of a consultation or conversation with a health professional, where it is felt absolutely necessary by the patient to do so, staff should ensure that:
• Any recording is done openly and honestly.
• The recording process itself does not interfere with the consultation process or the treatment or care being administered.
• The patient understands that a note will be made in their health record stating that they have recorded the consultation or care being provided.
• The patient is reminded of the private and confidential nature of the recording and that it is their responsibility to keep it safe and secure.
• Any recording is only made for personal use.

6.2 Covert patient recordings
Although we cannot place restrictions on a patient wishing to covertly record a consultation or conversation with a health professional, where staff are aware that covert recording has occurred they should ensure that:
• The issue is discussed with the patient as per 6.1 above.
• Relevant staff should consider providing patients with a written record summary, and or a verbatim record (if practical) of their consultation for their own personal use.
• Patients are advised that they are entitled to see their notes, if they so wish, by informally asking the healthcare professional in charge of the consultation, or to request a paper copy of their medical notes formally through a Subject Access Request (SAR) made under the Data Protection Act 1998.
• Patients are given information on how they can complain if they have an issue with their treatment and care, and their attention is drawn to the relevant guidance from the Care Quality Commission (see below) and Information Commissioner’s Office.

7.0 MOBILE PHONE CHARGERS

7.1 Mobile phones need to be charged via the mains power supply, consequently there may be a ligature / other health and safety risks involving wires. All patient areas must risk assess this activity before mobile phone chargers are used.

7.2 Only approved chargers compatible with the make and model of the phone may be used when charging mobile phones on Trust premises. Whether Trust or personal property, the charger must be up to date in relation to portable
appliance testing (PAT) before permitted for use. Failure to observe this requirement will contravene Health and Safety Regulations and could place individuals at risk.

7.3 To avoid probability or likelihood of leaving devices unplugged medical devices are not to be unplugged to charge phone.

7.4 Recent information has also been identified regarding the potential danger of using an electrical device whilst still attached to the mains electricity supply, therefore mobile phones must not be used whilst still plugged in to the mains electrical supply.

8.0 REPORTING BREACHES

8.1 Any staff member who witnesses the use of video or audio recording which has not been agreed by all concerned must:
- ask the individual to stop
- inform a senior manager
- inform information governance leads via completion of a Datix incident form

If the individual is a patient complete Datix incident form and inform also their doctor, named nurse and care co-ordinator (where appropriate).

9.0 MONITORING AND REVIEW

9.1 This policy and procedural guideline will be reviewed and monitored for compliance 3 yearly or as required by legislation/best practice guidelines.

9.2 Auditing for compliance will be undertaken a minimum of 3 yearly by operational managers/leads and the results presented to the appropriate Trust committee for consideration.

9.3 Following an incident where a mobile phone interferes with medical equipment this must be reported on Datix. The Integrated Risk Team will then be responsible for reporting this to the MHRA and NPSA as required.

10.0 REFERENCES

- NHS Protect, Patients recording NHS staff in health and social care settings (March 2016) Policy@nhsprotect.gsi.gov.uk
- NHS Protect – Misuse of Social Media to Harass, Intimidate or Threaten NHS Staff May 2016 (Policy@nhsprotect.gsi.gov.uk)
PROTOCOL FOR PATIENTS’ and VISITORS’ USE of
MOBILE PHONES within SECURE SERVICES

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The Director responsible for monitoring and reviewing this protocol is:

The Director of Specialist Services
ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

PROTOCOL FOR PATIENTS’ and VISITORS’ USE of MOBILE PHONES
within SECURE SERVICES

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PROTOCOL FOR PATIENTS’ and VISITORS’ USE of MOBILE PHONES within SECURE SERVICES

1.0 INTRODUCTION

1.1 The EPUT secure services will ensure that there are systems and procedures in place to support the unit in the management of mobile telephones used by patients and visitors, taking into account the security needs of the service. This protocol applies to all patients and visitors within the secure services directorate.

2.0 OBJECTIVES

2.1 To maintain and manage overall safety and security within the secure services, mobile phone detectors will be deployed in some secure service sites (Brockfield House and Robin Pinto Unit) to monitor any possible breaches in this and other policies which relate to the use of mobile phones within secure service sites.

3.0 REVIEW AND MONITORING

3.1 In accordance with sections 5.1.3 and 5.2.4 (below) the use of mobile telephones by patients will be subject to an ongoing risk assessment by the multi-disciplinary teams.

3.2 The risk assessment must balance the support of patients in maintaining communication with staff, relatives, carers, etc. with any associated risks arising from the individual patient having ready access to mobile telephone communication. In the case of patients’ personal mobile phones this includes any additional functions the particular phone may possess such as internet access and camera/ sound recording functions.

3.3 The risk assessment should include consideration of:

- Issues related to any past history of criminal activity
- Previous drug or alcohol problems
- The likelihood of the patient making (or attempting to make) contact with their victims or to plan meetings with others for illegal or subversive purposes.
- Accessing of pornographic material, which may have a negative impact on the treatment some patients are receiving
- All patients personal phones must be checked for mobile internet use and other mobile phone functionality (e.g. camera and other recording capabilities) as the MDT will need to give consideration to whether it is appropriate for the patient to be able to use such mobile phone functions whilst on leave.
4.0 REFERENCE TO OTHER TRUST POLICIES / PROCEDURES

- CP54 Trust Mobile Phone policy
- CPG 54 Trust Mobile Phone procedural guidelines

5.0 PROCEDURE

5.1 Patients - Ward Purchased mobile phones

5.1.1 Within all wards in the secure services patients will have the opportunity to be loaned a basic (non-smart) mobile phone which they can use with certain restrictions and with MDT agreement. These phones will lack the utility to access the internet, take pictures or have any recording function (audio or video). Such basic phones can be supplied (loaned) by the ward to the patient but will remain the property of the Trust.

5.1.2 These phones are of two types. One will allow calls or texts to any telephone number. Another type (Doro Secure 580) is defaulted to only allow up to four contact numbers to be stored. Additionally, the Doro Secure phone cannot be used for text messaging but can receive them. It will be up to the individual MDT, having assessed possible risks of the patient being loaned a Trust phone, to determine which phone type is more appropriate to manage the potential risk of the patient making inappropriate calls.

5.1.3 Where loaned a basic phone by the Trust patients will be required to purchase their own SIM card and top-up vouchers and these will remain the patient’s property.

5.1.4 When not in use all Trust mobile phones will be stored by staff who will be responsible for their management and security. For those patients who have signed the agreement these mobile phones will be logged out at the nursing station from 07.30hrs and must be returned by 22.00hrs.

5.1.5 Patients who wish to loan a Trust mobile phone will be required to sign and abide by the Agreement which sets out the conditions of its use (Appendix 2)

5.1.6 Calls will not be forwarded or transferred from the ward phone to the service user’s mobile phone.

5.1.7 Mobile telephones will be counted and audited daily; records will be kept in the security book.

5.1.8 On issuing the phone the SIM card’s serial number (SSN), and the phone’s number and IMEI number will be logged against the assigned service user. The phone will also be numbered and the service user will be assigned the same phone for every use.
5.1.9 If a service user transfers to another ward, the phone must be returned to the existing ward.

5.2 **Patients and Visitors – Personal mobile phones (including smart phones)**

5.2.1 Prior to entering the Secure Services all patients and visitors will be reminded of the restrictions regarding their own personal mobile phones.

5.2.2 If a visitor or relative brings in a smart mobile telephone for a patient to use they will be advised of the restrictions as to their use by patients. Provided it has been agreed by the patient’s MDT for him/her to have a mobile phone while on leave of absence, the patient’s visitor or relative will be asked to give the smart phone to reception staff for safe keeping and storage for the patient. In the latter case the patient will only be able to use the phone in accordance with this protocol.

5.2.3 When not being carried while on leave of absence all patients will surrender their personal mobile telephones (and the SIM cards within them) to secure services staff for safekeeping. At Brockfield House, the telephone number of the mobile telephone will be given both to security (reception) staff and to the individual ward who will record and keep this logged.

5.2.4 Any patient wishing to use their own mobile telephone whilst on community leave must make the request to their multidisciplinary team for discussion and a decision will be made at a ward round.

5.2.5 The granting of the patients’ requests for access to a mobile phone will be primarily for use on unescorted leave. However, if as part of a structured care plan for the purpose of preparatory skills development, the multidisciplinary team feel the patient should have access to a mobile phone whilst on escorted leave, this may be granted.

5.2.6 At Brockfield House, the issuing and return of the mobile phone will be managed by the reception office staff. The charger and phone must be stored securely in reception when not in use (or in the ward property cupboard at Robin Pinto Unit and the Wood Lea clinic).

5.2.7 The secure services will not routinely accept responsibility for re-charging of mobile phones. As indicated in Appendix 1 of these guidelines, the reception staff at Brockfield House will, at the patient’s request, charge the mobile phone prior to the leave provided they are given, at least, twenty-four hours’ notice.

5.2.8 Patients who have been granted permission to use their own mobile phone while on leave must sign an agreement (see Appendix 1).
5.3 **Visitors**

5.3.1 All visitors to clinical areas, including professional visitors, will be advised of the secure service’s policy which prohibits the taking of personal mobile telephones into these locations for reasons of security. For the purpose of this policy (and the Security and Etiquette protocol – SSOP 40) a clinical area is defined as any area to which patients have access, even if the access is only occasional and supervised (e.g. Gym). This prohibition includes ward staff rooms. Any visitor who refuses to adhere to this restriction will be denied access.

5.3.2 A lockable facility will be available for storing mobile phones before visiting clinical areas.