Our Ref: LW/lmw/FOI.352.23
Date: 30th November 2023

Laurie Wrench
Deputy Director of Governance
North Staffordshire Combined Healthcare NHS Trust
Lawton House
Bellringer Road
Trentham
ST4 8HH

Tel 01782 275030

Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 7th November 2023**.** Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:

1. Does your trust use CCTV cameras or other comparable equipment within seclusion rooms/suites and/or 136 suites/health-based places of safety**.** Please state where this is used and number of locations (i.e., CCTV is used in 2x seclusion rooms and 1x 136 suite)

   If the answer is no, please state if CCTV has previously been used or if the Trust is planning to implement this in seclusion rooms and/or 136 suites.
   If the trust has previously used CCTV or is planning to use this, please continue to answer the following questions in relation to the policies previously in place, or about to be implemented.
   Harplands hospital has x1 seclusion suite and 1 x 136 suite within that unit we have a non-recordable CCTV system.

2. Please provide information detailing the **consent processes** for use of CCTV in seclusion rooms and/or 136 suites.
   Patients are orientated to the environment within the seclusion suite if and when their mental state allows and informed of the cameras which are in plain sight which allows the staff to sit within the observation area without standing watching through the windows. Privacy can be allocated to the camera over the toilet and shower unless safety assessment indicates otherwise.

   Within the Section 136 suite signage is available to advise of the CCTV live feed. When patients are informed of their rights under Section 136, they are informed of this, this is also provided in a patients' rights leaflet. In the Section 136 suite the toilets and shower room are not monitored via CCTV live stream

3. Please provide information detailing **where the equipment is located** and what can be viewed, for example does this include a view of both the patient bathroom and bedroom spaces. please include the patient population, i.e., older adults, CAMHS, secure services.
   The equipment for seclusion is within the observation area and can view ALL areas with a privacy option if safety allows. The camera is within the seclusion suite itself. Seclusion is mainly used for adults of working age within Acute or Psychiatric Intensive Care Unit (PICU) beds, however there can be exceptions based upon safety for under 18's and over 65's.
   The Section 136 may be utilised for children, adults, and older adults – the suite space is covered by CCTV but not the bathroom/ shower area. The equipment for the Section 136 suite is located in the observation area outside of the actual suite.

4. Please provide details of **where the CCTV monitor screen is located** (i.e., where the footage is viewed from).
   The observation area is in both the seclusion suite and the Section 136 suite.

5. please provide copies of the trust's **standard operating procedures**, policies and procedures or other relevant document outlining CCTV use in seclusion and/or 136 suites. If these documents do not exist, please state.
   Please see Appendices 1-3 attached.

6. Please provide copies of the Trust's **equality impact assessment** relating to use of CCTV in seclusion and/or 136 suites. If these documents do not exist, please state.
   Please see Appendix 4 attached.

7. Please provide copies of the Trust's **data protection impact assessment** relating to use of CCTV in seclusion and/or 136 suites. If these documents do not exist, please state.
   Please see Appendix 5 attached.

8. Please detail any **patient involvement** in decisions around use of CCTV in seclusion rooms and/or 136 suites. For example, meeting minutes, patient consultation outcomes. If this has not occurred, please state.
   A service user representative was on the working group prior to opening of PICU. Minutes are available for this meeting.

9. Details of numbers of and copies of **complaints** relating to CCTV use (since Jan 2020). **0**

10. Details of and numbers relating to use of CCTV footage from seclusion rooms and/or 136 suites in relation to **court proceedings and/or coroners reports** (since Jan 2020) **0**

11. Details of, copies of and numbers relating to incident reports relating to trust CCTV use in seclusion rooms and/or 136 suites (since Jan 2020) **0**

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision.

The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely

Laurie Wrench
Deputy Director of Governance

Document level: Trust
Code: 5.39
Issue number: 1

CCTV POLICY

Lead executive	Director of Infection Prevention and Control
Authors details	**Estates Operations Manager**

Type of document	Policy
Target audience	Trust Wide
Document purpose	

Approving meeting	Finance and Resource Trust Board	Meeting date	1st December 2022 10th November 2022
Implementation date	30th November 2022	Review date	30th November 2025

Trust documents to be read in conjunction with	

Document change history		Version	Date
What is different?			
Appendices / electronic forms			
What is the impact of change?			

Training requirements	

Document consultation	
Directorates	
Corporate services	
External agencies	

Financial resource implications	

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1.0 Introduction

North Staffordshire Combined Healthcare NHS Trust places the health, safety and welfare of its service users, staff and visitors high amongst its priorities and will ensure it maintains a safe and secure environment throughout the organisation. Surveillance systems are now widely used within NHS care settings with the express intention of providing a safe environment. These can include, but are not limited to, Closed Circuit Television (CCTV) and Automatic Number Plate Recognition (ANPR). Any type of surveillance can only be operated and used safely within a stringent framework encompassing legal and regulatory requirements.

1.1 In drawing up this policy, due account has been taken of the following: -

- The Data Protection Act;
- Surveillance Camera Code of Practice 2013 issued under the Protection of Freedoms Act 2012 (POFA code)
- In the picture: A data protection code of practice for surveillance cameras and personal information, produced by the Information Commissioners Office (ICO);
- The Human Rights Act;
- The Regulation of Investigatory Powers Act;
- Caldicott Report;

1.2 The Data Protection Act 1998 came into force on the 1st March 2000 and contains broader definitions than those of its predecessor (1984) Act and more readily covers the processing of images of individuals caught by CCTV cameras. The changes in data protection legislation mean that for the first time legally enforceable standards will apply to the collection and processing of images relating to individuals.

1.3 An important new feature of the legislation is the Surveillance Camera Code of Practice 2013 which sets out the measures which must be adopted to comply with the Data Protection Act 1998. This goes on to set out guidance for the following of good data protection practice. The Code of Practice has the dual purpose of assisting operators of CCTV systems to understand their legal obligations while also reassuring the public about the safeguards that should be in place.

2.0 Scope

This policy is binding on all employees of the Trust, persons providing a service (voluntary or paid) to the Trust, patients, visitors and all other persons whose image(s) may be captured by a surveillance system.

3.0 Legal Framework and Requirements

3.1 Article 8 of the Human Rights Act 1998 protects the right to respect for private and family life. No public Authority may interfere with this right except when in accordance with the law and when necessary. Any interference must be proportional to the threat or risk to community safety, comply with all relevant legal requirements, be necessary for safety and the prevention and detection of crime and cause the minimum of interference to the individual. The use of CCTV must therefore be open to scrutiny and be fully documented.

Prior to considering compliance with the principles of the DPA, a user of CCTV or similar surveillance equipment, will need to determine two issues:

- The type of personal data being processed, i.e. is there any personal data which falls within the definition of sensitive personal data as defined by Section 2 of the DPA;

  'Sensitive personal data' includes:
  - racial and ethnic origin;
  - offences and alleged offences;
  - criminal proceedings, outcomes and sentences;
  - trade union membership;
  - physical or mental health details;
  - religious or similar beliefs;
  - sexual life

- The purpose(s) for which both personal and sensitive personal data is being processed. The data must be:
  - fairly and lawfully processed;
  - processed for limited purposes and not in any manner incompatible with those purposes;
  - adequate, relevant and not excessive;
  - accurate;
  - not kept for longer than is necessary
  - processed in accordance with individual's rights;

- secure;
- not transferred to countries without adequate protection;

3.2 The Information Commissioner will take into account the extent to which users of CCTV and similar surveillance equipment have complied with this Code of Practice when determining whether they have met their legal obligations when exercising their powers of enforcement.

3.3 Any removable drives, including CD's, DVD's hard drives and video tapes will also be deemed to be part of the CCTV system and will also be covered by the content of this policy.

3.4 The Local Security management Specialist (LSMS) is contactable via the Estates Agency to provide technical advice.

3.5 The Information Commissioner has issued a data protection code of practice for surveillance cameras and personal information and the Trust is required to comply with the guidelines within that document.

4.0 Definitions

4.1 Closed-circuit television (CCTV) is the use of video cameras to transmit a signal to a specific, limited set of monitors. It differs from broadcast television in that the signal is not openly transmitted.

4.2 Automatic Number Plate Recognition (ANPR) is a system that uses cameras to identify the number plates of cars entering and leaving car parks. The information recorded is used to determine whether cars have been on site legitimately by checking against a database of registered users (visitors can register on a daily basis via touchscreens provided). When vehicles are detected that are not on the database the system operator uses the DVLA's vehicle keeper database to find out who the keeper is, and then issue a Parking Charge Notice (PCN).

4.3 Data Protection Act 1998 (DPA) is an Act of Parliament of the United Kingdom of Great Britain and Northern Ireland which defines UK law on the processing of data on identifiable living people. It is the main piece of legislation that governs the protection of personal data in the UK.

4.4 Information Commissioners Office (ICO) is the Government Office responsible for the enforcement of the Data Protection Act 1998, and also responsible for Freedom of Information.

4.5 Surveillance Camera Code of Practice (SCCP) June 2013 is the code of practice issued by the Secretary of State under Section 30 of the Protection of Freedoms Act 2012.

4.6 In the picture: A data protection code of practice for surveillance cameras and personal information is a document produced by the Information Commissioners Office (ICO) and sets out the Information Commissioner's recommendations on how the legal requirements of the DPA can be met.

4.7 Freedom of Information (FOI) 2000 provides public access to information held by public authorities. The Act covers any recorded information that is held by a public authority in England, Wales and Northern Ireland.

- Public authorities include government departments, local authorities, the NHS, state schools and police forces.

- Recorded information includes printed documents, computer files, letters, emails, photographs, and sound or video recordings.

4.8 Protection of Freedoms Act 2012 (POFA) - specifically Part 2; Regulation of Surveillance.

5.0 Duties

5.1 Trust Board

The Trust Board has overall responsibility for ensuring that the Trust meets its statutory obligations and that effective security arrangements are in place and are periodically reviewed.

5.2 Security Management Director

Executive Director of Operations is the Trust Executive Director with nominated responsibility for security matters as defined in the Secretary of State for Health's Directions to NHS Bodies on Security Management Measures 2004.

5.3 Security Manager

The Security Manager (LSMS) has specific responsibility for Security matters within the Trust and to ensure that a consistent approach is adopted towards the provision of Security advice and monitoring. The Security Manager discharges the role of Local Security Management Specialist as defined in the Secretary of State for Health's Directions to NHS Bodies on Security Management Measures 2004.

5.4 All Managers

Managers are responsible for: The development and adaptation of Trust Security procedures to ensure that they are relevant to specific Directorate / Departmental needs; Overall supervision of the day to day security measures within their Directorate or Department; Ensuring that any incident of crime or suspected crime is reported to Security Department; Ensuring that appropriate education and training is provided for all staff.

5.5 All Staff

All members of staff have a responsibility to ensure that they comply with relevant Security policies and procedures (see Trust Intranet for policies). It is also essential that all Security incidents involving, or observed by staff, are reported in accordance with the Trust's incident reporting procedure.

6.0 Policy Statement

6.1 All associated information, documents, and recordings obtained by CCTV are held and used in accordance with the Data Protection Act.

6.2 Images obtained from CCTV recordings will not be used for any commercial purpose. Recordings will only be released to the media for use in investigation of a specific crime and with the written consent of the Police. Recordings will not be released to the media for purposes of entertainment.

6.3 Archived CCTV images will not be kept for longer than is necessary for the purpose of Police evidence. Once there is no longer a need to keep the CCTV images, they will be destroyed as confidential waste.

6.4 All associated information, documents, and recordings obtained and used by CCTV are protected by the Data Protection Act.

6.5 Cameras monitor activities on Trust premises, car parks and other public areas to identify criminal activity whether occurring, anticipated, or perceived in order to enhance the safety and wellbeing of staff, patients, and visitors.

6.6 Except when specifically authorised by the NHS Protect, using specific Directed Surveillance as stipulated in the Regulation of Investigatory Power Act 2000 (RIPA), staff must not direct cameras at an individual, their property, or a specific group of individuals.

6.7 The planning and design of CCTV systems has endeavoured to ensure maximum effectiveness and efficiency but cannot guarantee to cover or detect every incident occurring within the areas covered.

6.8 Warning signs, as required by the Code of Practice of the Information Commissioner are displayed at all access routes to areas covered by the Hospital CCTV.

6.9 No CCTV scheme should be initiated, installed, moved or replaced without prior approval by the Caldicott Guardian, or someone delegated to approve such schemes. The Data Protection Officer must also be informed.

7.0 Operation of the System

7.1 All schemes will be monitored and managed using the following procedures and must be formally approved (as above) prior to any installation.

7.2 The Quality and Governance Committee will assess the overall appropriateness of and reasons for, using CCTV or similar surveillance equipment.

7.3 The assessment process and the reasons for the installation of the scheme will be clearly documented.

7.4 Assessment / findings will be shared with the Directorate/Division involved. Once agreement gained, log with the Quality and Governance Committee.

7.5 The purpose of the scheme will be documented in accordance with current legislation.

7.6 Any new schemes will be checked against our current notification that is held by the Information Commissioner.

7.7 The person(s) or organisation(s) who are responsible for ensuring the day-to-day compliance with the operational requirements of such schemes and this policy will be documented.

7.8 Each CCTV system will have an accountable 'Scheme Manager' who is responsible on a day-to-day basis for the appropriateness of its use. This will generally be the senior manager of the unit / area concerned.

7.9 All camera installations and service contracts should be undertaken by National Security Inspectorate (NSI) approved security companies.

7.10 All CCTV equipment should be serviced and maintained on an annual basis and recorded locally and a copy of the information sent to the Security Manager.

7.11 All CCTV images if recorded must be retained for a minimum of 31 days and then erased permanently.

7.12 A daily log sheet must be completed when the tapes are changed and the images checked for quality.

7.13 CCTV is commonly used in public areas where the public have unlimited access. If CCTV is to be used in communal areas for example day rooms or dining rooms there must be a clear reason for installation and there should be a patient leaflet recording this reason which is given to all patients who will use that area.

7.14 The Code of Practice requires that signs are placed in all areas covered by CCTV so that everyone is aware they are entering a zone covered by surveillance equipment. The signs need to contain the following information:

- Identity of the organisation responsible for the scheme

The purposes of the scheme
Details of who to contact regarding the scheme

- The purposes of the scheme
- Details of who to contact regarding the scheme

7.15 The equipment should be sited in such a way that it only monitors the spaces which are intended to be covered by the equipment.

7.16 It is important that the images produced by the equipment are as clear as possible in order that they are effective for the purposes for which they are intended.

8 Access To and Disclosure of Images

8.1 Processing the images

8.1.1 Images, which are not required for the purpose(s) for which the equipment is being used, should not be retained for longer than is necessary and will be disposed of in a secure manner ASAP. While images are retained, it is essential that their integrity be maintained, whether it is to ensure their evidential value or to protect the rights of people whose images may have been recorded. It is therefore important that access to and security of the images is controlled in accordance with the requirements of the DPA.

8.1.2 All images are digitally recorded and stored securely within the systems hard drives, for up to 31 days when they are then automatically erased.

8.1.3 Where the images are required for evidential purposes in legal or Trust disciplinary proceedings, a cd-r disc recording is made and placed in a sealed envelope signed and dated and held by the Data Protection Officer / LSMS until completion of the investigation. Viewing of images is controlled by the Data Protection Officer / LSMS or a person nominated to act on his behalf. Only persons trained in the use of the equipment and authorised by the Data Protection Officer / LSMS can access data.

8.1.4 Criteria for the viewing of images by non-security related personnel: At the discretion of the responsible officer, individuals may be allowed to view images:

- If they are investigating an untoward incident
- In the case of a missing patient
- To identify persons relating to an incident

Areas which would normally result in permission being refused include:

- Where the person wishing to view has no connection with the incident or has no management role relating to an incident
- Where viewing is purely salacious
- Where the performance of a member of staff not relating to crime, fraud or the investigation of untoward incidents is involved.

Access to the recorded images must be restricted to a manager or designated member of staff. All accessing or viewing of recorded images must only occur within a restricted area and other employees should not be allowed to have access to that area or the images when a viewing is taking place.

If images are to be specifically retained for evidential purposes i.e. following an incident, break-in, etc, then these will be retained in the Trust Data Protection Officer / LSMS office to which access is controlled. Requests may be granted by the Trust Data Protection Officer / LSMS and will arise in a number of ways including :

- Requests for a review of images, in order to trace incidents that have been reported to the Police
- Immediate action relating to live incidents e.g. immediate pursuit
- Individual police officer seeking to review images.

Any request for recordings from the Police, in the process of their enquiries, the appropriate view (Appendix 1) and/or release (Appendix 2) form must be completed and handed to the Trust Data Protection Officer /LSMS before the Trust Data Protection Officer /LSMS approves the release of the CCTV footage.

8.2 Access to and disclosure of images to third parties

8.2.1 It is important that access to, and disclosure of, the images recorded by CCTV and similar surveillance equipment is restricted and carefully controlled. This will ensure that the rights of individuals are preserved, but also to ensure that the continuity of evidence remains intact should the images be required for evidential purposes e.g. a Police enquiry or an investigation being under taken as part of the Trusts' disciplinary procedure.

8.2.2 Access to the medium on which the images are displayed and recorded is restricted to Trust staff and third parties as detailed in the purpose of the scheme.

8.2.3 Access and disclosure to images is permitted only if it supports the purpose of the scheme. Under these conditions the CCTV images record book and the appropriate view (Appendix 1) and/or release (Appendix 2) form must be completed.

8.3 Access to images by individuals

8.3.1 Section 7 of the Data Protection Act 1998 gives any individual the right to request access to personal data. Individuals must make their request to access to the Trusts' Data Protection Lead by completing the appropriate view / release form (Appendix 3). The Trusts' Data Protection Lead will determine whether disclosure is appropriate and whether there is a duty of care to protect the images of any third parties. If the duty of care cannot be discharged then the request can be refused.

8.3.2 A written response will be made to the individual, giving the decision (and if the request has been refused, giving reasons) within 21 days of receipt of the enquiry. If disclosure is appropriate a payment to the Trust will be required.

9.0 Use of Mobile Telephones Equipped With Cameras and Other Recording Devices

9.1 This section should be read in conjunction with the current Trust "Policy on the Issue, use and Security of Mobile Telephones" with particular attention being drawn to section 4 and 6.

9.2 North Staffordshire Combined Healthcare presently issues mobile telephones to staff who require such equipment to necessitate their duties on behalf of the Trust. Their issue is for the purpose to voice communication only, except whereby their use has been authorised for the purpose of mobile communication over the internet or to facilitate the use of email on the move.

9.3 Where used on Trust sites mobile phones should not be used for inappropriate use particularly in respect of photographing patients, visitors, relatives, and members of the public - the Trust in all cases prohibits the use of any visual or other recording device whilst present on Trust premises, or engaged in business on behalf of the Trust. This should be widely publicised in patient literature and supported by appropriate signage across Trust premises.

9.4 Such measures are deemed necessary by the Trust in order to comply fully with the Data Protection Act, and as such any act involving the capture of either visual or audible data is not covered by current licenses held by the Trust, and would therefore be deemed unlawful.

9.5 Any suspicion or allegation of impropriety or misuse of a mobile telephone, will be investigated by the Security Management Specialist, and or the Police, and may result in disciplinary action or prosecution of the member of staff.

10 Covert CCTV Surveillance

Under the Regulation of Investigatory Powers Act 2000 covert or directed surveillance can only be carried out with the permission of the Chief Executive or under instruction from the police. Covert surveillance should be strictly targeted at obtaining evidence where there are grounds for suspecting criminal activity and that notifying the individual about the monitoring would prejudice its prevention or detection. Covert surveillance must not continue when an investigation is complete. Cameras should not be placed in areas which would reasonably be expected to be private (e.g. toilets).

11 Responsibilities

11.1 The Trust Board has corporate responsibility for the implementation of policy, and in monitoring its effectiveness.

11.2 The Trust Board discharges this responsibility through the appropriate Executive Director for Security whom is the Director of Nursing as the Trust's SMD.

11.3 The Trust's Data Protection Officer is also personally accountable for ensuring that the policy is adhered to and monitored.

12 Enforcement

The Data Protection Commissioner has the power to issue Enforcement Notices where they consider that there has been a breach of one or more of the Data Protection Principles. An Enforcement Notice would set out the remedial action that the Commissioner requires of the Trust to ensure future compliance with the requirements of the Act.

Additionally any such would be investigated by the Trust, and may result in disciplinary action or prosecution of the person(s) concerned.

13 Complaints

Grievances and complaints regarding the operation of the Trusts CCTV system should be processed through the Trusts complaints procedure.

14 Review

This policy will be reviewed 3 yearly, or earlier in the light of changing circumstances by the Quality and Governance Committee.

Appendix 1

Application for access to recorded images

Section 1 - Declaration
I understand that any information I obtain from CCTV is protected under the Data Protection Act 1998.

Section 2 - Details of Person who will supervise the Access				
Title	Mr	Mrs	Miss	Ms
Other Title (e.g. Dr, Rev)				
Surname				
First name/s				
Position				
Date Image Was Viewed				
Signature				

Section 3 - Details of Person Requesting Access				
Title	Mr	Mrs	Miss	Ms
Other Title (e.g. Dr, Rev)				
Surname				
First name				
Position				
Address				
Telephone Number				
Date Image Was Viewed				
Signature				

The reason for access: (tick below)		
Preventing or detecting crime or disorder		
Apprehension and prosecution of offenders (including use of images as evidence in criminal proceedings)		
Interest of public and employee safety.		
Protecting public health		
Staff disciplinary investigations		
Reasons - please explain		
Description of Individual		

Details of Person who assess the request of Access
Print Full Name ……Position ……
Signature
……..Date……..
Access approved / Access not approved
Reasons ……..……..
…….

Date(s) and time(s) of incident	
Location / Camera Number to be viewed	
Type of access required	Viewing / Copy of image / Other

Section 4 - Details of Person who assess the request of Access				
Title	Mr	Mrs	Miss	Ms
Other Title (e.g. Dr, Rev)				
Surname				
First name/s				
Position				
Date				
Signature				

Access Approved

Access Not Approved

Reasons

Appendix 2

Application for Release of Recorded Images

Section 1 - Declaration
I understand that any information I obtain from CCTV is protected under the Data Protection Act 1998.

Section 2 - Details of Person Releasing the Image				
Title	Mr	Mrs	Miss	Ms
Other Title (e.g. Dr, Rev)				

Surname	
First name/s	
Position	
Date Image Was Released	
Signature	

Section 3 - Details of Person Requesting Access				
Title	Mr	Mrs	Miss	Ms
Other Title (e.g. Dr, Rev)				
Surname				
First name				
Position (PC No if Police)				
Address				
Telephone Number				
Date Image Was Released				
Signature				

The reason for access: (tick below)		
Preventing or detecting crime or disorder		
Apprehension and prosecution of offenders (including use of images as evidence in criminal proceedings)		
Interest of public and employee safety.		
Protecting public health		
Staff disciplinary investigations		
Reasons - please explain		
Return Date		

Appendix 3

Application for access to recorded images (subject access request)

Section 1 - About yourself
The information requested below is to help **North Staffordshire Combined Healthcare NHS Trust** to satisfy itself as to your identity and find any data held about you.

Title	Mr	Mrs	Miss	Ms
Other Title (e.g. Dr, Rev)				

Surname / family name				
First name/s				
Maiden name / former name				
Sex (tick box)	Male		Female	
Height				
Date of Birth				
Place of Birth	Town		County	

Your current home address (to which we will reply)	Postcode
A telephone number will be helpful in case you need to be contacted	Tel No :

If you have lived at the above address for less than 10 years, please give your previous addresses for the period				
Previous address(es)				
Dates of occupancy	From		To	
Dates of occupancy	From		To	

SECTION 2 - Proof of Identity
To help establish your identity your application must be accompanied by TWO official
documents that between them show your name, date of birth and current address. For example, a birth / adoption certificate, driving license, medical card, passport of other official document that shows your name and address. Also a recent full face photograph of yourself.

Failure to provide this proof of identity may delay your application

SECTION 3 – Supply of information
You have a right, subject to certain exceptions to receive a copy of the information in a permanent form. Do you wish to (please select) :

☐ Only view the information

SECTION 4 – Declaration
DECLARATION (to be signed by the applicant)

I have read and understood the accompanying leaflet explaining North Staffordshire Combined Healthcare Trust's policy in relation to the purpose of the CCTV surveillance and the arrangements for access to record images.

I certify that the information that I have supplied in this application is true and accurate and I am the person to whom it relates.

SECTION 4 – Declaration

I understand that is it necessary for (health body) to confirm my identity and it may be necessary to obtain more detailed information in order to locate the correct information.

I enclose a non-refundable payment of £10 for the search to be completed.

Signed by		Date	

WARNING A PERSON WHO IMPERSONATES OR ATTEMPT(S) TO IMPERSONATE ANOTHER MAY BE GUILTY OF AN OFFENCE

NOW - Please complete Section 4 and then the CHECK box (section 5) **before** returning the form.

SECTION 5 - To help us find the information
If the information you have requested refers to a specific offence or incident, please complete this section.

Please complete a separate box in respect of different categories / incidents / involvement, continue on a separate sheet, in the same way if necessary.

If the information you require relates to a vehicle, property, or other type of information, please complete the relevant section.

Were you (tick below)				
A person reporting an (alleged) offence or incident				
incident				
A witness to an (alleged) offence or incident				
A victim of an (alleged) offence				
A person accused or convicted of an offence				
Other - please explain				

Date(s) and time(s) of incident

NOTE: The **North Staffordshire Combined Healthcare NHS Trust** reserves the right to obscure or suppress information relating to other third parties (under the terms of the Data Protection Act 1998).

Further Information These notes are only a guide. The law is set out in the Data Protection Act 1998. Further information and advice may be obtained from the

Information Commissioner
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Tel: (01625) 545745

Please note that this application for access to information must be made direct to **North Staffordshire Combined Healthcare NHS Trust** and **NOT** to the Data Protection Commissioner.

Signed by		Date	

A written response to your application will be made within 21 days.

Appendix 1

Application for access to recorded images

Section 1 - Declaration

I understand that any information I obtain from CCTV is protected under the Data Protection Act 1998.

Section 2 - Details of Person who will supervise the Access				
Title	Mr	Mrs	Miss	Ms
Other Title (e.g. Dr, Rev)				

Surname	
First name/s	
Position	
Date Image Was Viewed	
Signature	

Section 3 - Details of Person Requesting Access				
Title	Mr	Mrs	Miss	Ms
Other Title (e.g. Dr, Rev)				
Surname				
First name				
Position				
Address				
Telephone Number				
Date Image Was Viewed				
Signature				

The reason for access: (tick below)		
Preventing or detecting crime or disorder		
Apprehension and prosecution of offenders (including use of images as evidence in criminal proceedings)		
Interest of public and employee safety.		
Protecting public health		
Staff disciplinary investigations		
Reasons - please explain		

Details of Person who assess the request of Access
Print Full Name ……Position ……
Signature
……..Date……..

Access approved / Access not approved

Date(s) and time(s) of incident	
Location / Camera Number to be viewed	
Type of access required	Viewing / Copy of image / Other

Section 4 - Details of Person who assess the request of Access				
Title	Mr	Mrs	Miss	Ms
Other Title (e.g. Dr, Rev)				
Surname				
First name/s				
Position				
Date				
Signature				

Access Approved

Access Not Approved

Reasons

Appendix 2

Application for Release of Recorded Images

Section 1 – Declaration

I understand that any information I obtain from CCTV is protected under the Data Protection Act 1988.

Section 2 - Details of Person Releasing the Image	
Title	Mr ☐ Mrs ☐ Miss ☐ Ms ☐
Other Title (e.g. Dr, Rev)	
Surname	
First name/s	
Position	
Date Image Was Released	
Signature	

Section 3 - Details of Person Requesting Access				
Title	Mr	Mrs	Miss	Ms
Other Title (e.g. Dr, Rev)				
Surname				
First name				
Position (PC No if Police)				
Address				
Telephone Number				
Date Image Was Released				
Signature				

The reason for access: (tick below)		
Preventing or detecting crime or disorder		
Apprehension and prosecution of offenders (including use of images as evidence in criminal proceedings)		
Interest of public and employee safety.		
Protecting public health		
Staff disciplinary investigations		
Reasons - please explain		
Return Date		

Appendix 3

Application for access to recorded images (subject access request)

Section 1 - About yourself

The information requested below is to help **North Staffordshire Combined Healthcare NHS Trust** to satisfy itself as to your identity and find any data held about you.

Title	Mr				Mrs				Miss				Ms			
Other Title (e.g. Dr, Rev)																

Surname / family name				
First name/s				
Maiden name / former name				
Sex (tick box)	Male			Female
Height				
Date of Birth				
Place of Birth	Town		County	

Your current home address (to which we will reply)	
Postcode	
A telephone number will be helpful in case you need to be contacted	
Tel No :	

If you have lived at the above address for less than 10 years, please give your previous addresses for the period				
Previous address(es)				
Dates of occupancy	From		To	
Dates of occupancy	From		To	

SECTION 2 - Proof of Identity

To help establish your identity your application must be accompanied by TWO official documents that between them show your name, date of birth and current address.

For example, a birth / adoption certificate, driving license, medical card, passport or other official document that shows your name and address.

Also, a recent full face photograph of yourself.

Failure to provide this proof of identity may delay your application.

SECTION 3 - Supply of Information

You have a right, subject to certain exceptions to receive a copy of the information in a permanent form. Do you wish to (please select) :

☐ View the information and receive a permanent copy

☐ Only view the information

SECTION 4 – DECLARATION (to be signed by the applicant)

I have read and understood the accompanying leaflet explaining North Staffordshire Combined Healthcare Trust's Policy in relation to the purpose of the CCTV surveillance and the arrangements for access to recorded images.

I certify that the information that I have supplied in this application is true and accurate and I am the person to whom it relates.

SECTION 4 – Declaration

I understand that is it necessary for (health body) to confirm my identify and it may be necessary to obtain more detailed information in order to locate the correct information.

I enclose a non-refundable payment of £10 for the search to be completed.

Signed by : Date :

WARNING A PERSON WHO IMPERSONATES OR ATTEMPT(S) TO IMPERSONATE ANOTHER MAY BE GUILTY OF AN OFFENCE.

NOW – please complete Section 4 and then CHECK box (section 5) **before** returning the form.

SECTION 5 – To help us find the information

If the information you have requested refers to a specific offence or incident, please complete this section.

Please complete a separate box in respect of different categories / incidents / involvement, continue on a separate sheet, in the same way if necessary.

If the information you require relates to a vehicle, property, or other type of information, please complete the relevant section.

Were you (tick below)				
A witness to an (alleged) offence or incident				
A victim of an (alleged) offence				
A person accused or convicted of an offence				

Other - please explain :

Date(s) and time(s) of incident :

Place of incident happened :

Brief details of incident :

Before returning this form, please check:	
Have you completed ALL sections in this form?	
Have you enclosed TWO identification documents?	
Have you signed and dated the form?	
Have you enclosed the £10 (ten pound) fee?	
Included a stamped addressed envelope for the return of proof of identity / authority documents (where appropriate).	

NOTE : The North Staffordshire Combined Healthcare NHS Trust reserves the right to obsecure or suppress information relating to other third parties (under the terms of the Data Protection Act 1998).

Further Information

These notes are only a guide. The law is set out in the Data Protection Act 1998. Further information and advice may be obtained from the :

Information Commissioner
Wycliffe House
Water Lane
Wilmslow
CHESHIRE
SK9 5AF

Tel Number : (01625) 545745

Please note that this application for access to information must be made direct to **North Staffordshire Combined Healthcare NHS Trust** and **NOT** to the Data Protection Commissioner.

Signed :

Date :

Staffordshire and Stoke on Trent Inter-agency – Section 136 Policy

Document Information	
CATEGORY	Policy
THEME	Mental Health Act 1983
DOCUMENT REFERENCE	MHA14 - Section 136 Policy
POLICY LEAD	Staffordshire Policy Working Group for Section 136
APPROVAL DATE	2nd September 2021
APPROVAL BODY	Quality Committee
RATIFICATION DATE	9th September 2021
REVIEW DATE	30th September 2024

CHANGE CONTROL DETAILS (complete as appropriate)

Date	Version	Description	Reason for changes
31-05-2016	2	Final Version	1st review
22-11-2017	3	Final Version	Final Review
February 2021	4	Final Version	Final Review

Memorandum of Understanding between:

Signature
Print
Date

Signature
Print
Date

Signature
Print
Date

Signature
Print
Date

North Staffordshire Combined Healthcare NHS Trust

Signature
Print
Date

City of Stoke-on-Trent

Signature
Print

Date

University Hospitals of North Midlands NHS Trust

Signature:
Print:
Date:

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1. Introduction

1.1 This document has been developed following consultation with the Staffordshire Police Force, Staffordshire Health Trusts, West Midlands Ambulance Service, and Local Authorities The policy provides a framework that will support improved service delivery and the appropriate use of resources and is supplemented by detailed local procedures. This provides both an overarching policy, operational procedures and considers the following guidance and legislation.

Mental Health Act 1983 and all relevant amendments
Mental Health Act Code of Practice as revised 2015 (MHA COP)
Mental Capacity Act 2005
Police and Criminal Evidence Act 1984 and all relevant amendments
Police and Criminal Evidence Act Code of Practice (PACE)
Human Rights Act 1998
Data Protection Act 1998
Equality Act 2010

2. Guiding principles

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

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

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

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

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

3 Legal Criteria

3.1 *S136 (1) "if a constable comes across a person who appears to him/her to be suffering from mental disorder and to be **in immediate** need of **care or control**, the constable **may**, if he/she thinks it necessary to do so in the interests of that person, or for the protection of other persons, remove that person to a place of safety…"*

3.2 *S136(2) "A person removed to a place of safety under this section may be detained there for the permitted period of detention for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment and care."*

3.3 Subsection 136(2a) in subsection 136(2) the permitted period of detention means:

a. The period of 24 hours beginning with:
   i. In a case where the person is removed to a place of safety, the time when the person arrives at that place of safety;
   ii. In a case where the person is kept at a place of safety, the time when the constable decides to keep the person at that place; or

Where an authorisation is given in relation to the person under Section 136B, that period of 24 hours and such further period as is specified in the authorisation.

3.4 136B – 'Consecutive period' Extension of detention for 12 hours

1. The Section 12 doctor who is responsible for the examination of a person detained under Section 136 or Section 135 may, at any time before the expiry of the period mentioned in subsection 136 (2a), authorise the detention of the person for a further period not exceeding 12 hours (beginning consecutively at the end of the first 24 hours).
2. An authorisation under subsection (1) may be given only if the Section 12 doctor considers that the extension is necessary because the condition of the person detained is such that it would not be practicable for the assessment of the person for the purpose of Section 136 to be carried out before the end of the period of 24 hours (or, if the assessment began within that period, for it to be completed before the end).
3. If the person is detained at the police station, and the assessment would be carried out or completed at the station, the Section 12 doctor may give an authorisation under subsection (1) only if an officer of the rank of superintendent or above approves it.

The maximum period a person may be detained under Section 136 is 24 hours (with the option of extending by 12 hours). In practice, detentions should not need to be this long. Arrival at the first place of safety starts the 24 hour time period, this would include the time of arrival at A&E, if the individual went there first (MHA COP 16.26).

Consecutive periods of detention under Section 136 are unlawful.
Please note that S136 is subject to PACE but it is not a criminal offence.

4. Detention under Section 136

4.1 Role of the Police Officer

The police must determine the individual:

- was found **anywhere other than:**
  - any house, flat or room where that person, or any other person, is living, or
  - any yard, garden, garage or outhouse that is used in connection with the house, flat or rooms.
  - For the purpose of exercising this power the Police Constable can enter any place where the power may be exercised by force.
- The individual **appears to be mentally disordered,** is in need of **immediate care or control,** and that this is **the most appropriate course of action.**

It is not appropriate to encourage a person outside in order to use Section 136 powers.

Mental disorder - The police are not expected to be mental health experts. Intoxication with alcohol or drugs by themselves is not a mental disorder.

Immediate Care and Control / Appropriate action – Where there is no immediate need for the person to have care or control, officers must consider alternatives to Section 136. If an individual is requesting support or agreeing to care, officers must consider alternative options unless the risks or the person's behaviour suggests otherwise.

4.2 Considerations before the implementation of S136

Before deciding whether or not to keep a person at, or remove a person to, a place of safety under Section 136(1), the Constable is now required, if it is practicable to do so, to consult one of a list:

a. A registered medical practitioner,
b. A registered nurse,
c. An Approved Mental Health Professional, or
d. A person of a description specified in regulations made by the Secretary of state.

Locally this will include contact with Community Street Triage, Access Team, or Site Manager at the Mental Health PoS for advice and information pertaining to the individual. Are they known? Options available - do they have a care plan / crisis plan? Do they have an imminent appointment / can an urgent appointment be organised? Can Triage attend the scene to offer support?

Can the person stay with a responsible family member / friend / carer and see their GP?

Is the person's behaviour due to physical injury (e.g. head injury), illness (e.g. diabetes, epilepsy or sickle cell disease), or self-harm (e.g. overdose, self-inflicted injury) if so emergency assistance should be given and an ambulance called.

If an offence has been committed, should the individual be arrested?

4.3 Criminal Offence / Arrest

Section 136 cannot be used following an arrest for a criminal offence; if officers have concerns about an individual's mental health who they have arrested, they must inform the custody sergeant who can arrange for a mental health assessment in police custody.

Where an individual is detained by the police under Section 136 but has committed a criminal offence, the person should be arrested unless the offence is so trivial as to be safely set aside. This might well occur where the offending was very low-level, possibly 'victimless' and where the behaviour is most likely to be related to their mental health condition.

For offences which are not trivial, it is ultimately up to the discretion of the arresting officer to decide if the person should be removed to police custody or to prioritise detention in a health based place of safety.

In these circumstances, the arresting officer must inform the person in charge of the place of safety so that arrangements can be made to take the person to police custody when appropriate following discharge of the Section 136

Following any arrest for an offence, an ambulance must still be called where the individual is presenting with any of the conditions outlined in the appendices.

There must be no assumption by police officers or anyone else, that the individual cannot be prosecuted because of their mental health condition. A thorough criminal investigation of the incident should occur on each occasion.

If the person is drunk and there is no evidence of mental disorder, officers could consider dealing with the individual for drunkenness in a public place, drunk and disorderly or drunk and incapable or contact paramedics if there are concerns about the individual's physical health.

4.4 Circumstances where Section 136 must not be used

S136 of The Mental Health Act must not be used where:

- Any of the statutory criteria are not fulfilled.
- After arrival at the police station following an arrest, the person shows signs of possible mental disorder. The custody officer may, however, request a Mental Health Act assessment within the legal framework of PACE.
- An application has already been made to detain the person under the Mental Health Act but the person escapes from custody before being admitted to hospital or nursing home
- A person, already detained under the Mental Health Act, has failed to return from leave or is absent without leave.

4.5 Information to be given to the detainee:

Police officers must use tact and discretion in communicating to the person that they have been **detained** under S136 of the Mental Health Act due to concerns about their health, safety or the safety of others. It may be necessary to repeat this several times.

Whilst S136 does not use the term arrest, it is a preserved power of arrest under S26 of The Police and Criminal Evidence Act (PACE).

There is no requirement to caution a person detained under s136 and this should be avoided.

4.6 On detention:

Staffordshire Police Contact Services and Contact Service Operators will be informed;

The operator will:

- request the attendance of an ambulance for medical assessment / Transportation via 999;
- contact the chosen PoS to check availability
- Provide an estimated time of arrival for the detainee to the PoS and basic information about the case.
- Provide information of any risks identified

Police officers bear the legal responsibility for the health and safety of their detainee until formal, agreed handover to NHS staff at the PoS;

4.7 Where a person is detained under Section 136(2) or (4) , a Constable may search the person, at any time while the person is so detained, if the constable has reasonable grounds for believing that the person:

a) May present a danger to himself or herself or to others, and
b) Is concealing on his or her person an item that could be used to cause physical injury to himself/herself or others.

The search power is designed to ensure the safety of all involved and should be used appropriately to support policing and health agencies to effectively care for and support the person. The new power does not include any restrictions around age or any other characteristic of the person to be searched. However, the power does not require a person to be searched. Any search conducted by the officer under new section 136C is limited to actions reasonably required to discover an item that the officer believes that the person has or may be concealing. The officer may only remove outer clothing. The officer may search the person's mouth, but the new power does not permit the officer to conduct an intimate search.

5. Transportation

5.1 The West Midlands Ambulance Service will provide an initial health based assessment to determine any immediate health care needs and then transport from the location where the person was detained to the designated PoS, and from the PoS to the mental health provision if admitted and not at the same location. West Midlands Ambulance Service will provide a copy of the Physical Health Assessment (Patient Clinical Record) to the PoS .

The detained person will then be conveyed to a PoS in line with the **West Midlands Ambulance Service and Staffordshire and Stoke-on-Trent Transportation Policy**. This is not only important in terms of the patient's dignity, it is also important in terms of the skills of ambulance service staff in assessment whether other medical risks may be masked by mental ill-health and/or drugs and alcohol, requiring urgent medical assessment in an emergency department.

The police will on ALL occasions travel with the patient either in the ambulance or police vehicle as the police hold the detaining power which cannot be delegated. **Where police vehicle is used for Transportation the paramedic will travel in the police vehicle.** Where an ambulance is unavailable, police officers must still make their initial assessment in accordance with appendices 2 and 3 with due allowance made by other professionals for the limited mental health knowledge. In exceptional circumstances, police officers may decide to expedite Transportation themselves; this must be in cases of urgency where it is necessary to safely manage a risk of violence or to prevent escape. When doing so, consideration must be given to ambulance staff travelling in the police car with appropriate medical kit. Police vehicles must never be used where there is a medical emergency. Where a patient is presenting with a RED FLAG trigger condition (see appendix 3) an ambulance must be used. In all cases, Transportation arrangements must be recorded on the Section 136 Record, and incidents reported to the Locality Group via the exception monitoring form.

5.2 Role of the Ambulance Service:
The ambulance service is the preferred method of transportation. It is up to the ambulance service to make operational judgements as to the most appropriate type of vehicle.

It is the responsibility of the ambulance crews to consider the presentation of the patient detained by the police, particularly focusing on their physical needs. Where paramedics or technicians believe that the patient requires medical treatment they must advise that person's removal to an emergency department. Ambulance staff may consider it necessary to provide emergency treatment, after paying due consideration to issues of capacity and consent. Details of this treatment must be recorded on the S136 Record and handed over to the PoS staff.

Where it is considered that the safety either of the patient, the ambulance staff or the police officers would be at risk during transfer, ambulance crews must give consideration to requesting a pre-hospital doctor via **emergency on call service** for sedation, if appropriate

6. Designated Places of Safety (PoS)

6.1 The definition of 'Place of Safety' is found Section 135 (6) and (7) and states:
"Place of Safety" means residential accommodation provided by a local social services authority under Part 1 of the Care Act 2014 or Part 4 of the Social Services and Well-being (Wales) Act 2014 a hospital as defined by this Act, a police station, an independent hospital or care home for mentally disordered persons or any other suitable place.

For the purpose of Subsection (6):

a) A house, flat or room where a person is living may not be regarded as a suitable place unless:
   i. If the person believed to be suffering from a mental disorder is the sole occupier of the place, that person agrees to the use of the place as a place of safety;
   ii. If the person believed to be suffering from a mental disorder is an occupier of the place but not the sole occupier, both that person and one of the other occupiers agree to the use of the place as a place of safety;
   iii. If the person believed to be suffering from a mental disorder is not an occupier of the place, both that person and the occupier (or, if more than one, one of the occupiers) agree to the use of the place as a place of safety;

b) A place other than one mentioned in paragraph (a) may not be regarded as a suitable place unless a person who appears to the Constable exercising powers under this section to be responsible for the management of the place agrees to its use as a place of safety.

6.2 Where a person (of any age) has been detained by a police officer under S136 of the Mental Health Act, the detainee will ordinarily be taken to a designated PoS in accordance with this agreement.

Where a person is detained under the provision of S136 of the Mental Health Act, the initial decision to remove the person to a PoS will be taken by the police officer. The detained person will be taken to a designated PoS as appropriate taking account of identified risks and circumstances (see appendices 2 and 3).

Individuals should be taken to the nearest available health-based place of safety to the point of detention (MHA Code of Practice 16.28).

6.3 Health Based Designated Place of Safety

The local health based places of safety in Staffordshire and Stoke-on-Trent are:

- Harplands Hospital – Stoke on Trent
- St Georges Hospital - Stafford

Where there is no medical emergency identified by WMAS and risks are manageable, the designated Mental Health PoS is the preferred option in the majority of cases.

Where officers contact the nearest health based place of safety and find that it is occupied, they are either asked to wait outside, if the place of safety is likely to become imminently free, or the person in charge of the place of safety must assist to locate the next available local health based place of safety in Stoke-on-Trent / Staffordshire. A local NHS protocol governs these arrangements.

Local Clinical Commissioning Groups are responsible for commissioning and providing sufficient safe and secure health-based places of safety, including for people under the age of 18 (MHA COP 16.32).

6.4 Police Custody based Places of Safety

PLEASE NOTE – It has been agreed that Health care provision cannot be provided within Staffordshire and Stoke on Trent therefore the 3 criteria cannot be met so Police Stations/Custody WILL NOT be used as a place of safety in any circumstances. Officers must liaise with Health staff in order to provide the necessary resources to manage an individual within a health based place of safety.

Police and Crime Act Legislation states that Police custody must not be used as a place of safety except in exceptional circumstances, for example, it may be necessary to do so because the person's behaviour would pose an unmanageably

high risk to other patients, staff or other users if the person were to be detained in a healthcare setting. This will be a joint decision between the Police and Healthcare Professionals and will be authorised by an Inspector or above following the following three conditions must be satisfied before the person arrives:

1. the behaviour of the person poses an imminent risk of serious injury or death to that person or others (regulation 2(1)(a)(i)).

   The decision-maker must be satisfied that the person's behaviour poses an imminent risk of serious injury or death to the person or to others. The decision-maker should consider whether, if no preventative action is taken: the person's behaviour presents a risk of physical injury to the person or to others of a level likely to require urgent medical treatment and that risk already exists or is likely to exist imminently.

   Such judgements will inevitably be partly subjective and informed by wider experience of dealing with potentially dangerous or volatile detainees. For example, a verbal threat to use violence may not of itself meet the threshold. However, if the person has already been violent towards officers the consideration may be different. The likely ability of the person to inflict the degree of serious injury is also a factor (thus for example issues like stature, strength, and co-ordination may be relevant considerations).

   Being intoxicated and/or uncooperative may not necessarily, of themselves, meet the threshold. Past behaviour (for example a criminal record for a violent offence) can be relevant, but should not be taken as an indication, in isolation from any demonstrable current behaviour, that the person poses an imminent risk of serious injury or death to themselves or others.

2. because of the risk posed, no place of safety other than a police station in the relevant police area3 can reasonably be expected to detain the person(regulation 2(1)(a)(ii)).

   The decision-maker must be satisfied that no place of safety in the area other than a police station can reasonably be expected to detain the person in the light of the risk posed. Consultation with healthcare professionals, as specified under section 136(1C), will serve to help officers identify the availability and capacity of places of safety, and will assist with facilitating access to them.

   This condition may be satisfied where:

   - a place of safety that could normally manage the person's behaviour is not available – for example because it is temporarily out of commission or already fully occupied (and cannot be cleared readily);

   - a place of safety is available but is not reasonably able to manage the person – for example because of a lack of sufficiently trained and equipped staff, or because the physical characteristics of the facility, including security and the ability to safeguard other patients (for example in shared assessment areas), are inadequate in the circumstances.

   Although this condition requires the decision-maker to consider the availability of places of safety in the "relevant" police force area, this does not prevent a place of safety in a different police force area from being used if deemed necessary and appropriate. The availability and suitability of such facilities will most likely depend upon existing regional/cross-border agreements.

3. so far as is reasonably practicable, a healthcare professional is present and available to the detainee throughout the period in which he or she is detained at the police station (regulation 2(1)(a)(iii)).

The decision-maker must be satisfied that a healthcare professional will be present and available throughout the period of detention, so far as is reasonably practicable (regulation 4(1)(b)).

Under 18's will never be detained to police custody based place of safety under any circumstances.

The 24-hour period starts on arrival at any place of safety (including non-designated places of safety e.g. A&E, a residential care home).

7. Section 136 at a Health Based Place of Safety

7.1 Arrival at the Place of Safety:

On arrival at the PoS, the officer must identify and introduce themselves to the nurse in charge and inform them of how the detainee presented on detention and why the officer believed the person was in need of "care or control". This will assist in the assessment of the individual particularly if he/she has calmed down or settled since the detention. A full summary of events must be recorded on the Section 136 Record.

A person is defined as 'arriving' at a PoS when their care has been accepted by the NHS professionals managing that location or by the custody officer at a police station. Disputes about acceptance must be referred to the S136 locality groups if they cannot be resolved by operational supervisors at the time and an exception monitoring form should be completed.

When the Officers telephone the POS prior to their arrival, if the POS is not available but the assessment is underway, it may be an option for the Officers to attend the POS and wait with the detained person until the POS is vacated, but this must be agreed by both parties.

7.2 Police Presence at the 'PoS' (Place of Safety)

Following the transportation of a detainee to the PoS under Section 136 of the Mental Health Act, the police will not be required to remain at the PoS, once the after care of the individual person has been accepted by the POS unless to provide support where increased risk has been identified. There must be identified, objective reasons based on risks and threats for police officers to remain after arrival in a mental health PoS, utilising the risk assessment tool. The assessment of the level of risk attributed to the detainee whilst at the PoS is the joint responsibility of the police and health staff that are present at the time (see Appendix 2). The level of police support will then be tailored accordingly. The final decision of whether police remain in support lies with the Site Manager. The number of police officers required is a police decision. Officers remaining must be released as soon as is appropriate. If there is dispute which cannot be resolved by those immediately involved, staff will need to refer to their own organisation's escalation procedure.

All staff involved in the management and assessment of a person in a PoS are empowered under The Mental Health Act to detain the person for the purpose of the mental health assessment.

7.3 Role of the Nurse in Charge:

The S136 assessment process will usually be co-ordinated by the nurse in charge. The role of the nurse in charge is as follows:

- Receive notification regarding an imminent S136 arrival, and make the necessary preparations. All referrals should be directed to the separate place of safety entrance.
- Meet and greet the patient and officers, who will be invited to sit in the waiting area.

- Initiate the record of detention. **The 24-hour period starts on arrival at any place of safety** (including non-designated places of safety e.g. A&E, a residential care home).
- Scrutinise the legality of the detention before the S136 is accepted. If it is clear the section was wrongly applied, it is invalid. An exception monitoring form must be completed to record an illegal application of Section 136. If invalid, the nurse in charge should undertake an initial assessment to establish If the person is willing to stay and if not, if there is any other legal basis to hold the person in the place of safety – e.g. Mental Capacity Act / Common law.
- Discuss with the detaining officer whether they are required to remain.
- Ensure that the patient is comfortable with beverages and food, offered in accordance with assessed need.
- Perform a baseline triage assessment of the patient's physical and mental health needs. The nurse in charge must then prescribe and organise the appropriate level of supervision and support, referring to relevant Trust policies on observations, physical monitoring, smoking etc.
- If the patient appears to be intoxicated, the nurse in charge must undertake appropriate monitoring and make a judgement about the patient's suitability for assessment.
- Explain to the patient their situation, what to expect and their rights under Section 136, in both verbal and written forms. They must also be informed of their right to have someone informed about their situation.
- Assessments should commence within 3 hours of arrival, unless there are clinical grounds to delay the assessment (See point 11.1below).
- **Immediately contact** an AMHP to arrange the assessment (even if clinical grounds for delay are triggered), calling the AMHP, 8.30 am to 5.00 pm Monday to Thursday and 8.30 am – 4.30 pm Friday via one of the Single Point of Access teams; at other times via the Emergency Duty Service in Staffordshire or the Emergency Duty Team in Stoke –on-Trent (see Appendix 1).
- If the person does not appear to have a mental disorder, they should inform the AMHP so they can instruct a Doctor to assess the person.
- Ensure the Section 136 Record is completed contemporaneously.

Where the person awaiting assessment absconds from the designated PoS, the hospital must immediately invoke their missing person's procedure – notifying the police with relevant details including commencement and expiry times of the S136 and any risks associated with that individual.

8. Section 136 in Police Custody

8.1 Role of the Custody Officer

Once all three conditions have been satisfied (6.4 above) for a person to be accepted into custody as the place of safety, the custody officer will inform the person of their rights and when detained in custody the person must receive hourly checks by the Custody Sergeant.

- The Mental Health Act 1983; and
- PACE Act 1984.

Once at the police station the custody officer is required to:

- Scrutinise the legality of the detention and check the reasons why Police custody is being used as a Place of Safety. If the person does not present with unmanageable high risk behaviour, other place of safety options must be explored.
- Initiate a custody report and ensure that the Section 136 record is started.
- Assessments should take place within 3 hours unless there are clinical grounds to delay the assessment (See point 11.1)

- **Immediately contact** an AMHP to arrange the assessment (even if clinical grounds for delay are triggered), calling the AMHP, 8.30 am to 5.00 pm Monday to Thursday and 8.30 am – 4.30 pm Friday via one of the Single Point of Access teams; at other times via the Emergency Duty Service in Staffordshire or the Emergency Duty Team in Stoke –on-Trent (see Appendix 1).
- Ensure that the person is informed of their rights under The Mental Health Act and PACE. Including their right to legal advice, to see a healthcare professional and to have someone informed where they are.
- Request immediate physical health assessment by a healthcare professional in custody.
- Ensure that the Section 136 record is completed and forwarded to the appropriate Mental Health Law Team (See appendix 1).

9. Section 136 in alternative Places of Safety

9.1 When it is appropriate to use a suitable place as a place of safety

Even where a place may appear to be suitable and relevant persons likely to agree to its use as a place of safety – it does not necessarily follow that such a place should be used. In particular such places should not be used simply because they appear to be the easiest or most convenient place of safety. In all considerations, the best interests of the person requiring a place of safety should be paramount when deciding which place should be used.

9.2 Use of private dwellings as a place of safety

It should not be assumed that the person might prefer to remain at, or be taken to a family home. In some circumstances, for example, relationships within the home may contribute to mental distress.

In cases where a section 135(1) warrant has been used to enter a private address, the use of that same address as a place of safety – with the person subject to the warrant thereby remaining in familiar surroundings – may avoid any distress that the person might otherwise experience if transported to another place of safety. In such cases a mental health professional will already be present and it may be in the best interests of the person that an assessment be carried out on the spot.

In section 136 cases, the use of a private dwelling as a place of safety would usually involve the person being taken – on the authority of a police officer – to their home or the home of someone they know, such as a family member, guardian, or friend, where they might be able to benefit from familial support and reassurance pending a Mental Health Act assessment.

9.3 Voluntary sector provision of places of safety

Increasingly, local areas have developed a range of informal help and support facilities, such as crisis cafés, drop-in centres, calm spaces and other similar establishments. These are often run by third sector organisations or local community-based groups. Such places are generally designed to support individuals on a self-referral or drop-in basis. They may, therefore, be of particular assistance to police officers where, for example, it is thought that use of the power to exercise section 136 powers is not appropriate. However, there may be occasions when such facilities could be considered for use as a suitable place of safety.

Local policies on the use of police powers and places of safety should identify new places of safety and the circumstances in which those places can be used (for example, whether as bespoke places of safety, or as additional, contingency support for use on an ad-hoc basis). While voluntary sector places of safety can be an important additional resource, health service commissioners remain responsible for ensuring the provision of sufficient health-based places of safety.

Where formal arrangements can be concluded with local organisations on the use of premises as places of safety, these might cover such issues as the provision of specific facilities, understanding of safety and welfare arrangements and the circumstances in which they might be used. However, when using such a place the police officer must still check, in each individual case, that the responsible person agrees (as required in section 135(7)(b)) to the use of the premises as a place of safety. Ad hoc decisions to use premises as a place of safety where no prior understanding or arrangements exist will require greater care and checking that the responsible person understands what he or she is agreeing to.

10. Section 136 Rights

10.1 All people detained under S136 must be given their rights verbally and in writing. They must be informed:

- that they are detained under S136 and what this means; this includes explaining to them that they have not committed a criminal offence;
- that they can have another person of his or her choice, to be informed of their removal and their whereabouts, (s56 of PACE 1984); and
- that when he/she is removed to a PoS which is a police station, they have a right to access free legal advice (s58 of PACE 1984).

If the person is removed to a PoS at a setting other than a police station and makes a request for legal advice, this should be facilitated.

'There is no requirement for an Appropriate Adult to be present if a person is detained under Section 136 of the Mental Health Act 1983 for assessment'. (PACE COP pg. 71).

Once the assessment is complete, the individual must be informed of the outcome and any plans for follow up care if they are not admitted to hospital.

Information leaflets must be available at each PoS. Section 136 leaflets are available in other languages.
http://www.mentalhealthlaw.co.uk/Foreign-language_information_leaflets

11. Care and Support of individuals detained under Section 136

11.1 Use of Restraint

The use of physical restraint or force may be required when removing a person to, or in a place of safety, for the protection of the person or others (such as the public, staff or patients). If physical restraint is used, it must be necessary and unavoidable to prevent harm to the person or others, and be proportionate to the risk of harm if restraint was not used. The least restrictive type of restraint must be used.

Where the person resists the restraint in a violent prolonged manner, the physical stress on the person's body may result in death.

Where police officers are involved in any prolonged restraint, they must treat the situation as a medical emergency and obtain emergency medical care for the person by summoning an ambulance to take the person to an accident and emergency department. The provision of such emergency medical care must take priority over the provision of mental health care. In all circumstances a Police 'Use of Force Form' will be completed and submitted

Where staff from a health based place of safety are also involved in a restraint, the appropriate Trust form should also be completed. Place of safety staff must also refer to the local policy governing physical intervention.

11.2 Treatment

Section 136 does not give authority for treatment. Consent must be sought for any treatment. If the individual lacks capacity to consent, treatment could be considered under the Mental Capacity Act and also common law may be an option in an emergency. Treatment of under 16 who are not competent to decide about treatment could be given via parental consent. The reasons for treatment and the legal basis need to be documented in the S136 Record.

12. Assessment

12.1 The detained person must not be kept in a PoS longer than is necessary for the assessment to take place. The assessment (interview) process should aim to begin within 3 hours of the start of detention, unless there are clinical grounds to delay the assessment.

Assessments must not be delayed in order to make care arrangements e.g. out of area beds, CTO re-call arrangements. The individual must be seen so that their immediate care needs can also be established.

The locally agreed clinical grounds to delay assessments are as follows –

- The person is too intoxicated with alcohol or drugs (including prescription) to be assessed.
- The person is too physically unwell / has been transferred to A&E for treatment.
- There is insufficient information about the person and it is necessary to delay the assessment until that information can be obtained.
- The person needs to be transferred between places of safety. Note: the assessment should still proceed as soon as the person arrives at the new place of safety.
- The person requires an interpreter including sign language or Makaton.
- The person has requested a specific individual to be present during the assessment and this request has been agreed by the assessing team.
- Delaying the assessment may benefit the individual e.g. the person has been very distressed or a period of sleep would benefit the person / assessment.
- The person has a specific need and the assessing team agree that it is appropriate to delay the assessment until an assessor / professional with relevant experience can be present / consulted.

Doctors examining patients should, wherever possible, be approved under S12 of The Mental Health Act. Where the examination has to be conducted by a doctor who is not approved under S12, the doctor or AMHP concerned must record the reason.

Assessors should ensure that any reasonable adjustments are made for people with an impairment that constitutes a disability under the Equality Act.

Where individuals have specific needs e.g. Autism, Learning Disability, Hearing Impairment or are under 18, one of the assessing team should have knowledge and experience of working with those specific needs. If this is not possible, the team should be accompanied by, or consult someone with appropriate knowledge and experience.

Should detention be considered necessary, it is considered best practice for each doctor to complete separate recommendations.

12.2 Role of the Registered Medical Practitioner:
Where a person has been detained under S136, they must be assessed by a registered medical practitioner. The registered medical practitioner will be required to:

- Assess the person and determine whether the person has a mental disorder and requires admission under The Mental Health Act. It is important to note that these are separate questions. If it is felt the person does not have **any** mental disorder, they must be immediately released from S136 by the doctor. *The test of mental disorder is whether one exists, not its nature or degree.* If the person has a mental disorder, they **must** be also assessed by an AMHP.
- Liaise closely with the nurse in charge or the custody officer.Liaise closely with the AMHP.
- Liaise with the second doctor if appropriate.
- Together with the AMHP, consider possible alternatives to admission to hospital.
- If admission is required, the doctor is responsible for identifying a bed.
- Record their assessment, conclusions and recommendations on the S136 record form.

12.3 Role of the AMHP:

If the person is felt to have a mental disorder then the local authority has a duty to provide an AMHP to assess any individual detained under S136. The AMHP must provide clear information to the person about their rights, taking into account any language, learning, or cultural needs as outlined in s132 of the Mental Health Act. The AMHP shall keep the relevant police officers in the case fully informed throughout the assessment period. The AMHP should also:

- interview and assess the person;
- co-ordinate a full Mental Health Act assessment where required;
- consult fully with the doctor(s);
- contact the detained person's relatives or friends;
- find out if a previous psychiatric history exists;
- establish if any mental health support services are involved and to contact the relevant agencies where known;
- consider possible alternatives to admission to hospital;
- liaise with the custody officer or the nurse in charge regarding the case progress;
- complete an AMHP report form, and attach it to the S136 record form or write in the record.

13. <u>Discharge of the S136</u>

13.1 The authority to detain a person under Section 136 ends as soon as the assessment has been **completed and suitable arrangements have been made**. This may include detention under part 2 of the Act, informal admission, an offer of community treatment or other arrangements necessary for a safe discharge, including necessary social arrangements.

Where a doctor concludes that the person is not mentally disordered, the person can no longer be detained and must immediately be released – (MHA COP 16.27).

If the doctor sees the person first and concludes that they *have a mental disorder* but that compulsory admission to hospital is not necessary, the person must still be seen by an AMHP. The AMHP must consult the doctor about any arrangements that might need to be made for the person's treatment or care.

In circumstances where the person on S136 has agreed to admission, or is admitted prior to assessment of an AMHP, the AMHP is still required to attend (COP 16.51).

If the decision of the registered medical practitioner/AMHP is to admit a person to hospital compulsorily under the Mental Health Act 1983, it is the responsibility of the AMHP to ensure the application for admission is completed and that the person is taken to hospital (s6 of the Mental Health Act 1983).

The assessing psychiatrist / doctor should ensure a bed is available and to inform the AMHP which ward is expecting the person. The Custody Sergeant / Nurse in charge of the place of safety must be also informed and updated if there is a delay in obtaining a bed. AMHPs are responsible for coordinating the transport of people who are being admitted (see Transportation Policy).

The nurse in charge of the place of safety must contact the police prior to discharge if the individual has been arrested for any criminal offence or if there are any further concerns non-mental health related.

14. Transport following Discharge of S136

14.1 Where the assessment concludes that the individual requires admission to hospital as an informal or formal patient, if the police are still in attendance because of the individuals behaviour they may be required to support the Transportation process. The AMHP should discuss this with the officers and with the control room

Securing arrangements for admission to hospital remains the responsibility of the AMHP, who should follow the Transportation Policy. Where it has been agreed that the police should resume other duties, they should not become re-involved in supporting any Transportation unless the risk assessment has altered.

If the outcome of the assessment is not admission, the Trust and the police have a responsibility to make sure they are returned home or to a safe address.

The AMHP, Nurse in Charge and / or Custody Sergeant should establish if the individual has any friends / family who can transport the individual home, if not:

- The police will be responsible for repatriating all those persons who are in Police Custody.
- The Trust will be responsible in any other situation.

15. Transfers between Places of Safety

15.1 Section 44 of the Mental Health Act 2007 amends S135 and S136 to enable a person detained at one PoS to be transferred to another. Individuals may be transferred before their assessment has begun, after it has started or following its completion, while waiting for appropriate arrangements for care and treatment to be put in place (MHA CoP, para. 16.53 and 16.55). There is no restriction on the number of the times that a person may be transferred. However, repeated transfers are unlikely to be in anyone's interests. Before any transfer, the 5 Mental Health Act Principles must be considered.

15.2 Decision to Transfer:

Unless it is an emergency, a person must not be transferred without the agreement of an AMHP, a doctor or another healthcare professional who is competent to assess whether the transfer would put the person's health or safety (or that of other people) at risk. The person in charge of the PoS should participate in the decision-making (CoP, par. 16.53).

The new PoS must be willing and able to accept the patient, unless there is a medical emergency requiring transfer to A&E, or unmanageable high risk behaviour requiring transfer to police custody, nevertheless contact should be made in advance of arrival

The times of detention in each PoS must be clearly recorded on the S136 record, which must travel with the person and information shared effectively between the transferring and receiving PoS. The maximum period of detention is not affected by transfer to another PoS and runs from the arrival time at the first Place of Safety

Where police officers are involved in the transfer, the authority of a police supervisor will be sought prior to the transfer taking place unless there is a need to respond to unmanageable high risk behaviour, or the person needs to go to A&E because they require urgent medical attention.

16. Accident and Emergency Department (A&E)

16.1 Where an individual requires urgent physical health assessment and management, they should be taken to any of the below A&E Departments:

- Royal Stoke University Hospital, Newcastle Road, Stoke on Trent, ST4 6QG
- (Before 22.00 hrs) County Hospital, Weston Road, Stafford ST16 3SA
- Queens Hospital, Belvedere Road, Burton -on- Trent, Staffordshire, DE13 0RB
- Tamworth area access Good Hope Hospital, Birmingham B75 7RR

The 24-hour period starts on arrival at any place of safety (including non-designated places of safety).

If the person is transferred to A&E from another place of safety, anytime spent at the emergency department needs to be included in the overall maximum period of detention for assessment.

Where Police Officers are involved in the transfer of the person detained under S136 to A&E, the police officers will inform the Site Manager at the appropriate place of safety of the person detained under S136 in A&E.

West Midlands Ambulance Service will contact and inform A&E that they are on their way with a person detained under Section 136 and a standby alert will be created.

On arrival at A&E physical health staff will assess the physical health needs and inform the mental health liaison team that the person is subject to detention under Section 136. Mental health liaison team staff will co-ordinate the mental health act assessment and start the process off. All relevant staff part of the mental health act assessment team will be arranged to meet the individual person at A&E for the assessment to be started as soon as they are medically fit to take part in the assessment process.

Police officers will remain in A&E with the person until it is deemed suitable for the police to either handover the Section 136 to a member of staff from the mental health liaison team or until the risk management decisions have been made on whether the police remain or leave A&E – see appendix 4.

Anyone taken to A&E and accepted there for assessment/treatment must be informed of their rights whilst detained. This will be done verbally and by the provision of the ‘rights leaflet’ by the police or AMHP (if in attendance), or the mental health liaison team staff member.

Where an individual is transferred from another health based place of safety, they should be accompanied by a member of staff from the place of safety, and original S136 record accompanies them.

Once A&E staff considers the person ‘fit for discharge’ then the person will be Section 44 transferred to an available Mental Health Unit PoS for conclusion of the mental health assessment. The mental health liaison team will provide support to identify a vacant POS. A&E staff should record a summary of any interventions provided and conclusions on the Section136 Record form.

If the person is going to be admitted to hospital for a physical health condition, the S136 assessment must still take place for the S136 to be discharged. Assessment may also be necessary if the individual would need to remain at A&E for some time because of their medical or physical healthcare needs. The AMHP should consult with A&E and the assessing doctors to establish if the assessment can take place. It may not be possible to undertake an interview in a suitable manner because of the individual's condition or treatment requirements.

17. Children and Young People

17.1 Where the person detained is under the age of 18, they should be taken to an appropriate place of safety. A child or young person must not be taken to a place of safety in a police station; a local health-based place of safety should be used.

17.2 A child and adolescent mental health services (CAMHS) consultant or an AMHP with knowledge and experience of working with children / young people should undertake the assessment.

If arranging for a CAMHS specialist to assess the person would result in a substantial delay, then those assessing the person should at least discuss the case with an appropriately experienced person. Where appropriate, and depending on specific circumstances, consultation with carers may help, particularly in the case of children and young people.

18. Escalation Policy

18.1 Stage 1:
If there is a dispute between the detaining officer and the nurse in charge/receiving person concerning this guidance and the issue cannot be resolved, the matter must be escalated to the duty (CADRE) inspector who should then discuss the issue with the Site Manager / Site Manager / in an attempt to resolve the matter. If the issue is still not resolved, the Hospital Manager (on call if out of hours) and the Police Force Duty Officer should attempt to resolve the issue. Where possible, agency locality meeting representatives should be involved. If the matter is resolved to a satisfactory outcome for all then the procedure ends. Alternatively stage 2 should be instigated. This process must be recorded in the relevant sections of the S136 record form.

18.2 Stage 2:
Where the matter is resolved at the time but the outcome is not satisfactory to any party, the next stage is to escalate to the Section 136 Locality meeting for the relevant area – An Exception Monitoring form should be completed (appendix 5)

19. Incident review and Debrief

19.1 The locality operational groups are responsible for reviewing incidents that occur in relation to Section 136.

All incidents of violence or damage towards/within a PoS, staff or property must be referred to the Locality S136 Operational Group in the appropriate area.

20. Accountability, Audit and Monitoring

20.1 North and South Staffordshire have joint Locality S136 Operational Groups. These meet bimonthly and their purpose is to promote the implementation of this guidance, monitor practice fidelity and devise ways to improve standards pertaining to S136.

The S136 Record form not only provides a contemporaneous record of the S136 event, but also captures all the data required to monitor S136 activity. This form will be used in all the PoS and move with patients subject to S44 transfers. Completed forms will be held by the Mental Health Act Administration Teams within the Mental Health Providers Trusts and the information collated and presented to the Locality S136 Operational Groups.

All parties to this agreement will ensure that it is implemented in accordance with local procedures. Part of this policy will include provision for auditing the maintenance and the management of compliance with the terms of this document. Any issues can be addressed within the local S136 operational groups.

Places of Safety and Contact Numbers **Appendix 1**

Designated Health Places of Safety in Staffordshire and Stoke-on-Trent

Place of Safety Tel: 01785 257888
St Georges Hospital
Midlands Partnership NHS Foundation Trust (MPFT)
Corporation Street
Stafford
ST16 3AG

Harplands Hospital – Place of Safety Tel: 01782 441600
Crisis Care Centre
North Staffordshire Combined Healthcare NHS Trust
Hilton Road,
Harpfields
Stoke-on-Trent
ST4 6TH

Designated Police Stations in Staffordshire and Stoke-on-Trent

Staffordshire Police general contact Tel: **101**

Watling Police Station
Watling House
Watling Street
Gailey
Stafford
ST19 5PR

Burton Police Station
Horninglow Street
Burton
DE14 1PA

Northern Area Custody Facility
Crown Road
Off Forge Lane
Etruria
Stoke on Trent
ST1 5NP

<u>Emergency Duty – Social Care & Health</u>:

Stoke-on-Trent Emergency Duty Service Tel: 01782 234234

Staffordshire Emergency Duty Service Tel: 0845 6042886

Mental Health Crisis Care Centre for North Staffordshire:

Access Team, Harplands Hospital Tel: 0800 0328 728 (option 1)

Single Point of Contact South Staffordshire:

South Staffordshire West Tel: 01785 221140

South Staffordshire East Tel: 0300 555 5001

Appendix 2

Flow Chart of Options for Transportation of S135/S136 to Place of Safety

Person Detained under S135 or S136 requiring Transportation

Police/AMHP to contact Ambulance Service for assessment and transport – WMAS to respond within 30 minutes. (In cases of S135 this will be a planned time to meet)

Transportation Options

- Ambulance with police following.
- Ambulance with Police sitting in ambulance.
- Police vehicle with paramedic sitting in police vehicle.

WMAS staff to apply Red Flag Criteria – Appendix 3
WMAS to record the use of force on Section 136 record

Emergency Cases

Accident & Emergency Department

- Serious physical injury requiring urgent treatment inc. suspected head injury,
- suspected overdose,
- ABD/ Excited Delirium,
- Extreme intoxication.
- **Police will remain with the detained person.**
- *WMAS to convey to next POS*

Non-Emergency Case

Designated nearest health place of safety

- Minor cuts/scrapes
- Moderate intoxication
- Display manageable risks
- **Police handover responsibility to Health POS**

OR

Alternative health place of safety when first choice is occupied

Alternative health based place of safety should be found and considered if the first choice facility is occupied/unavailable. **Police handover responsibility to Health POS**

Exceptional Use

Police Station

- Medically 'fit' for detention in custody including, minor cuts/scrapes
- Unmanageable risk of violence
- Last resort

Section 44 transfer when 'fit' or manageable risk s136(3) MHA. WMAS to convey under Section 44.

West Midlands Ambulance Service (WMAS) - RED FLAG CRITERIA

Police Officer / Paramedic triggers for conditions requiring

Treatment or Assessment in an Emergency Department

Dangerous Mechanisms:
Blows to the body
Falls>4 Feet
Injury from edged weapon or projectile
Throttling/strangulation
Hit by vehicle
Occupant of vehicle in a collision
Ejected from a moving vehicle
Evidence of drug ingestion or overdose

Serious Physical Injuries:
Noisy breathing
Not rousable to verbal command
Head injuries

- Loss of consciousness at any time
- Facial swelling
- Bleeding from nose or ears
- Deep cuts
- Suspected broken bones

Actual or Attempt of self-harm:
Head banging
Use of edged weapon (to self-harm)
Ligatures
History of overdose or poisoning

Psychiatric Crisis
Delusions/Hallucinations/Mania

Possible Excited Delirium:
Two or more from:

- Serious physical resistance/abnormal strength
- High body temperature
- Removal of clothing
- Profuse sweating or hot skin
- Behavioural confusion/coherence
- Bizarre behaviour

Specialist Practitioners:

ONLY AT THE REQUEST OF PARAMEDICS/ TECHNICIANS – ACCESSED VIA EOC

Where immediate management of RED FLAG conditions necessitates the intervention or skills of a Specialist Practitioner or where without medical oversight the journey would involve too much risk, either to the patient, the paramedics or the police officers.

This should include situations where rapid tranquilisation is considered necessary, in accordance with NICE GUIDELINES 2005.

Transportation to the nearest ED:

Should NOT be undertaken in a police vehicle UNDER ANY CIRCUMSTANCES where a RED FLAG trigger is involved.

This includes remaining in ED until the person is medically fit for discharge to health based PoS, to Police Station or from S136 detention.

It is the responsibility of the Police to outline to ED the LEGAL ASPECTS of detention; it is the responsibility of the Ambulance Service to outline the MEDICAL ASPECTS.

Risk assessment for police to remain at place of safety

Low Risk
No behavioural indicators (other than very mild substance use) are presented
And
No recent criminal/medical indicators that the individual is violent or poses an escape risk or is a threat to their own or others safety.

Medium Risk
Some behavioural indicators (including substance use) are presented
And
Some recent criminal/medical indicators that the individual is violent or poses an escape risk or is a threat to their own or others safety.

High Risk
Behavioural indicators (including substance intoxication) are causing significant concern
And
Significant recent criminal/medical indicators that the individual is violent or poses an escape risk or is a threat to their own or others safety.

Low Risk
Officers remain at A&E pending transfer to 1st choice PoS; they do not remain once at PoS.

Medium Risk
Agreed between staff/supervisors as to whether the police will remain – disputes resolved via local monitoring board.

High Risk
Police officers MUST remain at A&E and/or PoS in sufficient number.

Section 136 / Section 135 / Transportation
EXCEPTION MONITORING FORM

To be filled by any professionals involved in Section 136, S135 and Transportation where the standards agreed in those policies have not been met, issue has been escalated to Locality Group

Date of Incident / Issue	
Location/Place of Safety	
Name of patient	
Date of birth	
Home Address	

Record unresolved issues below:

Record any other relevant information below:

Additional space over the page if required

Name of person completing form	
Role of person completing form	
Signed	
Date	

Please send this completed form to one of the following:
Mental Health provider Trust – Locality Meeting Chairperson / Mental Health Act Law Team
Staffordshire - Principal Officer Mental Health Law
Stoke-on-Trent - AMHP Team Manager
Staffordshire Police – Force Mental Health Lead
West Midlands Ambulance Service - Divisional Support Officer

Section 136 / Section 135 / Transportation
CONTINUATION OF EXCEPTION MONITORING FORM

Additional space if required:

Operation Group Review of Issue raised and response following discussion

Record date discussed in Operational Group	
Outcome of Discussion	
Record any further action required and/or identified and any feedback to be provided to staff involved at the time the issue was initially raised.	
Date feedback provided to staff initially involved.	

FORM L9

Mental Health Act 1983
Section 136 Assessment Record

Name of Person:	**FIRST NAME**	**NHS No:**	
	LAST NAME	**Unit No:**	

Details – provided by the detaining police officer			
Date of Arrest		**Time of Arrest**	

Community Street Triage Team		Access Team		Site Manager						
Yes	No	Yes	No	Yes	No	**If yes, advice given**	**Yes**		**No**	
						If yes, alternative to Section 136 offered?	**Yes**		**No**	
Time contacted:						**If yes, was the advice followed?**	**Yes**		**No**	
If No, please state reason:						**If No, please state reason:**				

Section 136 of the MHA 1983 empowers a constable to remove to 'a place of safety' any person who they come across:	**Yes**	**No**
Give detail: (state location/address where you came across this person)		
And who appears to be suffering from **mental disorder**	**Yes**	**No**
Evidence of mental disorder:		

And who is in need of **immediate care**	**Yes**	**No**	Or **Control**	**Yes**	**No**
Why:					
And who needs to be **removed for their own interests**	**Yes**	**No**	Or **for the protection of others**	**Yes**	**No**
Why:					

Ambulance contacted?	**Yes**		**No**		**Date:**		**Time:**	
Expected time of arrival of ambulance?					**Time:**			
Ambulance attended?	**Yes**		**No**		**Date:**		**Time:**	
					Physical Health Screen	**Yes**	**No**	
Ambulance assessment outcome-person to be conveyed to?					**A&E**		**POS**	
Transportation to place of safety via:					**Ambulance**		**Police Vehicle**	
Police have to justify why they are transporting?								
Record any reason for delay in Transportation or why ambulance was not contacted at all?								

Police officer to contact POS prior to the removal of a person to a place of safety under section 136, in order to help secure their acceptance into a health-based place of safety. (MHA COP 16.33)	**Yes**		**No**		**Date:**		**Time:**	
Name of Nurse informed:								

Date of Arrival at First Place of Safety		**Time of Arrival at First Place of Safety (See Below)**	

NOTE: The 24 hour detention period starts when the person arrives at any place of safety, which includes any hospital, care home, police station or any other suitable premises if the occupier consents. E.g. If the person is taken to A&E prior to a designative place of safety (Police Station or MHU) the 24 hours starts at the arrival at A&E.

At Place of Safety	**Harplands Hospital (MHU)**		**St Georges Hospital (MHU)**	
	A&E		**Other (Care Home other Premises)**	
	Police Custody		**Station Code**	
If not a MHU, explain why:	**No MHU Locally**		**MHU Full**	
	MHU closed due to no staff		**Unmanageable high risk behaviour**	
	Physically unwell		**Other (State)**	

Details of Detained Person – provided by the detaining police officer

Date of Birth:	**/ /**		**Age:**			
Gender	**Male**		**Female**		**Transgender**	
Pregnancy	**Yes**		**No**		**Not applicable**	
Marital Status	**Married**		**Single**		**Civil Partnership**	
Home Address:						
	POST CODE:					
Telephone Number:						
Spoken Language:						
Name of GP:						
GP's Address:						
	POST CODE:					

Details of Next of Kin, Relative or Friend

Last Name:		**First Name:**		
Home Address:				
Telephone Number:		**Contacted and informed**	**Yes**	**No**

Equality Act 2010 (MHA COP paragraph 16.63) - The Equality Act make it unlawful to discriminate (directly or indirectly) against a person on the basis of a protected characteristic or combination of protected characteristics. Protected characteristics under this Act include, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The protected characteristic of disability includes a mental impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities.

THE PERSON'S SEXUAL ORIENTATION				*Place a cross in one box only*	
Heterosexual		Lesbian		Gay	
Bisexual		Do not wish to disclose			
OTHER DISABILITY					
Physical Disability:		Visual Impairment		Auditory Impairment:	
Physical Disability: Other		Mental Health needs:		Learning Disability	
Other Disability (none of the above)		Long term health condition		No Disability	
RELIGION OR BELIEF / OR NON-BELIEF				*Place a cross in one box only*	
No Belief		Buddhist		Hindu	
Jewish		Muslim		Sikh	
Christian		Not stated		Any other religion	

Ethnicity			
Category	Cultural Background	Code	**Please Tick**
White	British	W1	
	Irish	W2	
	Any other white background	W9	
Mixed	White and Black Caribbean	M1	
	White and Black African	M2	
	White and Asian	M3	
	Any other mixed background	M9	
Asian or Asian British	Indian	A1	
	Pakistani	A2	
	Bangladeshi	A3	
	Any other Asian background	A9	
Black or Black British	Caribbean	B1	
	African	B2	
	Any Other Black Background	B9	
Chinese or other Ethnic group	Chinese	01	
	Any other Ethnic group	09	
Not Stated		NS9	

Risk Assessment Information for handover to the place of safety			
Has the person received any medical attention prior to arrival at a place of safety?	**Yes**	**No**	
If Yes, describe further:			
Has the person been restrained?	**Yes**	**No**	
If Yes, how and for how long:			
Has the person been searched?	**Yes**	**No**	
If Yes, has anything been retained:			
Is the person on medication?	**Yes**	**No**	**Unknown**
Is the person suffering from the effects of drink?	**Yes**	**No**	**Unknown**
Is the person suffering from the effects of drugs?	**Yes**	**No**	**Unknown**
Has the person taken an overdose?	**Yes**	**No**	**Unknown**
If Yes, if known give details:			

Are there any RISK FACTORS the place of safety or assessment staff should be aware of? (Consider Self-harm, suicide, physical aggression, self-neglect, absconding, drug abuse, use of weapons, etc.)	**Yes**	**No**
If Yes, describe further:		
PNC (Police National Computer) / **FLINTS / GENIE / Local Intelligent Systems check completed?**	**Yes**	**No**
If Yes, any details to be aware of:		

Police Risk Assessment	**Low**	**Medium**	**High**
Following discussion with the lead nurse a decision has been made for the police to remain beyond handover?	**Yes**		**No**
If Yes, reason for the police to remain to be recorded here:			

Reporting Officers Details			
Print Officers Name		**Rank/Div. No.**	
Incident No		**Station**	
Reporting Officers Signature			
Supervised by		**Rank/Div. No.**	
Time of Departure of the Police			

Escalation Procedure (Stage 1)			
Escalation Procedure needed?		**Yes**	**No**
If YES, explain reason why:			
Senior On-call Manager Mental Health			
Duty Inspector for the Police			
Date		**Time**	
Outcome of discussion:			
Is the outcome satisfactory to all parties?		**Yes**	**No**
If NO, escalate to Stage 2 – to be discussed at Section 136 Locality Meeting.			

Acceptance of Section 136 at Place of Safety		
CHALLENGE THE POLICE OFFICERS - DO NOT LET THEM LEAVE - IF THEY HAVE NOT COMPLETED THIS PAPERWORK.		
Accepted at the place of safety as a lawful section 136 detention?	**Yes**	**No**
Name of professional:		
Designation:		
If No, reason for not accepting:		
Signature:		

To be completed on arrival at Place of Safety by lead professional.

Police Station – Place of Safety – PACE Code of Practice C – Patient Rights (MHA COP 16.66)						
Copy of the Notice of Rights and Entitlements Given	**Yes**	**No**	**Date:**		**Time:**	
If not given record reason why?						

Health Based Place of Safety Section 132 – Giving of Patient Rights				
Name of Lead Professional:				
Date		**Time**		
Section 132 Rights Given? (Please Circle)	**Yes**	**No**	**Both Orally and in writing**	
If Rights not given record reason why?				

Background Information		
Currently known to Mental Health Services?	**Yes**	**No**
If Yes, currently on CPA	**Yes**	**No**
Name of Care Co-ordinator		
Any outstanding appointments?	**Yes**	**No**
If Yes to any of the above, describe further:		
Past History of Section 136 Detention?	**Yes**	**No**
If Yes, describe further:		
Past History of Psychiatric Contact?	**Yes**	**No**
If Yes, describe further:		
Initial Risk Assessment		

Risk of Violence Aggression		**Harm to Self**		**Risk to Physical Health**		**Risk of Withdrawal from Alcohol / Drugs**		**Other (specify)**	

Comments
Support Plan (e.g. Level of Observation, Physical Checks)

Breath Alcohol Levels (BAL's) should not be undertaken without the person agreement and a clear explanation of the reasons why the test is being carried out i.e. suspicion of head injury or to establish the level of alcohol intoxication

The Site Manager/Place of Safety Nurse is responsible for monitoring intoxicated detainees and declaring when they are ready to be assessed. If the Doctor or AMHP are not happy delegating this responsibility, they should be asked to attend and make an initial assessment.

Breath Alcohol Level (BAL)		**Date:**		**Time:**	
70 or above	**There will be a delay in assessment.**				
35 – 70	**Start of assessment is on the Judgement of the Senior / Place of Safety Nurse.**				
35 or below	**Below drink drive limit and should be assessed.**				

Section 136 of the Mental Health Act 1983 - Transfer to another place of safety under Section 44 (Mental Health Act 2007 Amendment). The whole of this form must accompany the detainee to the subsequent place(s) of safety where this section and the rest of the form will be completed.

Place of Safety transferring FROM:	**Harplands Hospital (MHU)**		**St Georges Hospital (MHU)**	
	A&E		**Other** (Care Home other Premises)	
	Police Custody		**Station Code**	
Place of Safety transferring TO:	**Harplands Hospital (MHU)**		**St Georges Hospital (MHU)**	
	A&E		**Other** (Care Home other Premises)	
	Police Custody		**Station Code**	
Date:		**Time:**		
Explain why:	**MHU Full**		**MHU closed due to no staff**	
	Unmanageable high risk behaviour		**No longer unmanageable or a high risk.**	
	Physically unwell		**Other (State)**	
Section 44 Transportation to new place of safety via:	**Ambulance**		**Police Vehicle**	
	Other (describe)			
	Record any reason for delay in Transportation.			
Name of Health professional / AMHP supporting transfer				

ASSESSMENT BY THE DOCTOR AND AMHP SHOULD BEGIN AS SOON AS POSSIBLE AFTER THE ARRIVAL OF THE INDIVIDUAL AT THE PLACE OF SAFETY. IN CASES WHERE THERE ARE NO CLINICAL GROUNDS TO DELAY ASSESSMENT, IT IS GOOD PRACTICE FOR THE DOCTOR AND AMHP TO ATTEND WITHIN THREE HOURS; THIS IS IN ACCORDANCE WITH BEST PRACTICE RECOMMENDATIONS MADE BY THE ROYAL COLLEGE OF PSYCHIATRISTS.

Contact With Assessing Team			
Name of Doctor		**Time**	
AMHP agency contacted		**Person**	
Date of Referral		**Time**	
Estimated Time of Arrival		If over three hours please record reasons over the page	

Are there clinical grounds for delay in start assessment?			
The person is too intoxicated with alcohol or drugs (including prescription) to be assessed.		The person requires an interpreter including sign language, Makaton.	
The person is too physically unwell / has been transferred to A&E for treatment.		The person has requested a specific individual to be present during the assessment and this request has been agreed by the assessing team	
There is insufficient information about the person and it is necessary delay the assessment until that information can be obtained.		The POS nurse believes that delaying the assessment may benefit the individual. E.g. the person has been very distressed or a period of sleep would benefit the person / assessment	
The person has been transferred to Police Custody because of aggressive / unmanageable behaviour. Note: the assessment should still proceed as soon as possible in Police Custody.		The person has a learning disability or is under 18 and the assessing team agree that it is appropriate to delay the assessment until an assessor / professional with relevant experience can be present / consulted	
Comments			
Time resolved and ready for assessment to begin.			

Other Reasons for assessment delay
Comments

Details of Assessors					
AMHP	NAME				
Doctor	NAME:		**Section 12 Doctor**	**Yes**	**No**
If not approved under Section 12, the doctor should record the reasons they are completing the assessment.					
Assessment started:	**Date:**		**Time:**		
Reason(s) for any delay:					

Date detention due to expire: (See arrival date and time on page 2)		**Time detention due to expire:**	

Extending the Detention Period						
The new maximum period of detention of 24 hours can be extended by up to a further 12 hours – to a maximum of 36 hours – but only in very limited circumstances.						
The person's condition (physical or mental), it is not practicable to complete a Mental Health Act assessment within the 24 hour period. This might arise, for example, if the person is too mentally distressed, or is particularly intoxicated with alcohol or drugs and cannot co-operate with the assessment process. A delay in attendance by an Approved Mental Health Professional or medical practitioner is not a valid reason for extending detention.						TICK
A decision to extend the detention period can only be taken by the responsible medical practitioner if the person is being held at a police station, and it is intended for the assessment to take place at a police station, the authorisation to extend the maximum detention period must also be approved by a police officer of the rank of superintendent or higher.						
The registered medical practitioner who is responsible for the examination of a person detained under Section 136.	**Name:**		**Date:**		**Time:**	
Where required - police officer of the rank of superintendent or higher.	**Name:**		**Date:**		**Time:**	

With 12 hour extension period agreed - date detention due to expire:		**With 12 hour extension period agreed - Time detention due to expire:**	

Patient Name:		Date of Birth:	

Date and Time	Management / Care Plan whilst awaiting assessment in the Place of Safety.	Signature
	• What level of supervision does the person require? • Do you need to maintain eye contact with the person at all times? • Is additional nursing support required? • Is the person likely to withdrawn from alcohol/substances, how will this be managed? • Does the person require review by a doctor pre-assessment? • Do we need to contact the person's relatives? • Does the person's care co-ordinator need to be contacted?	
	If you are recording your assessment in Lorenzo, please ensure you record the same on this paperwork. **Remember to record the date and time when assessment commences of all written entries and who is involved in the assessment.**	

Patient Name:		Date of Birth:	

Date and Time	Assessment Notes - Co-ordinator / Doctor / Nursing	Signature
	If you are recording your assessment in Lorenzo, please ensure you record the same on this paperwork. **Remember to record the date and time when assessment commences of all written entries and who is involved in the assessment.**	

Patient Name:		Date of Birth:	

Date and Time	Assessment Notes - Co-ordinator / Doctor / Nursing	Signature
	If you are recording your assessment in Lorenzo, please ensure you record the same on this paperwork. **Remember to record the date and time when assessment commences of all written entries and who is involved in the assessment.**	

Patient Name:		Date of Birth:	

Date and Time	Assessment Notes - Co-ordinator / Doctor / Nursing	Signature
	If you are recording your assessment in Lorenzo, please ensure you record the same on this paperwork. **Remember to record the date and time when assessment commences of all written entries and who is involved in the assessment.**	

Patient Name:		Date of Birth:	

Date and Time	Assessment Notes - Co-ordinator / Doctor / Nursing	Signature
	If you are recording your assessment in Lorenzo, please ensure you record the same on this paperwork. **Remember to record the date and time when assessment commences of all written entries and who is involved in the assessment.**	

Patient Name:		Date of Birth:	

Date and Time	Assessment Notes - Co-ordinator / Doctor / Nursing	Signature
	If you are recording your assessment in Lorenzo, please ensure you record the same on this paperwork. **Remember to record the date and time when assessment commences of all written entries and who is involved in the assessment.**	

Patient Name:		Date of Birth:	

To prevent duplication - See attached AMHP report for further information regarding the assessment completed by Approved Mental Health Professional.	Copy Attached TICK

Mental Disorder present?	Yes	No
Note: This assessment is based on the presence of mental disorder not the degree of mental disorder		
If Yes - the person must remain at the Place to Safety to be seen and assessed by an AMHP before the Section 136 can be discharged. The AMHP should consult the doctor about any arrangements that might need to be made for the person's treatment or care.		
If No - Discharge immediately. (If the person has a physical condition requiring attention, or is vulnerable (e.g. Children) arrangements should be made to support / safeguard the individual)		

Overall Outcome of Assessment: (Tick One Only)

Formal Admission to Hospital		Informal Admission to Hospital			
Gatekeeping team informed of admission?	Yes	No	Spoke to:		
Ward admitted to:		Date:		Time	
If detained on which Section:	Section		2	3	
Please Note: If outcome of assessment is admission to hospital (both informal and formal), date and time of admission will be the same as the date and time detention under Section 136 ends.					

Referred to Access Team		Referred to Home Treatment Team	
Referred to a Community Mental Health Team		Follow-up with current Community Mental Health Team	
Already known / Referred to Substance Misuse Services		Follow-up with own General Practitioner	
No follow-up required.		Arrested and taken into Police Custody	
Other			

More detail:

End of Detention under Section 136:	Date:		Time:	
Detained person informed of the outcome of the Section 136 assessment:	Date:		Time:	
Detained person asked to complete service feedback questionnaire?	Yes		No	
Detained person vacated the place of safety at?	Date:		Time:	

For all current service users - Information regarding Section 136 Assessment:

Emailed to Care Co-ordinator:						
By:	Senior / Place of Safety Nurse	Mental Health Law Team	Date:		Time:	

Signature of Site Manager / Custody Sergeant:	
Print Name of Site Manager / Custody Sergeant:	

National Early Warning Score (NEWS)

Ward		NHS Number	
Name		DOB	

Date															
Time															
Respiration Rate	≥25														
	21-24														
	12-20														
	9-11														
	≤8														
Record respiration rate															
Oxygen Saturation	≥96														
	94-95														
	92-93														
	≤91														
Percentage of Oxygen Given	%														
Record oxygen saturation %															
Blood Pressure	≥230														
	221-230														
Record systolic & diastolic	211-220														
	201-210														
	191-200														
	181-190														
Inform nurse in charge if systolic is above this line	171-180														
	161-170														
	151-160														
	141-150														
	131-140														
	121-130														
	111-120														
	101-110														
Score systolic BP only for NEWS	91-100														
	81-90														
	71-80														
	61-70														
	51-60														
	≤50														
Record blood pressure															
Pulse / Heart Rate	≥140														
	131-140														
	121-130														
	111-120														
	101-110														
	91-100														
	81-90														
	71-80														
	61-70														
	51-60														
	41-50														
	31-40														
	≤30														
Record pulse / heart rate															
Temperature	≥39														
	38.1-39°														
	37.1-38°														
	36.1-37°														
	35.1- 36°														
	≤35°														
Record temperature															
Levels of Consciousness (AVPU)	**A**lert														
	Voice / **P**ain / **U**nresponsive														
Blood Sugar *															
Calculate NEWS score using guide below* and see overleaf for actions															
Staff Initials															

***Only record blood sugar if the patient deteriorates, or if AVPU scores 3 and GCS is activated.**

* NEWS key colour code for scoring	0	1	2	3	See overleaf for actions and GCS

How to calculate NEWS Score

- Record all observations overleaf.
- Note whether observation falls in shaded 'At Risk Zone'. Score as per NEWS key.
- Add points scored and record total 'NEWS Score' in bottom row of chart.

How to use the physical observation chart

Start up	Observations	NEWS scores	Action		
			NEWS Score	**Frequency of monitoring**	**Clinical response**
1. This chart does not override clinical judgement. **If the patient scores 3 and above and has a valid reason, this must be documented/ careplanned and medical advice sought.** 2. This chart cannot be used for patients under the age of 16. 3. This chart cannot be used for patients who are pregnant. 4. Take chart to patient. 5. Record patient identification.	1. Record ALL observations with a 'firm' dot ● in black ink. 2. Write exact values of observations in the boxes provided. 3. Join repeated observations with a straight line over time to form a display. 4. If Systolic Blood pressure is recorded in the grey shaded box, please inform the nurse in charge.	1. Total the NEWS score including AVPU using 0 – 3 key scoring guide on the chart. 2. Record the total NEWS score in the box for NEWS.	**0**	**Minimum of weekly NEWS** unless alternative observations are agreed as part of the care plan.	- Routine monitoring and scoring; - Unless patient's physical condition indicates change – then a care plan is required.
			Total: 1-4 **Score of 3 in any one parameter see box below**	**Minimum - 2 Hourly** **Maximum - 4 hourly**	- Inform registered nurse who must assess the patient; - Registered nurse to decide if increased frequency of monitoring and/or escalation of clinical care required, i.e. medical review.
			Total: 5-6 **Or** **A score of 3 in any one parameter**	**Increased frequency to a minimum of 1 hourly.** If VPU scores 3 continue with GCS and NEWS scoring - Minimum of every 30mins for 2 hours if GCS 15. - 15 minute NEWS and GCS if GCS ≤ 14.	- Registered nurse to urgently inform the medical team caring for the patient or an available medic for urgent assessment within 30mins, if the patients' medical team is not available. - Contact duty team (2222) and Emergency Services (9)999
			Total: 7 **Or** **MORE**	**Increase frequency to 5 minutes and Therapeutic Observations (level 3/4)**	- Registered nurse to immediately inform medical team for emergency assessment; - Contact duty team (2222) and Emergency Services (9)999

How to calculate and action the Glasgow Coma Scale (GCS) 15 point score:

The GCS is a simple but effective way of assessing a patient's neurological condition. It categorises the patient's responses to certain stimuli and gives that response an overall score. It is divided into 3 main categories of response that are totalled to give an overall score.

- Score best motor, verbal and eye opening scores in the boxes provided following chart below.
- Add points score and record total 'Overall GCS score' in the box provided.

Score and Motor Response	**Score and Verbal Response**	**Score and Eye Opening**
6 - Obeys commands 5 - Localises pain 4 - Withdrawal to pain 3 - Flexion 2 - Extension 1 - No response to pain	5 - Oriented 4 - Confused conversation 3 - Inappropriate words 2 - Incomprehensible sounds 1 - No verbal response	4 - Spontaneous 3 - Open to speech 2 - Open to pain 1 - No eye opening

Date												
Time												
Motor Response Score												
Verbal Response Score												
Eye Opening Score												
Overall GCS Score												
Staffs Initials												

Document level: Trust
Code: R11
Issue number: 1

Seclusion and Long-Term Segregation (LTS) Policy

Lead executive	Director of Nursing and Quality
Authors details	Head of Nursing and Professional Practice Reducing Restrictive Practice Lead & Trust Resuscitation Lead

Type of document	Policy
Target audience	All Trust staff involved in Seclusion and Long-Term Segregation
Document purpose	The policy provides a set of standards and expectations to ensure that patients requiring seclusion or LTS receive safe, effective care which is compassionate and least restrictive practice remains at the forefront of clinical decision making.

Approving meeting	Quality Committee Trust Board	Meeting date	10th September 2019 26th September 2019
Implementation date	26th September 2019	Review date	31st October 2023

Trust documents to be read in conjunction with	
MHA18	Trust Policy MHA18, Deprivation of Liberty Safeguards, Policy, and Procedures (Mental Capacity Act, 2005).
R1	Trust Policy R1, Policy on the Use and Reduction of Restrictive Interventions Including the Use of Physical Holding Skills (MAPA®);
1.27	Trust Policy 1.27, Policy for the Management of Violence and Aggression using Rapid Tranquillisation;
5.01	Trust Policy 5.01, Incident Reporting Policy, and Guidance
R08	Refer to R08 Search of Patients (detained and informal), visitors and their property.
1.35	Trust Policy and Procedure for the Safe and Supportive Observation and Engagement of Patients

Document change history		Version	Date
What is different?	Re-write of policy following recommendations identified in the Mental Health Act 1983 monitoring visit (Ref. MHV1-7047245391) to PICU on 19th June 2019 and subsequent report received 24 July 2019. Increased focus on privacy, night-time checks, roles and responsibilities and positive engagement.	V1	23.8.19

Appendices / electronic forms	All appendices reviewed and updated; now include flow charts to support the clarity of processes, decisions and reviews required	V1	23.8.19
What is the impact of change?	Policy now reflects CQC recommendations and more robustly reflects the requirements MHA Code of Practice for Seclusion and Long-Term Segregation.	V1	23.8.19

Training requirements	There are no specific training requirements for this policy.

Document consultation	
Directorates	All Heads and Clinical Directors of each Trust Directorate
Corporate services	Document quality group and Senior Operating Team Meeting
External agencies	N/A

Financial resource implications	None

External references

1. NICE (2015). Violence and aggression: short-term management in mental health, health and community settings. https://www.nice.org.uk/guidance/ng10;
2. NICE (2010). Delirium: Diagnosis, prevention and management. https://www.nice.org.uk/guidance/cg103;
3. NICE (2014). Head injury: Assessment and early management https://www.nice.org.uk/guidance/cg176
4. RCN (2010). Restrictive physical intervention and therapeutic holding for children and young people https://www.rcn.org.uk/__data/assets/pdf_file/0016/312613/003573.pdf
5. This policy should be read in conjunction with the NICE Guideline (2015) Violence and aggression: short term management in mental health, health and community settings;
6. Mental Health Act 1983 Code of Practice (2015, chapter 26. Safe and therapeutic responses to disturbed behaviour);
7. The Mental Capacity Act, 2005, Deprivation of Liberty Safeguards and the Use of Restrictive Interventions;

Monitoring compliance with the processes outlined within this document	Via SLT performance reporting and as part of the Trust Annual Audit Cycle.

Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Less favorable / More favorable / Mixed impact**
Does this document affect one or more group(s) less or more favorably than another (see list)?		

– **Age** (e.g. consider impact on younger people/ older people)	No	
– **Disability** (remember to consider physical, mental and sensory impairments)	No	
– **Sex/Gender** (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
–		
– **Gender identity and gender reassignment** (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– **Race / ethnicity / ethnic communities / cultural groups** (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– **Pregnancy and maternity, including adoption** (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– **Sexual Orientation** (impact on people who identify as lesbian, gay or bi – whether stated as 'out' or not)	No	
– **Marriage and/or Civil Partnership** (including heterosexual and same sex marriage)	No	
– **Religion and/or Belief** (includes those with religion and /or belief and those with none)	No	
– **Other equality groups?** (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)	No	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
If you have identified potential negative impact: - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	NA	

Enter details here if applicable
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk

Was a full impact assessment required?	No
What is the level of impact?	NA

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1. Policy Introduction / Background

A safe and therapeutic culture should be provided for all people receiving treatment for a mental disorder including those who may present with behavioural disturbance. As a part of this there is often a requirement to balance the need for patient and staff safety against the need to ensure least restrictive practice for service users.

This policy outlines the procedure for utilising two such restrictive interventions, seclusion and long term segregation, recognising the need for these interventions to be used in a way that respects human rights and ensures these interventions are proportionate, in the best interests of the service user and use least restrictive principles.'

The policy provides a set of standards and expectations to ensure that patients requiring seclusion or LTS receive safe, effective care which is compassionate and least restrictive practice remains at the forefront of clinical decision making.

1.1 Policy Requirement

1.2 Policy Aim:

The Mental Health Act Code of Practice (2015, para 26.103) defines seclusion as "the supervised confinement and isolation of a patient away from other patients in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others".

If a patient is confined in a way that meet the definition above, even if they have agreed to or requested such confinement, they have been secluded. The use of any local or alternative terms (such as "therapeutic isolation") or the conditions of the immediate environment do not alter the fact that the patient has been secluded. It is essential that under such circumstances the person is afforded the procedural safeguards of the MH Act Code of Practice

The seclusion of a service user poses significant ethical and practical dilemmas, awareness of which is essential to promote best practice. Staff should be cognisant of the adverse effects on service users and the need to balance the rights of a person who is secluded to freedom, choice and autonomy with the rights of others to protection from harm. Additionally this should be underpinned by rigorous monitoring and evaluation

The policy aims to reinforce the least restrictive approach to ensuring that patients' needs are met safely and patients requiring seclusion and LTS are care for in line with the Mental Health Code of Practice.

1.3 Key Principle:

Least Restrictive Options:

The MH Act Code of Practice (2015) requires care and treatment to 'always be a means to promote recovery, be of the shortest duration necessary, be the least restrictive option and keep the patient and other people safe'.

In order to meet this requirement, when a person is at risk of presenting with challenging behaviour, assessment of the person's behavioural presentation is important in understanding an individual's needs and should seek to understand the behaviour in the broadest context.

Assessments should consider the views of patients and their families, carers and advocates. The results of the assessment should guide the development and implementation of effective, personalised and enduring systems of support that meet an individual's needs, promote recovery and enhance the quality of life outcomes for the individual and others who care and support them.

When concluded, assessments should describe behaviours of concern, identify factors which predict their occurrence, and describe the functions that behaviours serve or the outcomes they achieve for the individual. This then promotes the use of least restrictive options through proactive use of primary and secondary preventative strategies to respond to a person at risk of presenting with challenging behaviour.

Primary preventative strategies aim to enhance the person's quality of life and meet their unique needs, thereby reducing the likelihood of behavioural disturbance.

Secondary preventative strategies focus on recognition of early signs of impending behavioural disturbance and how to respond to them in order to avoid escalation of challenging behaviour. This includes the use of de-escalation strategies to promote relaxation.

De- escalation is the use of verbal and nonverbal communication to reduce or eliminate aggression and violence during the escalation phase of a patient's behaviour (National Institute of Clinical Excellence 2005). De-escalation offers a safer, less coercive, and alternative to traditional containment methods, such as seclusion, rapid tranquilisation, intensive supervision or physical restraint (Lavelle et al, 2016).

NSCHT requires de-escalation strategies used by staff to be person-centred and should typically involve establishing a rapport and the need for mutual co-operation, demonstrate compassion, attentiveness and concern, negotiating realistic options, use of open questions, empathetic and non-judgemental listening, distracting and redirecting the person into alternate activities that are meaningful to them, removing sources of excessive environmental stimulation and being sensitive to non-verbal communication. De-escalation strategies are non-confrontational and may, for a minority of patients, include prompts to encourage the person to access a low stimulus, private, relaxing area if this is known to help the person calm; however there is no

compulsion for the person to go to or to remain in such areas and staff must be mindful of this to ensure that seclusion or long term segregation criteria are not triggered or that the level of violence and aggression has escalated to the point where seclusion would be an appropriate intervention.

Additionally a member of staff must remain with the person to offer intensive nursing support. Such de-escalation strategies may be used proactively as part of a person's care plan (or equivalent e.g. chained behaviour management plan) to meet their needs in the least restrictive way.

As such the care plan must be individualised, based on assessment of a person's needs, including the continual attempt to understand the function of the behaviour for the person, consider the views of the person and their family/carers and be agreed by the multi-disciplinary team.

There must also be regular review of the person and their care in line with the policy 1.35 Safe and Supportive Observation and policy 1.64 Effective Care Planning.

2. Policy Synopsis:

- To provide guidance on when any period of seclusion is indicated.
- To minimise the frequency and duration of any period of seclusion and minimise any possible anti-therapeutic effects.
- To ensure the welfare and care of a secluded service user is given highest priority.
- To ensure clinical accuracy of documentation thus providing a complete record of all periods of seclusion.

3. When seclusion can be used:

Seclusion may only be used for the containment of severe behavioural disturbance that is likely to cause harm to others. It may not be used solely as a means of managing self-harming behaviour (MHA CoP, para 26.108). When a patient poses a risk of self-harm as well as harm to others, seclusion should only be used when the professionals involved are satisfied that the need to protect other people outweighs any increased risk to the patient's health or safety arising from their own self-harm and that any such risk can be properly managed.

Seclusion should not be used as a punishment or a threat, or because of shortage of staff. It must never form part of a treatment programme (MHA CoP, para 26.107).

Any situation whereby a service user is physically or mechanically confined to a seclusion room against their wishes should be regarded as the commencement of an episode of seclusion.

As seclusion may only be used to contain the severe behavioural disturbance that may cause harm to others, it is the responsibility to staff to assess the risk that a patient poses to others due to their challenging behaviour. In placing a patient in seclusion, staff must be able to demonstrate the decision-making which evidences that seclusion was used:

a) to manage severe behavioural disturbance which is likely to cause harm to others; and
b) as a measure of last resort.

During any period of seclusion it is vital that staff are aware of the need to maintain the service user's dignity. Staff must always be sensitive to age, gender, race, language preference and any sensory impairment and to determining the underlying cause of aggressive behaviour such as a culturally specific form of communication, or an attempt to communicate by an individual with a sensory loss.

3.1 Summary of criteria:

Seclusion should only be considered when the following criteria/conditions are met:

- The nurse in charge, having made an assessment considers that there is an immediate risk of harm to others.

- All other interventions have been considered, attempted or are not feasible. In particular verbal de-escalation, listening skills, negotiation skills, diversion activities and MAPA® techniques.

Where possible when determining if seclusion is necessary, the following factors should be taken into account, clinical need, safety of patient and others, and, where possible, Advance Statements and agreed care plans. Seclusion must be a reasonable and proportionate response to the risk posed by the patient. Consideration should be given to using seclusion and/or rapid tranquillisation as alternatives to prolonged physical intervention as identified in each individuals care plan, as indicated by individual risk assessment.

3.2 Monitoring for Seclusion:

Each episode of Seclusion requires an incident (Ulysses) report.

Each ward utilising the seclusion must have arrangements in place to scrutinise completion of documents used in seclusion (i.e. incident report, patient observation sheet and seclusion monitoring form).

Recording of seclusion will take place, from October 2019, in the Trust Electronic Patient Record (EPR). System "downtime" paper based forms will be available for completion in the meantime and these will be scanned into the EPR (patient clinical notes section) every 24hr period. Once the Electronic form is available, there may be occasions of system failure, the 'downtime' paper based forms will need to be reused and once the EPR becomes available again the relevant seclusion/long-term segregation forms should be transferred to the EPR, and the paper forms destroyed.

The MHA team oversee the audit of all seclusion documentation as part of the Trusts MHA annual audit cycle.

A themed report of Seclusion and LTS practice is provided on an annual and quarterly basis for the Trust Board and periodic reports issued when requested.

On rare occasions and in some exceptional circumstances seclusion may take place outside of designated seclusion facilities, e.g. if a patient is receiving a restrictive intervention that meets the definition of seclusion, this is a breach of the Code. The full safeguards of this policy apply and must be implemented for such incidents of seclusion AND, both the Director for Nursing, AHP and Quality and the Mental Health Act Manager should be informed.

3.3 Seclusion and Informal Patients:

Seclusion should only be used in hospitals and in relation to patients detained under the Act. If an emergency situation arises involving an informal patient, and as a last resort, seclusion is necessary to prevent harm to others, then an assessment for an emergency application for detention under the Act should be undertaken immediately (MHA CoP, para 26.106)

3.4 Seclusion and Advance Statements:

Patients must have the opportunity to complete an advance statement that expresses their preference on how an episode of severe behavioural disturbance should be dealt with. The purpose of this is to minimise the use of restraint, seclusion and long-term segregation. Nevertheless, the Trust recognises that some patients may indicate, as part of their advance statements, that they would choose seclusion over restraint as a way of managing their behaviour. In such circumstances, it must be explained to the patient that the Trust is obliged to attempt de-escalation in the first instance, that seclusion is a measure of last resort to be used only for managing behaviour that may harm others, and that its use cannot be included in a care plan.

3.5 Advance Care Planning/ Positive Behavioural Support Planning:

All patients who may be at risk of engaging in severe behavioural disturbance likely to cause harm to others should have a Care Plan (some services use the term Positive Behaviour Support Plan). Input should be sought from the patient in developing this plan, and where appropriate, from family members and carers. This plan should be clearly entitled and should describe the interventions that effectively manage incidents of severe behavioural disturbance for that patient.

Where it has been agreed in a Care Plan/ Positive Behaviour Support Plan with the patient that family member's carers or Independent Mental Health Advocates (IMHA) will be notified of significant behavioural disturbances and the use of restrictive interventions, this should be done as agreed in the plan. For patients under the age of 16 years, persons with parental responsibility (parents, family members or local authority children's services for looked after children) must be informed each time seclusion is employed. For patients between the age of 16 and 18 years, information may be shared with those with parental responsibility with the patient's consent.

A well-drafted Care Plan/Positive Behaviour Support Plan that is focused on understanding the patient's behaviour in the context of their needs may help to minimise the use of seclusion.

3.6 Additional Considerations for Children and Young People

Restrictive interventions such as seclusion and long term segregation should only be applied to children and young people after taking into account their physical, emotional and psychological maturity.

Staff must be mindful that seclusion or long term segregation, whilst traumatic for any individual may have particularly adverse implications for the emotional development of children and young people and should take this into account before making a decision to seclusion or long term segregation.

A child and adolescent trained clinician should make a careful assessment of the potential effects of seclusion, especially if the child or young person has a history of trauma or abuse. Seclusion or long term segregation should only be used when other strategies to de-escalate behaviours and manage risks have been exhausted.

Seclusion should only be used in hospitals and for children and young people who are detained under the Act.

4. Who else needs to be informed when initiating seclusion?

Family members, carers or Independent Mental Health Advocates (IMHA) should be informed, as agreed in the Advance Care Plan/Positive Behaviour Support Plan. For young people under 18 years (See above section).

5. Seclusion Environment:

Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purpose of seclusion and which serves no other function on the ward (MHA CoP, para 26.105).

The seclusion room or suite should (MHA CoP, para 26.109):

- Allow for communication for the patient when the patient is in the room and the door is locked, e.g. via an intercom
- Include limited furnishings which should include a bed, pillow, mattress and blanket or covering
- Have no safety hazards
- Have robust, reinforced window(s) that provide natural light (where possible the window should be positioned to enable a view outside)
- Have externally controlled lighting, including a main light and subdued lighting for night time.
- Have robust door(s) which open outwards
- Have externally controlled heating and/or air conditioning, which enables those observing the patient to monitor the room temperature.
- Have no blind spots, and alternate viewing panels should be available when required.
- Have a clock that is always visible to the patient from the room.
- Have access to toilet and washing facilities.

Resuscitation equipment is available within the observation area of the seclusion suite including an automatic external defibrillator, a bag valve mask, oxygen, cannulas, intravenous fluids, and suction and first-line resuscitation medications.

Seclusion should only be undertaken in a room or suite of rooms that have been specifically designed and designated for the purposes of seclusion and which serve no other function on the ward, (MHA Code of Practice 2015, chapter 26.105)

Within the Trust the only recognised seclusion room is within PICU at Harplands Hospital. Other services within the Trust may have to consider the transfer of a patient to this ward if assessment indicates that there may be a requirement to utilise seclusion.

Any intervention that meets the definition of seclusion, including such interventions that occur outside of designated seclusion rooms, must be treated as seclusion and the safeguards implemented (see section 3.2)

Staff must be mindful of the risks in attempting to move a service user from one area of the ward to another when they are resistive to this and in a high level of arousal/distress. In most cases best practice would suggest that wherever possible it would be preferable to initially manage the incident where it occurs at least until the service user becomes more agreeable to being moved. This may require staff to ask other service users to leave the area in order to maintain privacy/dignity.

Staff initiating seclusion need to consider whether the seclusion room will be locked or if the person will be supported by staff members. Regardless of this, the person being secluded should always be under continuous observation. In some cases, where physical interventions (MAPA® techniques) are necessary, a minimum of three staff will be required

6. Temporary Unavailability of Seclusion Suite or Emergency use of a non-designated seclusion area:

There may be occasions when the seclusion room is not available. The use of a non-approved room to confine a service user should only occur as an emergency measure, be reasonable and proportionate to the harm it is intended to prevent, be for the minimum time necessary. The full safeguards of this policy apply and must be implemented for such incidents of seclusion AND, both the Director for Nursing, AHP and Quality and the Mental Health Act Manager should be informed.

The environmental risks posed when using non-approved seclusion rooms must be noted and actions taken to safeguard both patients and staff. The use of enhanced observation levels (minimum level 3) and increased staffing levels must be part of the measures used to maintain safety of all concerned.

All reasonable efforts must be made to transfer the service user to a safer environment at the earliest opportunity and prompt referral to a PICU (Psychiatric Intensive Care

Unit) should be sought. The principles of seclusion regarding nursing and medical reviews must be applied. This ensures the provision of regular external clinical review of the intervention thereby providing greater safeguards for both patients and staff.

In such emergency situations, staff must understand that the use of a bedroom or non-recognised environment for seclusion, departs from the guidance in the MHA Code and as such the reasons and rational must be clearly recorded in the service users clinical notes.

Staff should clearly indicate in the seclusion documentation where the seclusion took place and the reasons why the seclusion room was not available. All actions must be documented within the patient's electronic record on Lorenzo.

The Seclusion Care Pathway Procedure:

7. Who can authorise seclusion?
Seclusion may be authorised only by the following:

- A psychiatrist
- An approved clinician who is not a doctor
- The professional in charge of a ward (e.g. lead nurse)

All attempts must be made to manage the patient's severe behavioural disturbance by other means. Seclusion should be used only when all other means have been exhausted

The person authorising seclusion should have seen the patient immediately prior to the commencement of seclusion.

7.1 Who needs to be informed?

When the decision to initiate seclusion is made by the professional in charge, by a psychiatrist who is neither the patient's Responsible Clinician nor an approved clinician, or by an approved clinician who is not a doctor, he/she should immediately inform the following personnel that the patient has been secluded:

a) The patient's Responsible Clinician or if unavailable, the duty doctor (this can be the trainee psychiatrist on-call)

AND

b) The Quality Lead Nurse Matron, in hours and Site manager out of hours.

Communicating with the personnel listed above should be within 30 minutes of the initiation of seclusion or as soon as is practicable.

If seclusion is authorised by a psychiatrist, the first medical review will be the one they undertook immediately before authorising seclusion.

8. Initiation of Seclusion:

In the event that all other least restrictive options have been exhausted and there are increasing concerns regarding the safety of the patient and / or others; it is permissible for the professional in charge or the patients Responsible Clinician to make a decision to utilise seclusion.

Staff must complete an incident form (Ulysses) and initiate the seclusion monitoring form (NB, the seclusion monitoring form will be a paper version which needs to be scanned and uploaded into Lorenzo (patient clinical notes section) until it is available as a form in the EPR, from October 2019). The seclusion monitoring form is Appendix 5 of this policy.

8.1 Responsibilities of Professional in Charge:

In addition to completing the incident and seclusion monitoring form's the professional in charge of initiating the seclusion should:

- Complete the Seclusion Monitoring form (this will remain paper based and available in the seclusion suite)

- Draw up an observation roster so that a member of staff trained to carry out such observations is observing the patient in seclusion at all times and inform staff of the existence of such roster

- Inform the care team of the seclusion and delegate responsibility for other patients to members of the care staff

- At each review point (see section 8), assess and decide whether it is appropriate to end seclusion.

- Complete a seclusion care plan on the EPR if seclusion continues beyond the first medical review

- Ensure that the patient's vital signs are identified and recorded accurately in accordance with NICE guidance on monitoring vital signs is given with regards manual restraint, rapid tranquilisation, and delirium and head injury (see Document list above).

- Make a brief entry in the progress notes section of the EPR during each shift to indicate that the patient remains in seclusion.

- Ensure that resuscitation equipment is available within the observation area of the seclusion suite and that this is checked on a daily basis.

9. Searching the patient prior to seclusion:

A member of the care team shall carry out a visual search of the patient to reduce availability of objects that could be used as a weapon, i.e. shoes, belts, lighters/matches, keys.

If staff members feel that a physical search is required, the policy on search of patients and their property must be adhered to and their rights incorporated. Reference should be made to the Trust's Policy for Searching Patients and their Property – R08.

10. Privacy and Dignity of the person using seclusion:

Staff may decide what the patient may take into the seclusion room or suite based on their clinical risk assessment, but patients should wear their personal clothing and retain other personal items such as those of cultural or religious significance, if this does not compromise the safety of the patient or other people.

It may be necessary to remove articles of clothing from the patient, if those clothes are deemed a risk to his/her safety. Should this occur, the privacy and dignity of the patient will be respected while alternative, 'anti-rip' clothing is provided. Sanitary products are available within the seclusion suite.

The seclusion suite is equipped with live feed non-recordable CCTV. The images are relayed to a monitor that is placed outside the seclusion room to provide better observation by increasing the field of vision. The CCTV enables staff to observe the person in seclusion throughout the whole seclusion suite including toilet/shower area, when risk assessed and identified as being appropriate to do so.

When the person first enters seclusion the CCTV is to be switched off in the toilet/shower area. The CCTV must only be used in the toilet/shower area if it is clinically indicated as being in the best interest of the service user. The decision to use CCTV in the toilet/shower area must be informed by an appropriate risk assessment, reflected in the person's seclusion care plan and recorded in the clinical record. There must be clear statements explaining the reason why observations in the toilet/shower area would be via the CCTV monitor, duration and patient presentation / risk factors deeming this appropriate.

The privacy and dignity of the individual must be taken into account and balanced against the potential risk factors when making a decision, about whether the CCTV needs to be turned on within the toilet and shower areas of the suite.

At all subsequent monitoring reviews (by Professionals, MDT and Medical staff), a review of the patients privacy and dignity must be included to establish; where a decision has been made to turn the CCTV on, if the CCTV can safely be switched off in order preserve the individuals privacy and dignity. Each decision must be documented on the patients seclusion record and added to the seclusion care plan where considered necessary and should highlight the rationale and risks identified to either keep the CCTV on or turn it off.

11. Care of the patient in seclusion:

11.1 Who should be observing the person in seclusion?

A suitably trained member of staff who has received an induction regarding the seclusion processes and procedures, should as a minimum be readily available within the seclusion suite at all times throughout the period of seclusion. A registered practitioner should be readily available and contactable at all times throughout the period of seclusion.

Staff should only carry out constant observation for periods not exceeding 2 hours before handing over to another staff member except in exceptional circumstances. Records must be contemporaneous.

The observing practitioner must have access to a personal alarm and they must retain the keys to the seclusion door.

Consideration should be given to gender of the person undertaking observations; this may be informed by the consideration of a patient's trauma history, religious or cultural beliefs.

11.2 Clinical observation:

The aim of clinical observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end.

The patient's behaviour, mental state and physical condition should be constantly observed using Level 3 Observation – by staff who have been inducted into the use of the seclusion suite and the practice of undertaking observations throughout the period of seclusion.

11.3 How often should observations be recorded?

Staff must complete the Seclusion Observation Record Sheet (appendix 6) every 15 minutes (MHA CoP para 26.123).

This will remain paper-based and will need to be scanned into Lorenzo (patient clinical notes section) at the end of every 24hr period.

As a minimum, a record should be made of the patient's appearance, what they are doing and saying, their mood, their level of awareness and any evidence of physical ill-health especially with regard to their breathing, pallor or cyanosis.

Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

11.4 Observation following rapid tranquilisation:

For patients who have received sedation, a trained professional will need to be outside the door at all times (MHA CoP, para 26.122). They must observe respiratory rate, bodily movements etc. The rapid tranquilisation Policy must be followed and observations recorded on a NEWS 2/PEWS tool (if appropriate and safe to do so).

If it is unsafe to approach the service user to obtain physical observations using, the Non-Contact Physical Health observations form (within NEWS 2/PEWS) can be utilised.

The length of time for this additional observation should be care planned in discussion with the staff taking into account the rapid tranquilisation pathway.

12. Seclusion Care Plan:

Staff should complete the form "Seclusion – Care Plan" on the EPR.

What should be in a seclusion care plan?

A seclusion care plan should set out how the individual needs of the patient will be met whilst in seclusion and record the steps that should be taken to terminate seclusion as soon as possible. It will include the following:

- A statement of clinical needs, including physical and mental health problems.
- A plan as to how needs are to be met, how de-escalation attempts will continue and how risks will be managed.
- Details of bedding and clothing to be provided.
- Details of how the patient's dietary needs will be met.

- Details of any family or carer contact/communication as per agreement in the Advanced Care Plan / Positive Behaviour Support Plan, this should include any gender specific requirements, and should consider the principles of trauma informed care.

- Details of any activities that should be made available to the patient whilst in seclusion. This should include such things as reading materials, entertainment facilities, rehabilitation input, spiritual support, access to physical exercise and specify the conditions under which these are to be facilitated.

- Details of the support that will be provided to the patient when seclusion ends.

The patient should be encouraged to contribute to the seclusion care plan and steps should be taken to ensure that the patient is aware of what they need to do for seclusion to end.

13. Reviews during Seclusion:

The need to continue seclusion should be reviewed in accordance with the procedure laid out in the Code of Practice (MHA CoP, para 26.112). The following principles apply:

• If not authorised by a psychiatrist, there must be a medical review within one hour or without delay if the patient is not known or there is a significant change from their usual presentation.
• Seclusion area to be within constant sight and sound of staff member
• Documented review by person monitoring at least every 15 minutes
• Nursing reviews by two nurses every two hours throughout seclusion
• Continuing medical reviews every four hours until first (internal) MDT
• First (internal) MDT as soon as is practicable
• Independent MDT after 8 hours consecutive or 12 hours intermittent seclusion (within a 48 hour period)
• Following first (internal) MDT, continuing medical reviews at least twice daily (One by Responsible Clinician)
• Following the Independent MDT, continuing (internal) MDT review at least once Daily
• **NB** – Family /Carers should be informed of the outcomes of each review.

13.1 Who should undertake the medical review?

If seclusion is authorised by a Consultant Psychiatrist, then the Consultant Psychiatrist will have seen the patient immediately prior to authorising seclusion. Their assessment may be the first medical review for the purpose of this policy.

If seclusion is authorised by an Approved Clinician who is not a doctor, or the professional in charge of the ward, or a Psychiatrist who is not a Consultant, the first medical review should be undertaken by the patient's Responsible Clinician or the duty doctor (out of hours) within an hour of the commencement of seclusion.

Overnight and on weekends, when the patient's own Responsible Clinician may not be available, the duty doctor must have access to an on-call doctor who is an approved clinician.

13.2. What needs to be included in the first medical review?

NB – any records recorded onto a paper document must be uploaded into the EPR within 24hrs of completion.

The doctor who completes the first medical review must:

- Undertake a medical assessment of the patient's mental and physical state.
- Record any obvious injuries
- Enter the assessment and action plan into the patient's electronic patient record on the seclusion monitoring form.
- Review and complete the Seclusion monitoring form on the EPR (or paper until EPR is updated in October 2019).
- If it is agreed that seclusion should continue, a seclusion care plan should be agreed and prepared by the professional in charge and completed on the EPR.

At each review, if it is agreed that seclusion will continue appropriate amendments should be made to the seclusion care plan.

All subsequent medical reviews should be undertaken by the Responsible Clinician, a doctor who is an approved clinician, or the duty doctor.

13.3 What further reviews are required?

At each review staff should complete the form Seclusion monitoring form on the EPR (Or paper until the EPR is updated) choosing the appropriate review type on the form.

All reviews provide an opportunity to determine whether seclusion needs to continue or should be stopped, as well as to review the patient's mental and physical state. Where agreed family members should be advised of the outcomes of reviews.

Patients and their families should be as fully involved as possible in developing and reviewing positive behaviour support plans (or equivalent). Patients eligible for support from an IMHA should be reminded that an IMHA can support them in presenting their views and discussing their positive behaviour support plan. The preparation of positive behaviour support plans also provides an important opportunity to record the wishes and preferences of families and carers and the involvement they may wish to have in the management of behavioural disturbances. Patients must consent to the involvement of families or IMHA's if they have capacity to give or refuse such consent.

13.4 Nursing reviews

Two Registered Nurses should review the patient every two hours from the commencement of seclusion. At least one of these two Registered Nurses should not have been involved directly in the decision to seclude.

Nursing observations should be documented every 15 minutes by a trained professional who is within the seclusion suite at all times (completed on the paper seclusion observation sheet – Appendix 6).

At any time staff should raise any concerns about the patient's condition with the Responsible Clinician or duty doctor.

The nurse in charge can end seclusion at any time if their assessment supports this. Unless the MDT have already determined the time that seclusion should end or be reviewed to end.

13.5 Medical Reviews

Medical reviews must take place every four hours until the first (internal) MDT review has taken place, including in the evenings, night-time, on weekends and on bank holidays. See section 13.9 for when the patient in seclusion is asleep. This will be the duty Doctor in consultation with the on-call approved clinician where necessary.

Medical reviews will include the following:

- A review of the patient's physical and psychiatric health
- An assessment of the adverse effects of medication
- A review of the observations required (the minimum prescribed in this policy must be adhered to)
- A re-assessment of medication prescribed
- An assessment of the risk posed by the patient to others
- An assessment of any risk to the patient from deliberate or accidental self-harm
- As assessment of the need to continue seclusion, and whether it is possible for seclusion measures to be applied more flexibly or in a less restrictive manner

13.6 MDT Reviews

First (Internal) MDT Review: This should be held as soon as is practicable. Membership should include:

- the Responsible Clinician/a doctor who is an approved clinician or an approved clinician who is not a doctor but has appropriate expertise;
- a senior nurse on the ward (band 6 or above);
- staff from other disciplines who would normally be involved in patient reviews

13.7. Further reviews required:

Medical review - After the First (internal) MDT, further medical reviews will take place at least twice daily in every 24 hour period. At least one will be carried out by the patient's Responsible Clinician, or an alternative approved clinician or duty doctor out of hours.

One of the two medical reviews should be an MDT review, involving staff from other disciplines who would normally be involved in patient reviews, in addition to a doctor and a nurse.

13.8. Independent MDT reviews

This should be held when a patient has been secluded for eight hours consecutively or for 12 hours intermittently in a 48 hour period. Minimum membership will include:

- a doctor who is an approved clinician or an approved clinician who is not a doctor;
- a nurse;
- Other professionals not involved in the incident which led to seclusion and an Independent Mental Health Advocate (IMHA) if possible.

The CoP does not specify the membership of the Independent MDT Review at weekends and overnight. The Trust therefore requires the review to be carried out by the Duty Doctor in consultation with the on-call Approved Clinician, a nurse as well as a senior nurse (band 6 or above) all of whom were not in the incident which led to seclusion.

If it is agreed by the Independent MDT review that seclusion needs to continue, the review should evaluate and make recommendations, as appropriate, for amendments to the seclusion care plan.

13.9. What happens if a review is required and the patient is asleep?

When the patient in seclusion is asleep, the Code of Practice (MHA CoP 26.136) allows Trusts to make different review arrangements in order to avoid waking the patient. Therefore, between 2300 hours and 0700 hours, medical and nursing reviews, First (internal) MDT review and Independent MDT reviews may be suspended if the patient is asleep.

In these circumstances, it must be documented that the patient was asleep and the review deferred until the patient is awake or 07:00hrs; whichever is sooner.

At other times, if the patient is asleep, attempts should be made by professionals to wake the patient up, if appropriate.

13.10. MDT reviews required at weekends

At weekends and overnight, membership of the MDT reviews is likely to be limited to medical and nursing staff, therefore the Site Manager should be involved and an on-call Approved Clinician.

13.11. Resolving disputes about ongoing seclusion

If any member of the multi-disciplinary team attending any review disputes the continued need for seclusion, the matter must be referred to either the Quality Lead Nurse / Modern Matron or out of hours; the Site Manager. Furthermore, the opinion of another approved clinician should be sought. For out of hours, as well as referring the matter to the on call manager, an opinion should be sought from the on-call consultant, and the on-call local manager advised of the outcome of the review.

14. Ending Seclusion:

Seclusion should immediately end when an MDT review, a medical review or the independent MDT review determined that it is no longer warranted. Alternatively, when the professional in charge of the ward considers that seclusion is no longer warranted, it may be terminated following consultation with the patient's Responsible Clinician or the duty doctor, either in person or the telephone (MHA CoP, para 26.144).

The Trust requires the nurse-in-charge to regularly assess and decide, in consultation with the senior individual on duty (i.e. Ward Manager, Quality Lead Nurse / Modern Matron, or the Site Manager; out of hours) whether it is appropriate to end seclusion.

Seclusion ends when the patient is allowed free and unrestricted access to the normal ward environment or transfers or returns to conditions of long-term segregation (MHA CoP, para 26.145)

Opening a door for toilet or food breaks or medical reviews do not, in themselves, constitute the end of seclusion.

The MHA Code of Practice recommends that in order to minimise the impact on a patient's autonomy, seclusion should be applied flexibly and in the least restrictive manner possible. Where seclusion is used for prolonged periods, subject to suitable risk assessments, flexibility may include allowing the patient to receive visitors, facilitating brief periods of access to secure outdoor areas or allowing meals to be taken in general areas of the ward. Such flexibility should be considered during any review, and it may provide a means of evaluating the patient's mood and degree of agitation under a lesser degree of restriction, without termination the seclusion episode (MHA CoP, para 26.111).

Staff should complete the Seclusion monitoring form to clearly indicate when and how the seclusion period was discontinued.

15. Re – integration to the ward & debriefing:

Following a period of seclusion the clinical rational should be explored with the patient, and they should be supported in the process of re-integration to normal ward activities. Nursing time should be set aside to facilitate this process.

Debrief discussions will include the following:

- Does the patient understand why they were secluded?
- How does the patient feel about the necessity, reasonableness and appropriateness of the use of seclusion?
- How does the patient feel now, after the event?
- How can the need for any further episodes of seclusion be avoided in the future?

15.1. Ongoing care planning:

The above discussion will feed into a review of the patient's ongoing Care Plan or Positive Behaviour Support Plan.

15.2. Debrief:

Post-incident debrief should be available to both staff and patients. Staff should be aware of Trust facilities for debriefing and should access this as required.

16. Reporting & Monitoring:

In addition to Incident 'Ulysses' reporting, the following people must be informed at commencement of seclusion:

- Quality Lead Nurse/ Modern Matron
- Associate Director for the Service or nominated manager.

17. Seclusion reviews at times of major disruption:

In the rare event of major disruptions (such as severe adverse weather or transport disruptions) which prevent access to or from inpatient sites over many hours, it may not be possible for doctors to attend in order to carry out seclusion reviews in person, as prescribed by this policy.

If no doctor is available, the senior nursing team (i.e. Ward Manager, Quality Lead Nurse / Modern Matron, Nurse Practitioners) in the inpatient ward should make telephone contact with the required doctor, discuss the patient's presentation, make a decision about whether seclusion is to continue, and record this in the appropriate review form in the EPR.

If seclusion continues, the patient should be reviewed by a doctor as soon as one is next available.

This is to be done only in the event of major disruptions which prevent physical access to the inpatient units. It is otherwise the expectation that all reviews will be completed as prescribed in this policy.

18. Seclusion MUST not be used in the following circumstances:

- As a punishment or a threat.
- As part of a treatment programme.
- As a means of managing staffing shortfalls

Long Term Segregation Care Pathway Procedure:

19. Longer Term Segregation (LTS):

19.1. CODE OF PRACTICE DEFINITION OF LONG-TERM SEGREGATION & GENERAL

Principles:

The Mental Health Act Code of Practice (CoP) 2015 defines Long-term segregation as follows. “Long-term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the patient to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determine that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. In such cases, it should have been determined that the risk of harm to others would not be ameliorated by a short period of seclusion combined with any other form of treatment.

The clinical judgement is that: If the patient were allowed to mix freely in the general ward environment, other patients or staff would continue to be exposed to a high likelihood of harm over a prolonged period of time.” (MHA CoP, para 26.150)

The Code of Practice further states that “…it is permissible to manage this small number of patients by ensuring that their contact with the general ward population is limited…” (MHA CoP, para 26.151).

There are exceptional circumstances where Long Term Segregation for an individual is in their best interest, despite it not directly being associated with a risk of violence or aggression (i.e. due to an individual’s sensory needs and associated distress/ risk when in the general ward environment). This policy will therefore apply to ALL individuals who are segregated from the general ward environment.

20. When should LTS be considered?

LTS may only be considered when:

- All other forms of treatment and management have been considered as ineffective/ inappropriate (e.g. Positive Behavioural plans including those to tackle incidents of violence and aggression, rapid tranquilisation and seclusion).
- It is in the best interests of the patient
- It is proportionate to the likelihood and seriousness of the harm threatened.
- There is no less restrictive alternative
- A patient may be felt to require LTS after a period in seclusion, when attempts to end seclusion have failed repeatedly due to ongoing high risk of harm towards others. In such cases, a decision should be made by the patient's Responsible Clinician about whether the use of LTS may be more appropriate than long periods in seclusion.

LTS may only be considered for patients detained under the MHA 1983.

20.1 Who needs to be involved in decisions relating to LTS?

Discussion must take place with the patient and their relatives or carers or advocate. The Code of Practice states that "…when consideration is being given to long-term segregation, wherever appropriate, the views of the person's family and carers should be elicited and taken into account…" (MHA CoP, para 26.150).

21. Long –Term Segregation environment:

The CoP states "…the environment should be no more restrictive than necessary. This means that it should be as homely and personalised as risk considerations allow…" (MHA CoP, para 26.151)

The minimum facilities required are:

- Bathroom facilities
- A bedroom
- Relaxing lounge area
- Access to secure outdoor areas
- Range of activities of interest and relevance to the patient

22. Initiating Long -Term Segregation:

It is anticipated that there would only be a very small number of Trust inpatients who would require Long-Term Segregation whereby their contact with the general ward

population is strictly limited.

At the Harplands clinicians should consider the transfer of an individual to the Psychiatric Intensive Care Unit (PICU), specific guidance for this service (Psychiatric Intensive Care Unit-Operational Framework) is available at the Harplands.

The decision to initiate Long- Term Segregation must be made by the MDT; it is then the responsibility of the patient's Responsible Clinician to complete the initial "Long-term Segregation monitoring form" (on paper until it is available as a form in the EPR from October 2019).

Additionally; The CoP requires a representative from the responsible commissioning authority to be involved in the decision to initiate LTS (MHA CoP, para 26.150).

22.1 Clinical Incident Form:

Where a decision to utilise Long Term Segregation has been made an incident report must be completed by the nurse in charge. This will include:

- The time date and time Long Term Segregation commenced and the name and designation of the person making the decision.
- The full reasons for the commencement of LTS.
- The time LTS ended and the rationale for this decision.

The use of LTS should be regarded as an "extra-ordinary event". It should therefore trigger a retrospective investigation report by the Quality Lead Nurse / Modern Matron.

22.2. Who else must be consulted when initiating LTS?

A decision to place a patient in LTS may only be made by the patient's Responsible Clinician and the multi-disciplinary team. Others who must be consulted:

- The views of the patient and his/her family/carers should be sought and taken into account.

- If it is felt that the patient may lack capacity to understand the rationale for LTS, a capacity assessment must be carried out. If the patient does lack capacity, all decisions made in his/her best interests should be documented.

- The patient's Independent Mental Health Advocate (IMHA) should be consulted. A representative from the responsible commissioning authority should be consulted.

- The local safeguarding team should be informed.

23. Care of the Person in Long-Term Segregation:

The CoP states that "…patients should not be isolated from contact with staff or deprived of access to therapeutic interventions…" and "…it is highly likely they should be supported through enhanced observations…" (MHA CoP, para 26.152).

Services must make an assessment of the appropriate enhanced observations required for supporting the patient and for the safe management of the patient's sustained risk of harm to others. This will generally be a minimum of 2:1.

Staff supporting the patient in LTS should make written records of the patient's condition at least every hour.

It may become necessary for a patient to be placed in seclusion while they are in LTS, if there is acute behavioural disturbance where there is a need to contain an immediate risk of harm to others. At such times, the procedure for seclusion as laid out in this policy should be followed. When seclusion is terminated, the patient will return to LTS.

24. Long-Term Segregation Care Plan:

Staff must complete a LTS Care Plan on the EPR.

24.1 What should be in the Care Plan?

Every patient in LTS must have a specific LTS treatment plan. This should be prepared with input from the patient, where possible.

The aim of the treatment plan should be to end LTS (MHA CoP, para 26.152)

The LTS treatment plan should clearly state why LTS is necessary and should be supported by a comprehensive risk assessment and therapeutic plan.

The LTS treatment plan must detail the steps and therapeutic goals to be achieved in order for LTS to be terminated.

24.2 Who should we share the LTS care plan with?

The patient should have access to a copy of the LTS treatment plan, where possible. If this is not appropriate or possible, the patient must be informed of the steps and therapeutic goals they should achieve in order for LTS to be terminated.

Patients in LTS, and their relatives/carers should be given information by the Ward Manger or Responsible Clinician regarding:

- the visiting arrangements based on risk assessment;
- Emergency procedures e.g. Panic alarms, staff response etc.

The information given to the patient must meet the individual's communication needs, for example people with additional needs such as physical, sensory or learning disabilities, and people who do not speak or read English.

25. Reviews during Long-Term Segregation:

Every formal review should attempt to determine if the risks have reduced sufficiently to allow the patient to be integrated into the wider ward community and to check on their health and welfare.

Less restrictive means of managing the patient's risks towards others must be considered at every stage.

25.1 LTS will be reviewed as follows:

Overview of LTS and Monitoring Process:

- Written record every hour by person supporting the patient in LTS.
- Daily review by an approved clinician, (who need not be a doctor)
- At least weekly review by the full MDT (including patient's Responsible Clinician or deputy, ward manager or deputy, and IMHA)
- Weekly review by a consultant psychiatrist not involved with the patient
- If LTS continues beyond 3 months, review by an external hospital, and discussion with IMHA and commissioner

25.2. Hourly Observation

Staff supporting the patient in LTS should make a record of the patient's mental state, communication, behaviour and risks to self and to others on at least an hourly basis.

Staff must complete Long-term Segregation observation record**.** This will remain a paper document and must be scanned into Lorenzo (patient clinical notes section) every 24hr period (Appendix 7).

25.3. Daily Reviews

There must be a daily review by an approved clinician, who need not be a doctor. This should be recorded in the electronic progress notes.

The approved clinician must complete Long- Term Segregation observation form to

indicate that the review has taken place and document the findings in the Clinical note section on the EPR, choosing the appropriate review title.

On weekends, the review may be conducted by telephone with nursing staff contacting the on-call consultant. Nursing staff will then complete the "Long term Segregation observation form" and document the findings in the Clinical note section on the EPR, choosing the appropriate review title.

25.4. Weekly Reviews:

The weekly review by the MDT should be carried out by the patient's Responsible Clinician or deputy, the ward manager or deputy, other members of the MDT who would normally be involved in the patient's care and the patient's IMHA.

Consideration should be given to whether less restrictive alternatives of managing the patient's risk to others are appropriate, and to provision of a full therapeutic programme, including, where appropriate, access to visitors. These considerations must be documented as part of the MDT review within Lorenzo.

Staff must complete the "Long-Term Segregation observation record sheet (Appendix 7) to indicate that the review has taken place and document the findings in the Clinical Note section on the EPR, choosing the appropriate review title.

Where successive MDT reviews determine that LTS continues to be required, more information should be available to demonstrate its necessity and explain why the patient cannot be supported in a less restrictive manner (MHA CoP, para 26.159)

The Code also requires periodic review of LTS by a senior professional not involved with the case (para 26.155). To meet this requirement, a weekly review of the patient and the treatment plan must be undertaken by a consultant psychiatrist who is not otherwise involved in that patient's care. The psychiatrist should complete the 'Long-Term Segregation observation' form to indicate that the review has taken place and document the findings in the Clinical note section on the EPR, choosing the appropriate review title.

25.5. Review of Extended Long-term segregation

If LTS continues beyond three months, a comprehensive review must be undertaken by an external organisation. The clinicians involved in this review must discuss the care of the patient with the patient's family, IMHA and the responsible commissioners. A written report should be provided to the detaining authority (e.g. Mental Health Law

Team or Ministry of Justice).

This review must be repeated every 3 months as long as LTS continues. This must be documented in 'Long- Term Segregation observation' form to indicate that the review has taken place and document the findings in the Clinical note section on the EPR, choosing the appropriate review title.

26. Termination of Long-Term Segregation:

LTS must be terminated when it is determined that the patient's risks have reduced sufficiently to allow them to be re-integrated into the ward.

The decision to terminate LTS should be taken by the MDT, following a thorough risk assessment and taking into account observations from staff of the patient's presentation during close monitoring of the patient's presentation in the company of others.

The MDT should consist of, as a minimum, the patient's Responsible Clinician and the Ward Manager. The patient's IMHA should also be consulted.

The RC and Ward Manager should complete the form "Long-term Segregation – observation form" and document the findings in the Clinical note section on the EPR, choosing the appropriate review title on the EPR.

27. Re-integration to the ward and Debrief:

The patient's LTS Care Plan and MDT review documentation should include a detailed account of all the steps to end LTS. The care plan should detail how the patient will be re-integrated back into the wider ward. It is expected that this will take place over a period of time, allowing the patient to gradually re-acclimatise to being in the company of other patients and staff.

Following the termination of LTS and complete re-integration into the ward, the patient should have a de-briefing session to explore their experience of LTS, their understanding of the rationale for it, and their current risks towards others.

28. Reporting and Monitoring:

In addition to Incident 'Ulysses' reporting, the following people must be informed at commencement of LTS, weekly reviews, and at termination:

- Associate Director of Directorate
- Deputy Director of Nursing, AHP & Quality

- Safeguarding Team
- Mental Health Law Manager

29. Trust Wide Monitoring of Seclusion and Longer Term Segregation:

The relevant directorate Clinical Director must monitor the use of seclusion within their services. The use of the Incident Reporting system and subsequent Investigation Report will allow for the monitoring of seclusion within clinical services and generate reports to provide assurance to the Senior Leadership Team meeting.

The Reducing Restrictive Practice Lead will produce quarterly figures on the use of seclusion within services and these will be presented to the Quality Committee on a quarterly basis.

30. Evaluation and Audit

The Trust will annually consider evaluation and audit of seclusion and long-term segregation as part of the Trusts annual audit cycle.

31. Supporting references:

Department of Health (2005): The Mental Capacity Act. Deprivation of Liberty Safeguards and the use of Restrictive Interventions.

Department of Health (2015): The Mental Health Act 1983: Revised Code of Practice.

Lavelle, M., Stewart, D., James, K., Richardson, M., Renwick, L., Brennan, G. & Bowers,
L. 2016, “Predictors of effective de-escalation in acute inpatient psychiatric settings",
Journal of Clinical Nursing, vol. 25, no. 15-16, pp. 2180-2188.

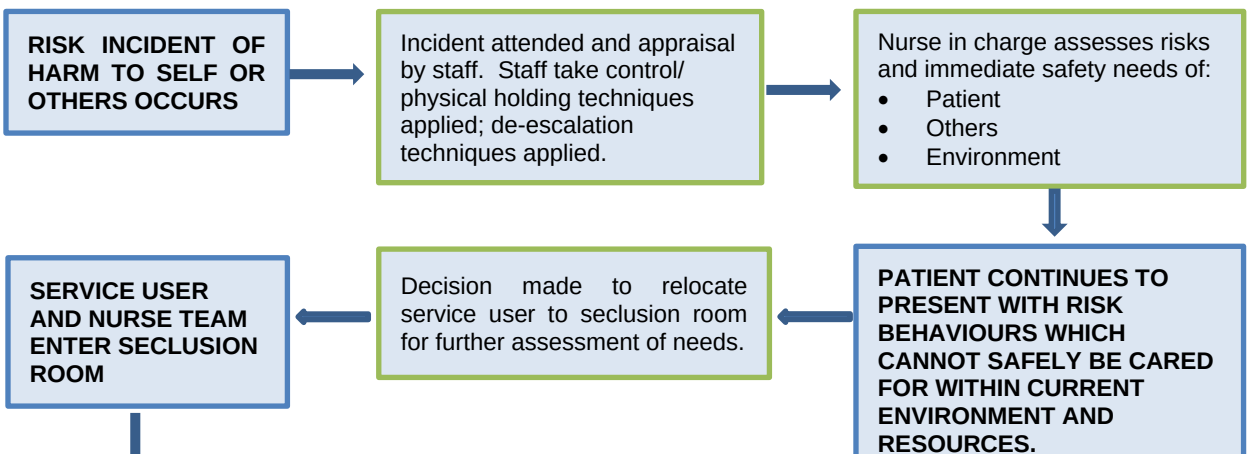
National Institute for Health and Clinical Excellence (NICE, 2005): Clinical Guideline 25; the short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments.

National Institute for Health and Care Excellence (2015): Violence and Aggression: short term management in mental health, health and community settings.

Royal College of Nursing (2013): Draft guidance on the minimisation of and alternatives to restrictive practices in health and adult social care, and special schools.

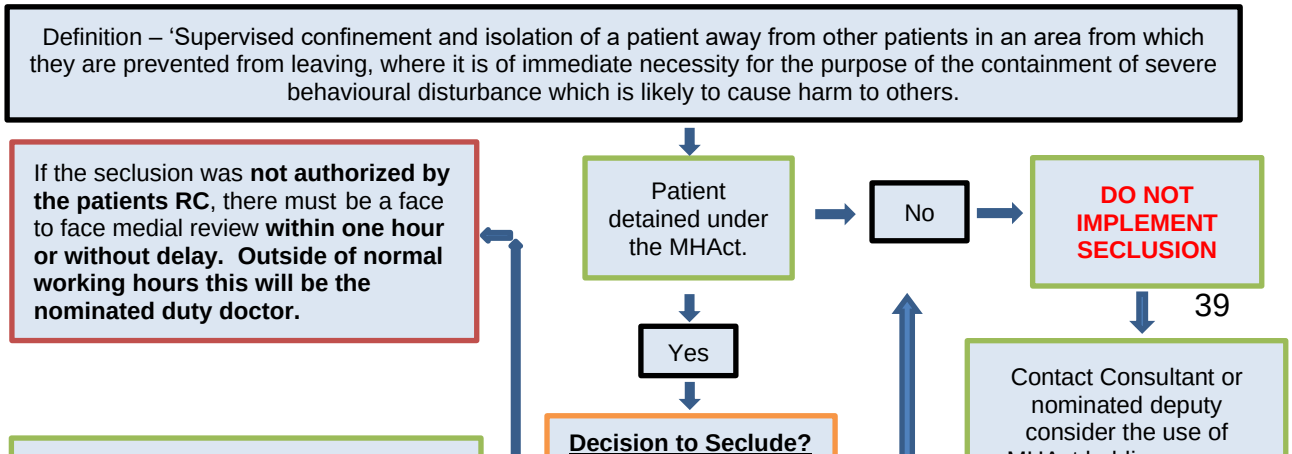
Flowchart – Assessment for Seclusion Process:

Appendix 1



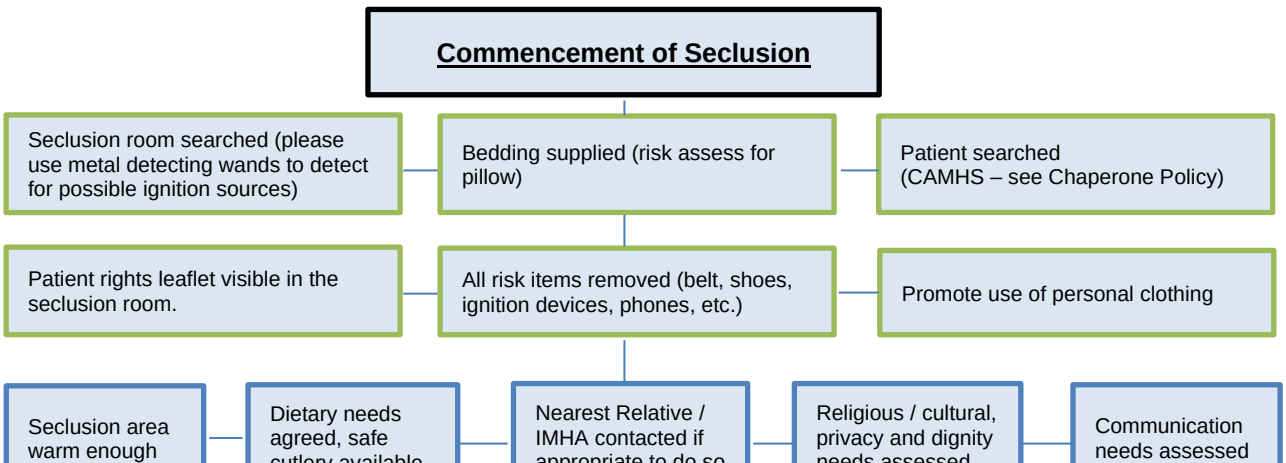
Co-produced between patient and nursing staff

nitiation process-Adults and Young People Appendix 2



Flowchart - Seclusion Procedure

Appendix 3



Risk event or risk behavior observed (self-harm, 'head banging', sexual safety concerns, violence or threats to harm, any other concerns, patient unobservable, physical health concerns noted, patient observed not to be moving).

Co-produced between patient and nursing staff

IMPORTANT POINTS TO NOTE

NURSING

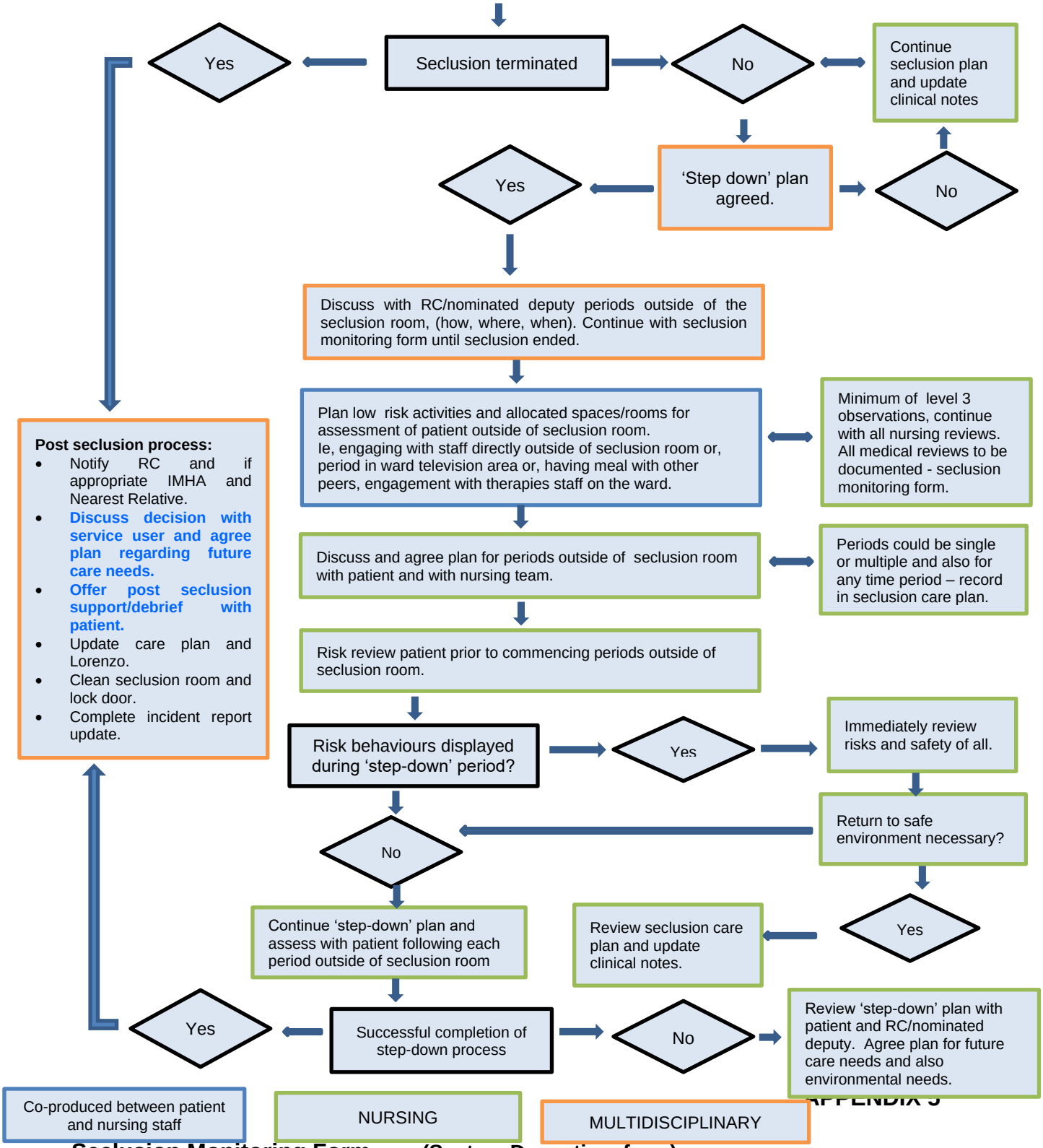
Dis on / rocess Appendix 4

Pathway for discontinuation of Seclusion

Following review of patient care needs, a reduction of risk behavior noted.

⬇

Discuss with RC/nominated deputy possibility of terminating seclusion



Seclusion Monitoring Form (System Down time form)

To be added

SECLUSION OBSERVATION RECORD SHEET – 15 MINUTE CHECK

APPENDIX 6

(The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end)

Level 3 Constant Visual	CCTV / Privacy:		Date:		Time:	
Full Name:		NHS No.				

What items has the patient taken into the seclusion room?

Following to be considered at each 15 minute review

Your assessment - The record made should include: •Diet and Fluids taken: (see chart). • Physical Health presentation • Physical description / ABCDE • the patient's appearance • what they are doing and saying • their mood • their level of awareness • any evidence of physical ill health especially following administration of rapid tranquilisation with regard to their breathing, pallor or cyanosis.

Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:

Two-Hourly Recommendation	Seclusion to continue		Seclusion to end	

Patient's condition - Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

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SECLUSION OBSERVATION RECORD SHEET – 15

MINUTE CHECK

(The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which seclusion can end)

Level 3 Constant Visual	CCTV / Privacy:		Date:		Time:	
Full Name:		NHS No.				

What items has the patient taken into the seclusion room?

Following to be considered at each 15 minute review

Your assessment - The record made should include: •Diet and Fluids taken: (see chart). • Physical Health presentation • Physical description / ABCDE • the patient's appearance • what they are doing and saying • their mood • their level of awareness • any evidence of physical ill health especially following administration of rapid tranquilisation with regard to their breathing, pallor or cyanosis.

Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:
Time:		Observed behaviour:	Time:		Observed behaviour:

Two-Hourly Recommendation	Seclusion to continue		Seclusion to end	

2

Patient's condition - Where a patient appears to be asleep in seclusion, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

LONG TERM SEGREGATION (LTS) 1 HOURLY OBSERVATION RECORD SHEET

APPENDIX 7

(The aim of observation is to safeguard the patient, monitor their condition and behaviour and to identify the earliest time at which LTS and to support subsequent approved clinician and MDT reviews)

Full Name:		NHS No.	
Date:			

The following information is to be considered and recorded as part of the 1 hourly review

Your assessment - The record made should include: •diet and fluids taken • physical health presentation • the patient's appearance • what they are doing and saying • their mood • their level of awareness, engagement with activities • any evidence of physical ill health especially following administration of rapid tranquilisation with regard to their breathing, pallor or cyanosis.

Time:		Observed behaviour:	Time:		Observed behaviour:

Time:		Observed behaviour:	Time:		Observed behaviour:

Time:		Observed behaviour:	Time:		Observed behaviour:

Time:		Observed behaviour:	Time:		Observed behaviour:

Patient's condition - Where a patient appears to be asleep, the person observing the patient should be alert to and assess the level of consciousness and respirations of the patient as appropriate.

Flowchart - Long Term Segregation
APPENDIX 8

Definition- Long Term Segregation
Long term segregation refers to a situation where, in order to reduce a sustained risk of harm posed by the service user to others, which is a constant feature of their presentation, a multi-disciplinary review and a representative from the responsible commissioning authority determines that a service user should not be allowed to mix freely with other service users on the ward or unit on a long- term basis.

Multi-disciplinary team meeting to discuss service user needs. Discussion regarding need to use LTS to keep the person safe.

Decision to use long term segregation procedure?

No

MDT to agree care plan based on least restrictive intervention necessary and proportionate to the level of risk presented by person.

Inform service user and involve in care plan development

Yes

Inform:
- ✓ Service user and/or advocate or nearest relative
- ✓ Safeguarding team

Complete:
- ✓ Initiation of LTS form
- ✓ Incident form (for initiation of LTS)
- ✓ Observation chart (patient must be on level 3 observations)
- ✓ Long term segregation care plan with service user involvement if possible
- ✓ **Document in service users clinical notes regarding decision to use Long Term Segregation.**

Reviews to be completed:
Every 24 hours: by an approved clinician (Doctor or medical officer/staff)
Weekly: MDT to include person's Responsible Clinician and IMHA/ Advocate
At least every 28 days: Independent review team which should consist of 1 senior clinician (another Consultant Psychiatrist) and two other review team members (from outside the service and who are independent to the case e.g. workforce safety lead, patient safety lead, social worker, Psychologist or QI Lead/modern matron)
3-Monthly: Multi professional team from another trust to be determined by the Director of Nursing and Quality/ or other Executive Director of the Trust. **The review should include discussions with the patients IMHA (where appropriate) and Commissioner.**
THROUGHOUT EACH REVIEW SERVICE USER AND SERVICE USER ADVOCATE/NEAREST RELATIVE TO BE INVOLVED AND INFORMED OF ANY DECISION

Following the end of Long Term Segregation:
Complete an Incident report to report end of Long Term Segregation

APPENDIX 9

Long Term Segregation Monitoring Form (System Down time form)

To be added

Data Protection Impact Assessment (DPIA)

A DPIA is a legal requirement and should be completed when sharing personal information, for example when commissioning a new service, working on a specific project/process/scheme or implementing a new system; **or** when making changes to any existing service/project/process/scheme. The DPIA must be completed at the start of the project to provide the Trust with the key assurances on data protection requirements and enable the Trust to evidence accountability in all activities.

Project name:

Changes to Darwin Estate (adding a High Dependency Area)

Name of Project Lead and Job Title

Rachel Bloor – Head of Nursing & Professional Practice

Date of Completion of DPIA

13.03.2023

Section 1 – Initiation Phase

1.1 Project outline – what and why

Note: Explain broadly what project aims to achieve and what type of processing it involves. You may find it helpful to refer or link to other documents, such as a project proposal. Summarise why you identified the need for a DPIA.

This is a change in the environmental configuration with the Darwin Centre, CAMHS inpatient unit. NSCHT and the Local Authority have been working together to support the complex needs of a patient. The patient has been court ordered under a Deprivation of Liberty Safeguards (DOLS) to remain within the Harplands Hospital as it was considered by the Court that this was the best place at that time to guarantee the patient safety. The patient is currently in the seclusion suite in PICU. NSCHT and the Local Authority are proposing to the Court the potential option of utilising step-down provision from our seclusion unit to the Darwin centre, whilst an appropriate community facility is sourced. This step-down facility will comprise of a bedroom, en-suite and lounge/therapeutic space (High Dependency Area) but initially the patient will remain in seclusion utilising the bedroom and bathroom area only, and staff will carry out observations from the therapeutic/ lounge space. The patient will be nursed in seclusion following the Trust's Seclusion & Long-Term segregation (R11) policy. The new configuration facility will be equipped with live feed non-recordable CCTV. When the patient is able to step down to the proposed High Dependency Area (HDA) the CCTV will no longer be in use. The HDA will offer a self-contained low stimulus environment that can be used to support the needs of patients as per NHS guidance (2018) for general assessment inpatient units for children in the future. DPIA is required as we are creating an additional seclusion area within the Trust and will use CCTV to support the observation of the patient. The CCTV will allow for staff to observe all areas of the suite to reduce restrictive intervention.

1.2 Use of personal data

Note: Will the project necessitate the collection/use/processing or sharing of personal or pseudonymised data? Personal data - Any information relating to an identified living person ('data subject') by way of an identifier such as a name, address, date of birth, NHS Number etc. Pseudonymised data - Personal data which has undergone pseudonymisation, which could be attributed to a natural person by the use of additional information, i.e. local identifier which would then be re-identified if needed.

The new configuration facility will be equipped with live feed non-recordable CCTV. The images are relayed to a monitor that is placed outside the seclusion room (bedroom & bathroom) to provide better observation by increasing the field of vision. The CCTV enables staff to observe the person in seclusion throughout the whole seclusion suite including toilet/shower area, when risk assessed and identified as being appropriate to do so.

The Trusts Seclusion & Long-Term segregation (R11) policy will be referred to in relation to privacy and dignity when using the toilet/shower.

No personal data will be saved or stored in relation to this. All information will remain within the Electronic Patient Record (EPR).

The system will be switched off when the patient is no longer in seclusion and using the HDA, screen will be removed.

1.3 Describe the nature of the processing

Note: how will you collect, use, store and delete data? What is the source of the data? Will you be sharing data with anyone? You might find it useful to refer to a flow diagram or other way of describing data flows. What types of processing identified as likely high risk are involved?

No data will be recorded or saved through the use of CCTV.

Staff will care for the patient using the Seclusion & Long-Term segregation (R11) policy and when in the HDA the Trusts 'Safe and Supportive Observation & Engagement of Patients Policy' (1.35). All patient details will be stored within the EPR system.

1.4 Data Flow Diagram

No data flows will be involved – the CCTV camera will be used as a live observational system only - no recording will take place within the system.

1.5 Data Controller/Processor Responsibilities

Note: What are the responsibilities linked to the processing? Who is the Data Controller, are there any Data Processors, Sub-Processors or any Joint Data Controllers?

NSCHT are the data controllers. The staff undertaking observations will be observing the patient via the live CCTV monitor. No recording will be made.

All information will be managed by the MDT team via the EPR system – Lorenzo.

Section 2 - Compliance with privacy laws

Note: Data Protection legislation is relevant to any DPIA, and a DP compliance check should always be carried out. The Data Protection Officer will be able to advise you on the relevance of other privacy laws.

2.1 UK General Data Protection Regulation (UK GDPR) and Data Protection Act 2018 (DPA)

Note: The template you have to fill in for the data protection compliance check can be found in Appendix A of this document. The Trust Information Governance Team will be able to assist with the completion, prior to approval granted by the Trust Data Protection Officer, SIRO and Caldicott Guardian.

A Data Protection compliance check has been carried out as part of this DPIA, the details of which are in appendix A. From this we have concluded: Any use of surveillance technology comes with increased risk, but having a robust system implemented in line with key legislation and codes of practice will ensure these risks can be mitigated.

Relevant training must be provided to staff involved in the ongoing management and use of the surveillance technology and ensure training remains in compliance with relevant legislation and the risk mitigations in Appendix B.

2.2 Human Rights Act (HRA) (Article 8)

Note: In most cases HRA considerations will be covered by the other work on this DPIA, including the Data Protection compliance check. If that is the case, you can simply record here that there are no special considerations that are not covered by other aspects of the DPIA. If there are any outstanding issues, describe them here.

Everybody is entitled to a private life as advocated by the Human Rights Act and using surveillance technology can be perceived to be intrusive and make people feel their privacy is affected. Service Users should not be subject to unnecessarily intrusive observations in a way that would breach this right.

However, surveillance technology, used correctly, can provide assurances to staff and service users alike, particularly in relation to providing a secure and safe environment.

Observations must be justified and proportionate and go no further than is reasonably necessary to achieve the objectives.

The Trust must be transparent about its use of surveillance technology and inform individuals about its use. This can be done verbally and via appropriate signage to ensure that the Human Rights Act is complied with-this notification is recorded in the patient's electronic health record.

2.3 Privacy and Electronic Communications Regulations 2003 (amended 2011) (PECRs)

Note: If the project involves electronic marketing messages (by phone, email or text), cookies, or providing electronic communication services to the public, you also need to make sure you comply with the PECRs.

The following guidance will help: Information Commissioner's Office PECR guidance.

Describe any issues here or confirm if not applicable.

Not applicable

2.4 Common Law Duty of Confidentiality

All Trust staff are required to adhere to the Common Law Duty of Confidentiality.

2.5 Other legislative requirements

Court Order / Deprivation of Liberty Safeguards (DOLS)

Section 3 – Technological requirements

3.1 Technology

3.1.1 What systems/assets will be used to support the project?

Note: Please list all software, hardware and information assets associated with this project

CCTV system as per the Trusts Seclusion & Long-Term segregation (R11) policy. HikVision CCTV/Surveillance Operating Equipment High-Definition Cameras VDU screen for viewing The digital video recording link within the system is disconnected to ensure the recording function is not operational. Camera equipment within the bedroom and bathroom area. Visual monitoring screen available for staff in the therapeutic lounge area.

3.2 Data collection

3.2.1 Will the project involve the collection of new information about individuals?

Yes: ☐ No: ☒

3.2.2 Will the project compel individuals to provide information about themselves during the course of the project?

Yes: ☐ No: ☒

3.3 Identification methods

3.3.1 Will there be new or different identity authentication requirements?

Yes: ☐ No: ☒

3.4 Involvement of external organisations

3.4.1 Will the initiative involve external organisations that will have access to the personal data?

Yes: ☐ No: ☒

3.5 Changes to the way data is handled – considering the actual processing

3.5.1 Will there be new or significant changes to the handling of special categories of personal data or data that would be considered sensitive by the data subjects? *(For example, data about racial/ethnic origin, political opinions, health information, sexuality, offences and court proceedings, finances etc.)*

Yes: ☐ No: ☒

3.5.2 Will the personal details about each individual in an existing database be processed in a new or different way?

Yes: ☐ No: ☒

3.5.3 If yes to the above, will this involve a large number of individuals?

Yes: ☐ No: ☐

3.5.4 Will the project use an automated-decision-making tool? *(Note automated-decision making is a computer-generated decision-making tool based on algorithms that make decisions without a human being)*

Yes: ☐ No: ☒

Section 4 – Pre-implementation

Note: Explain below what checks will be carried out before the service/project/scheme/system is implemented to ensure that the privacy solutions approved as part of this DPIA have been applied, and that the system or process is still legally compliant. Also include whether data subjects have been appropriately informed.

The court will have to approve the utilisation of the step-down provision at the Darwin centre.

Estates will support the environmental changes and will follow their approval process for sign off to ensure we have met all safety regulations.

The DPIA will need formal approval prior to the use of any surveillance system being used to ensure the legal basis is determined and that individuals rights are met.

Section 5 – Review

Note: Indicate below how and when the post-implementation review will be carried out:

Clinical reviews will take place, following Trust policy guidance inclusive of R11, 1.35 and when deemed appropriate by the clinical team.

For further details regarding clinical reviews see Quality Impact assessment.

Further review and use of the HDA will take place when the patient has left to ensure suitability for all other people that use the Darwin centre.

To be undertaken by:

Multi-Disciplinary Team

Date review required:

Ongoing – due to changes in clinical needs.

4.1 Formal Approvals

Note: All DPIAs must go through rigorous checks before receiving formal approval. Approval is received from the Trusts Data Protection Officer, Senior Information Risk Owner and Caldicott Guardian (where applicable).

Data Protection Officer Approval:

Sahra Smith

Print Name

14th March 2023

Date of Approval

Senior Information Risk Owner Approval:

Dave Hewitt CIO (in absence of SIRO)

Print Name

14th March 2023

Date of Approval

Caldicott Guardian Approval:

Dennis Okolo

Print Name

16th March 2023

Date of Approval

Appendix A

Data Protection Compliance Schedule

Completion of this schedule requires knowledge of Data Protection Legislation, including adherence to the Data Protection Act 2018/ UKGDPR. Assistance can be obtained from the Trust's Information Governance Team NSCHT.informationgovernance@combined.nhs.uk

	Question	Answer
1.	What type of personal data will be processed? (Please list every data requirement)	Live images are being used for observational purposes – this contains special category data/biometric data. Biometric data is defined under article 4 (14) of UK GDPR as "personal data resulting from specific technical processing relating to the physical, physiological or behavioural characteristics of a natural person, which allow or confirm the unique identification of that natural person, such as facial images or dactyloscopic data"
2.	What is the legal basis for processing the personal information for the given purpose? (Please provide the relevant legal basis from Article 6 of the UK GDPR as shown via the link – *https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/#what*)	Article 6 (1) (d) – processing is necessary in order to protect the vital interests of the data subject or of another natural person. Article 6 (1) (f) – processing is necessary for the purposes of the legitimate interests pursued by the controller or by a third party, except where such interests are overridden by the interests or fundamental rights and freedoms of the data subject which require protection of personal data, in particular where the data subject is a child.
3.	When processing special category data (i.e. health, sexuality, biometric data, religion etc.) enhanced privacy measures are applied, as the processing of such data is prohibited in principle. To enable this data to be shared, Article 9 of the UK GDPR lists lawful grounds for processing this type of data. Which article 9 exemption applies to this scheme/project/process/system?	Surveillance technology utilises biometric data to enable identification. Article 9 (2) (h) - processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of domestic law or pursuant to contract with a health professional – data may be processed by or under the responsibility of a professional subject to the obligation of professional secrecy under domestic law or rules established by national competent bodies or by another person also subject to an obligation of secrecy under domestic law or rules established by national competent bodies.
4.	Are there any special considerations relating to Article 8 of the Human Rights Act that will not be covered by the DPIA?	See 2.2 in main form.

5.	If consent is the lawful basis for processing the data, how will consent be obtained and how will you ensure it meets the definition of consent as detailed in the DPA18? (*Note: consent must be specific, explicit, an unambiguous indication of the data subjects wishes, validated by clear affirmative action or written statement*)	Consent is not the lawful basis for the use of this system.
6.	Will any of the personal data be processed under Common Law Duty of Confidentiality? If yes, how is that confidentiality being maintained?	Any staff member who is involved with the management and operations of the Trust surveillance technology is required to adhere to the Common Law Duty of Confidentiality, in ensuring that any information held within the systems are not disclosed without a valid reason, and strict codes of conduct and ethics are followed at all times, ensuring confidentiality is embedded into all activities related to the surveillance activities.
7.	How are individuals informed of how their personal data will be used?	Suitable signage indicating CCTV is in operation and its purpose will be clearly displayed. For the purposes of this system, they must also be made aware of what and how the system is being used and for what purpose.
8.	Does the project involve the use of personal data for purposes other than those listed in this DPIA?	No, the use of this surveillance technology is used for these specific purposes and will only be used for live observation purposes to ensure the safety and welfare of the individuals involved.
9.	How can data subjects exercise rights in relation to access to their own records?	Article 15 of the UK GDPR stipulates, **"The data subject shall have the right to obtain from the controller confirmation as to whether or not personal data concerning him or her are being processed, and, where that is the case, access to the personal data".** To ensure compliance with this requirement, the Trust has a robust Subject Access Request Policy in place with a team of staff whose role is to process requests within statutory timescales. Details of how to make a request are provided within the Trusts Privacy Notices. For the purposes of processing detailed in this DPIA, this right will not be applicable as recordings are not being made.

10.	How can the rights of data portability be met safely and effectively?	Data Portability is governed under Article 20 of UK GDPR, but only applies when the legal basis for processing data is reliant upon consent or for the performance of a contract, or when processing is carried out by automated means. As such for the purposes for processing as detailed in this DPIA, this right will not be applicable.
11.	How can data subjects exercise their rights to rectification and/or erasure?	Data subjects are entitled, under Article 16 of UK GDPR, to have any inaccurate information held by an organisation rectified as soon as possible. This can be as simple as a spelling error, incorrect name, former address, previous contact details etc. to ensure all information is kept accurate and up to date. The right to erasure, governed under Article 16, provide list of grounds where the right applies but is not an absolute right and only applies in certain circumstances, and will not apply to the use of surveillance technology for this purpose.
12.	How can data subjects exercise their right to restrict data flows or object to the processing of their data?	Data subjects are entitled, under Article 18 of UK GDPR, to restrict data flows or object to the processing of their data, but only in certain circumstances; namely when the accuracy of the data is contested, the processing is unlawful, the data controller no longer requires the data for the purposes that it was processed and their objection is not as a result of the data controller having the legitimacy to process. This right will not apply in relation to the use of surveillance technology for this purpose.
13.	What procedures will be in place to ensure that the data requirements are adequate, relevant and limited to what is necessary in relation to the purpose for which the data will be processed? (data minimisation)	In relation to surveillance technology, cameras will be positioned to capture agreed point within the suite to be able to observe the patient's safety and welfare with minimum intervention. No data is being collected as the record function is disabled.
14.	How will the data be kept accurate and up-to-date at all times?	This will not apply to visual footage. No recordings are being made.
15.	Is there concern that sharing the personal data to inform this project/process/scheme/system could cause upset/distress to the data subjects? If so please add how this will be addressed.	Data will not be gathered. The system will provide live observations only and no recordings will be made. Transparency principles will be applied to ensure service users and staff are aware of the live observation technology and why it is in place.
16.	What is the retention period in relation to the storage of the personal data?	No footage is recorded, the system is being used as a live observation system only. Transparency principles will be applied to ensure service users and staff are aware of the use of the surveillance technology and how it is being used.

17.	What technical and organisational security measures will be in place to prevent any unauthorised or unlawful processing of the personal data?	NSCHT have robust technical measures in place to protect infiltration, loss, destruction or damage through anti-virus software, two factor authentication methods, rigorous access measure and controls, regular audits of confidentiality as well as evidence and accountability with any suppliers that we use. The Trust are required to complete to satisfactory standards, the online self-assessment tool on confidentiality the Data Security & Protection Toolkit, a yearly submission to NHS England which demonstrates accountability and compliance to all key governance processes of which integrity and confidentiality of systems is a fundamental requirement. NSCHT are registered with the ICO with renewal of registration due in November 2023. All staff are trained on an annual mandatory basis in Information Governance and every staff member is issued with an IG/Data Protection Handbook and supported by a specialist IG staff with a Data Protection officer in place to oversee compliance. No recordings will be made - it will only be used for live observations so no data will be collected or processed.
18.	If there is a Data Processor/Sub-Processor involved, are the obligations of the Processor clearly defined in a contract?	An agreement is in place with the JPR Group to install and provide ongoing maintenance for the surveillance equipment. The system in this suite is only being used as a live observation system and no recordings are being made. If this is changed in the future, then a new DPIA will need to be completed and a Data Processing Agreement will be developed to demonstrate accountability.
19.	Does data get transferred outside of the United Kingdom and if so where? Also what provisions will be in place for data transfers outside of the UK?	No data is transferred outside of the UK

Appendix B - Data Protection Impact Assessment Risks

Risk Description	Inherent Privacy Risk			*Options for avoiding or mitigating this risk	Risk Owner	Residual Privacy Risk		
	Impact	Likelihood	Exposure			Impact	Likelihood	Exposure
Unauthorised personnel can accidentally see the live feed.	Medium	Medium	Medium	Monitor must be placed in such a position that only authorised staff are able to monitor the patient. All unit staff must be made aware of their responsibilities regarding the live feed data.	**Darwin Centre Staff**	Medium	Low	Medium
Live feeds are recorded.	Medium	Medium	Medium	In the event that the decision is made to record the feeds from this observation only monitoring station, a new DPIA must be completed and authorised by the Data Protection Officer, Senior Information Risk Owner and the Caldicott Guardian. Staff must not record the live feeds using any device.	**NSCHT Estates/ Facilities/ Darwin Centre Staff**	Medium	Medium	Medium
Failure to ensure that the rights and freedoms of the individuals are met	Low	Low	Low	It is essential that fairness, justification, proportionality and transparency principles are met and that individuals are informed appropriately about the use of this surveillance technology. Signage must be clear and placed in easily recognisable places to ensure individuals are being appropriately informed of the use of surveillance technology.	**Estates/ Facilities/IG Team**	Low	Low	Low