Pennine Care
NHS Foundation Trust

DOCUMENT CONTROL	
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Scope:	
This policy applies to all Pennine Care NHS Foundation Trust staff members	
Purpose:	
The purpose of this document is to provide details of the processes for Trust Staff to follow in the event of a service user alert needing to be generated.	
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Trust Security Manager – Karl Adderley	
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Individual(s) & group(s) involved in the Consultation:	
The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly: • Health & Safety Committee • PSIG	

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Responsibility of:	Trust Security Manager
Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):	
CO080	Placing a Risk of Violence Marker on Electronic and Paper Records
HI002	Electronic Mail Policy
Policy Associated Documents:	
TAD_CL084_01	Local Patient Alert Template
Other external documentation/resources to which this policy relates:	
	Equality Act 2010
CQC Regulations **This policy supports the following CQC regulations:**	
9, 11,12	Person Cantered Care, Need for Consent, Safe Care & Treatment

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1. INTRODUCTION

The following information provides details of the processes for Trust staff to follow in the event of a service user alert needing to be generated.

- Where there is significant concern in relation to risk to self and others that needs to be communicated to others.
- Where there is a need to communicate treatment, risk plan or actions required to maintain consistency in service user's treatment plan.

Examples might include:

- Missing Service User
- Risks involving NHS Services e.g. Service user persistently presenting at Accident and Emergency
- Unidentified service user i.e. in hospital but identity unknown
- Notifications of violent/aggressive or potentially violent/aggressive individuals, or individuals who otherwise pose a threat to NHS staff – these alerts would usually be issued to enable health bodies to consider whether preventative measures should be implemented or to alert appropriate staff to a potential thread, so that they can take appropriate measures to minimise risk to themselves and others.
- Notification of a potential threat to NHS property or assets, such as individuals or organised gangs who target the NHS to steal valuable medical or IT equipment
- MAPPA alerts where regionally significant individuals of concern are proved by local MAPPA health groups
- Requests for assistance or information made by the police – e.g. in relation to a person who is wanted for serious offences, to seek further information about potential offences or to assist in evidence gathering, such alerts will only be considered if there is also a possible impact on the safety/security of NHS staff and/or resources.

2. PURPOSE

The purpose of this document is to provide details of the processes for Trust Staff to follow in the event of a service user alert needing to be generated.

3. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

The decision to circulate information about a service user is serious and should only be undertaken following a multi-disciplinary discussion. If at all possible the consent of the service user should be obtained, however it is likely in many cases this will not be possible. Information should be circulated when absolutely necessary.

Where there are immediate significant concerns staff should make immediate direct verbal contact with services to ensure that the risks are communicated in a timely manner and check who should be in receipt of the alert.

Where there is significant concern or risk with regards to a service user consideration should be given to notifying police, GP and others who may be required to know.

The clinical team are responsible for deciding whether an alert needs to be raised in relation to a service user and who the alert should be disseminated to. Only those who need to know should be identified and informed. The information may only need to be sent to Accident and Emergency departments, Walk-In centres, drug teams or specific departments. This question should be considered in depth before details are completed on the Alert circulation.

The decision to issue an alert either internally or externally needs to be discussed with senior manager/ locality manager. For out of hours this should be discussed with the manager on-call. The service users consultant should be informed that an alert will be issued.

The Alert should include a list of recipients which should always include Governance Manager, Security Manager, Patient Safety Manager, and Information Governance Manager. Only those who need to know should be informed.

The Alert should be in the form of an attachment that is then sent electronically to the recipients identified by the Clinical Team/Governance Manager. (See attachment Information Alert for circulation – TAD_CL084_01).

The email should be titled “ALERT” with the service user’s initials only and tagged as “URGENT.” (The email should be sent to a secure email address as specified in the Email policy however, the sending of emails containing identifiable information to a non-secure NHS account is permitted in this instance due to the associated risks)

All alerts should be completed by the Clinical Team and include the:

3.1 Subject Identification

- To include descriptions of list of recipients
- The name and position of the referring person. This should be a senior manager, Governance Manager or team leader
- Full name of service user and any aliases or ‘also known as’ names
- Date of birth and any known false dates of birth
- Current address and any other addresses used recently
- Physical description and any identifying features – Height, build, hair and eye colour, any distinguishing marks such as tattoos etc.
- Electronic patient record ID number
- Sex of the service user
- Ethnic origin
- Details of last known whereabouts
- Photographs (if these are available, validated and of sufficient quality to avoid misidentification)
- NHS premises affected

3.2 Background Information

- A summary of the activities of the subject
- Copies of any incident reports (IR forms), PARS (Patient Assaults Relating to Staff) reports or other documents detailing the behaviour complained of
- Details of any police involvement, any known relevant previous convictions, any current court proceedings and any legal restrictions on the subject (e.g. injunction, bail conditions), if relevant to the alert and available.
- Details of concerns, reason for alert
- Description of risks to self or others
- Additional services who will be the recipients must be clearly indicated
- Course of action to be taken should the service user present and who should be contacted.
- How long this course of action is likely to be. Consideration should be given to whether there needs to be a Marker on Patients record, Please see Placing a Risk of Violence Marker on Electronic and Paper Records Policy CO080

3.3 Relevant Medical Information

It is the policy of the Trust to use (in any of its activities) the minimum of information about the subject's health or medical condition that is necessary, and to use this only if the alert's purposes would be hampered without such information. Examples of medical details that may be included are as follows:

- Information relating to possible attendance – for example, an insulin-dependent diabetic would be expected to call regularly for repeat prescriptions
- Information about fictitious ailments – for example, a subject who feigns injury or illness to obtain drugs or access to medical services/premises
- Information about appropriate treatment – if there is a protocol for advising staff how to handle the subject or how to avoid potential triggers of unacceptable behaviour
- Information in the interests of the subject – to help staff who are unfamiliar with the subject's medical history to decide on the appropriate treatment.

Please note that the above list is not exhaustive.

4. ALERT REVIEW/CHANGES WITHDRAWAL OF ALERT

Where the service area feels that other services across Greater Manchester should be informed, this must be done through the service user's clinical team. Contact with services should be made to establish the recipient of the alert.

Alerts should only be sent/ disseminated to the recipients identified in the email. Communicate the information to staff that need to know only.

If considered necessary to print off the attachment/alert, this should not be displayed in areas that are accessible by other service users or staff members who do not need to know.

It will be necessary to inform those in receipt of the alert of any significant changes or to recall the alert when the risks or concerns are removed. The clinical team are responsible for communicating any changes to all the recipients and should keep note of those who were in initial receipt of the alert to enable all to be notified of significant changes or withdrawal and the subsequent removal of alerts e.g. if a patient is detained into hospital or the risk changes.

For significant changes a new alert template should be completed as an attachment to the e mail notifying services of the changes.

Where an alert is withdrawn the initial alert sent should be attached with the WITHDRAWN watermark through the alert template. The procedure for this is as follows:-

- Open alert document initially sent out
- Click on format on toolbar
- Click on background
- Click on printed Watermark
- Type in text box **WITHDRAWN**
- Click Apply
- Close and Save
- Attach the amended alert and send electronically to all recipients informing them that the attached alert is withdrawn.

5. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider / challenge and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy / procedure

6. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

7. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

8. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

9. MONITORING

The effective application of this policy, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

10. REVIEW

This policy will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

11. REFERENCES

Equality Act 2010