NHS
Sheffield Health and Social Care
NHS Foundation Trust

Policy

NPCS 006 Blanket Restrictions

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Policy Owner	Head of Nursing and Head of Mental Health Legislation
Policy Author	Human Rights Officer

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Target audience: All SHSC staff working into ward, residential, supported living, respite and day care environments.	
Summary of policy: This policy defines blanket restrictions in accordance with the Mental Health Act Code of Practice 2015. It describes the actions to be taken if a blanket restriction is unavoidable, including the procedure to be followed if approval is needed urgently in response to a newly emerged risk. The policy incorporates the Restraint Reduction Network 4R's tool.	

Keywords	Blanket, restriction, service user, liberty, rights

Storage & Version Control
This is Version 4. The Register of Blanket Restrictions, was initially added in V3.3 in 2022 this version supersedes version 3.3 as of 2024. The restrictions register will be separated out from this policy document. As a dynamic register it is not appropriate to keep it in the static policy document. A Blanket Restrictions list is to be made available alongside the policy on Jarvis. Each individual ward will maintain a local list with their specific explanation of each restriction using the '4 Rs frame work.

This policy is stored and available through the SHSC intranet and internet. This version of the policy supersedes the previous 2020 version (see Version Control – next page). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
0.1	Draft policy creation	June 2016	No previous policy
0.2 – 0.3	Updated following consultation	July 2016	Amendments made during consultation
0.4	Re-formatted for new policy document template	Sept 2016	Re-formatted for new policy document template. Appendices updated.
1.0	Ratification and issue	Sept 2016	
2.0		August 2017	Amendments to policy and flow chart to ensure that both match the MHA MHA CoP and address issues raised in CQC inspections and CQC MHA monitoring visits.
2.1	Ratification and Issue	May 2018	
3	Updates following consultation and review of process	May 2020	Amendments to identification and justification documentation on registers. Amendments to frequency of review and responsibilities. Change in responsibilities of audit.
3.1	Update and changes following removal of EDG	July 2020	New assurance process identified.
3.2	Consultations	17/08/2020	Service Directors, Nurse Consultant, Associate/Deputy Directors and Senior Operational Managers.
3.3	Consultation, service user feedback, policy updated.	07/08/2022	The policy has been reviewed and amended to incorporate the RRN 4R's tool along with the information collated from the Big Conversation and service user feedback. The flow chart has been redesigned. Governance arrangements have changed. The terms Static and Dynamic blanket restrictions introduced.

4	Review of policy for effectiveness and operationalisation.	June – Sept 2024	Minor rewrite to clarify process in sections 5 and s 6.4.5 S13 contact details updated to reflect staff. Dynamic register removed from the policy and to be placed alongside policy on Jarvis. Template added for local registers to use.

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Blanket Restrictions Flowchart

Blanket restrictions are rules or policies that restrict a patient's liberty and other rights and are routinely applied (usually for all patients in the ward/service) without individual risk assessments to justify their application. No form of blanket restriction should be implemented unless expressly authorised and **subject to local accountability and governance** arrangements, as set out in the Trust blanket restrictions policy andsummarised in the flowchart below.

Is the proposed restriction a blanket restriction?

Yes (applied to whole ward / service)

- Complete a Restraint Reduction Networks 4R's review - Rule, Reason (risk), Rights, Review, and Impact for the blanket restriction.
- Implement the blanket restriction if deemed unsafe not to do so.
- Escalate immediately to the Clinical Director and / or Head of Nursing utilising the 4R's and explain the impact of applying this restriction.
- Complete an incident form for the application of this blanket restriction.

No (Individualised)

- The blanket restrictions policy does not apply
- Explain in the individual's risk management or care plan why the rule or policy is necessary and proportionate for this individual.
- Document the legal basis on which you are applying the rule, i.e., part of their care/treatment under Mental Health Act or with informed consent or in their best interests under the Mental Capacity Act.
- Complete and document a capacity assessment regarding the impact of the restriction.

Has the decision to implement this blanket restriction been supported at Clinical Director / Head of Nursing level or above?

Yes

- Add the blanket restriction to the local register and communicate to all service users and staff utilising the 4R's, Rule, Reason (risk), Rights, Review
- Discuss in the next ward level meetings and patient community meetings.
- On admission, give and record an explanation of Organisation wide and local blanket restrictions and the impact of these.

No

- Cease the blanket restriction immediately
- Consider the residual risk to service users and staff and how this can be managed.

Is the blanket restriction static or dynamic?

Static (semi-permanent, lasting over 3 months)

- The decision to impose the restriction must be reviewed at the next LPOG
- Description of, and rationale for a new blanket restriction agreed by Director of Nursing and Clinical Director or the Head of Nursing added to the organisation register.

Dynamic (short period to reduce a specific risk)

- Record on the local register only and communicate to all. Cease the blanket restriction as soon as possible and remove from register.
- The decision to impose the restriction must be reviewed at the next LPOG and onward reporting to the Quality Assurance Committee.

- Each area must review its existing blanket restrictions on a regular basis (at least quarterly) at its governance / business meeting and record the review in the minutes.
- The Quality Assurance Committee will receive a quarterly report from the Restrictive Practice Oversight Group and amend the Organisation Wide Blanket Restriction Register where agreed.
- A formal review of each local register will be completed annually by the service and the Patient Safety Team.

Consider the following questions for all restrictions:

- What is the rationale for imposing the restriction?
- Have least restrictive options been considered?
- Is the restriction necessary, proportionate, and justified?
- Who authorised the restriction?
- What impact will the restriction have on the patients?
- What is the balance of benefit and risk of imposing this restriction?
- Have risks and benefits been discussed with the patients?
- What are the patients' and carers' views and have they been recorded?
- What changes can be made to help lift the restriction?
- When will the restriction be reviewed? What is the review frequency? Who is responsible for ensuring the review takes place? Are review plans documented?

1. Introduction

This policy aims to enable clinical leaders to enact meaningful change at a local and organisational level, by shining a light on blanket restrictions. It will help them to identify and examine the existence and use of blanket restrictions and provide simple and effective reflective tools to reduce reliance on this restrictive practice. It is hoped that this reduced reliance will result in fewer incidents of other restrictive practice (e.g. restraint), so that people can take a more meaningful role in their hospital-based recovery and experience a smoother transition into community life. (Adapted from the Restraint Reduction Network Guide for Senior Leaders)

Blanket restrictions are sometimes needed in order to ensure safety within service areas operated by SHSC. However, such restrictions have the potential to have huge impacts on people's lives and can potentially breach Articles of the European Convention on Human Rights (ECHR), which requires public authorities to protect and respect a person's rights. This policy is in place to ensure that SHSC fulfils its legal and good practice obligations in relation to blanket restrictions, with the aim of reducing them to a minimum.

2. Scope

This is a Trust wide policy and applies to all areas in which the Trust supports people in ward, residential, supported living, respite, or day care environments.

3. Definitions

Blanket restrictions:
The term blanket restrictions refers to rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients [or service users], or to classes of patients [or service users], or within a service, without individual risk assessments to justify their application' (Mental Health Act Code of Practice 2015 Ch 8.5).

This definition is to be applied to all service areas within the Trust, not just hospital wards.

Note that blanket restrictions, as defined by the Mental Health Act Code of Practice (2015) require:

a) a RULE or POLICY which
b) Restricts LIBERTY or other RIGHTS and
c) WITHOUT an individual risk assessment for each person affected, is
d) APPLIED TO ALL PATIENTS [or service users] or to CLASSES of PATIENTS [or service users] or WITHIN A SERVICE

Within care settings (hospital or community-based) there can be two distinct types of blanket restrictions those that meet national guidance/ legislation (eg smoking, weapons, social media, drugs and alcohol policies) and those implemented within individual settings (e.g. mealtimes, bedtimes, restricted access to fresh air, possessions or areas of a unit such as a kitchen and bedrooms).

4. Purpose

Paragraph 1.6 of the Mental Health Act Code of Practice (2015) states:

Restrictions that apply to all patients in a particular setting (blanket or global restrictions) should be avoided. There may be settings where there will be restrictions on all patients that are necessary for their safety or for that of others. Any such restrictions should have a clear justification for the particular hospital, group or ward to which they apply. Blanket restrictions should never be for the convenience of the provider. Any such restrictions, should be agreed by hospital managers, be documented with the reasons for such restrictions clearly described and subject to governance procedures that exist in the relevant organisation.

In addition, Chapter 8 of the Mental Health Act Code of Practice is concerned with privacy, safety and dignity, including the duty of public authorities to respect patients' rights to a private life under Article 8 of the European Convention on Human Rights (ECHR). It pays particular attention to the practice of implementing blanket restrictions.

No form of blanket restriction should be implemented unless expressly authorised by the Director of Nursing in consultation with the Clinical Director or the Head of Nursing on the basis of the organisation's policy and subject to local accountability and governance arrangements (MHA Code of Practice Ch 8.9)

Blanket restrictions which have been approved by the Director of Nursing and presented to the Quality Assurance Committee via the Restrictive Practice Oversight Group quarterly report will be amalgamated into the organisation wide register appended to this policy. Any such appended restriction will be deemed to meet the MHA Code of Practice requirement for being expressly authorised by the Hospital Managers on the basis of Trust policy.

This policy describes how the Trust will meet the requirements of the MHA Code of Practice with regard to blanket restrictions, when these are unavoidable.

The purpose of the policy is to ensure that the Trust fulfils its legal and good practice obligations in relation to blanket restrictions, with the aim of reducing them to a minimum. The policy aims to support a culture where services are open and honest about the blanket restrictions that they employ and a proper process of consideration and documentation is applied to each such restriction.

5. Duties

The Chief Executive is responsible for ensuring that the systems on which the Board relies to govern the organisation are effective. The Statement of Internal Control is signed annually indicating that systems of governance, including risk management are properly controlled. The Trust's Chief Executive through the Executive Director of Operations is responsible for keeping the policy is updated and available for staff.

The Director of Nursing in consultation with the Clinical Director or the Head of Nursing is responsible for approving and monitoring blanket restrictions for use in specific service areas.

The Clinical Director and the Head of Nursing are responsible for ensuring that all Managers in their areas are aware of the policy and support its implementation.

Ward/Team/Department Managers are responsible for ensuring that the policy is fully implemented within the ward environment/the team/the department that they manage. They

must ensure that the policy is readily available to all staff at all times. Managers must ensure that the recording and auditing is completed in line with this policy. Managers must respond appropriately to any concerns regarding the implementation of this policy within their service area. Ward/Team/Department Managers must ensure regular review of the register (see section 6.4). Ward/Team/Department Managers must hold, update and make a local register available to all staff at all times.

All staff members are responsible for ensuring that their practice is safe and legal. All staff members are required to ensure they (and anyone they line manage) abide by SHSC requirements as set out in this policy. All staff members and managers must be vigilant to any changes in practice to ensure the accurate reporting and recording of blanket restrictions as per the flow chart.

6. Procedure

6.1 Principles of Practice

The specific processes that should be followed are set out below, and (in summary) in the flowchart in this policy. These are based on the following principles of practice and legal frameworks.

General principles

- Blanket restrictions include restrictions concerning: access to the outside world, access to the internet, access to (or banning) mobile phones and chargers, incoming or outgoing mail, visiting hours, access to food/drinks, access to money or the ability to make personal purchases, or take part in preferred activities. Such practices have no basis in national guidance or best practice; they promote neither independence nor recovery, and may breach a patient's human rights. (MHA CoP Ch 8.5)
- Blanket restrictions should be avoided unless they can be justified as necessary and proportionate responses to risks identified for particular individuals. The impact of a blanket restriction on each service user should be considered and documented in the individual's care plans. (MHA CoP Ch 8.5)
- Sometimes restrictions are needed for risk management in relation to one or more service users, resulting in blanket restrictions which necessarily impact on others who do not need such restrictions. For the other individuals affected, consideration should be given to how they are affected by these restrictions, whether these effects could be mitigated and the legal frameworks that are being used (see below). It may be appropriate to consider whether it is still appropriate for these individuals to share an environment.
- Restrictions should never be introduced or applied in order to punish or humiliate, but only ever as a proportionate and measured response to an identified and documented risk; they should be applied for no longer than can be shown to be necessary. (MHA CoP Ch 8.6)

Legal frameworks

- If the patient/service user is not subject to the Mental Health Act (either detained or consenting – under MHA s131- to informal admission and the attendant restrictions) the MHA CoP has no application. Due consideration must therefore be given to the alternative legal framework afforded by the Mental Capacity Act 2005 (MCA); i.e. any restriction, blanket or otherwise, is carried out with informed consent, or – if mental capacity is absent – in the patient/service user's best interests.

- If blanket restrictions amount to a deprivation of liberty as defined by the 'acid test' set in the *Cheshire West* case[1] (i.e. subject to continuous supervision and control and not free to leave) those subject to them must have their deprivation of liberty authorised by detention under the MHA (if they are in hospital), or by Deprivation of Liberty Safeguards under the MCA (if they are in hospital or a registered care home) or an order made of the Court of Protection (in any other setting).

6.2 Process – prohibited items and searching

6.2.1 There is an agreed Trust-wide list of items not allowed in care areas (lighters/matches and fire hazard materials; illicit drugs/substances; alcohol; medication from home; weapons/sharp instruments; rope; pornographic materials; violent/racist materials). By local agreement, other items may be added to this list.

6.2.2 If there is cause to search a detained patient or their belongings or surroundings, the search must be done in accordance with Trust policy and the MHA Code of Practice (Ch 8.29 – 8.46). Consult the policy with regard to informal/voluntary patients. Authority to search much be sought; those permitted to authorise a search are included in the Personal Search policy

6.2.3 Any private property that is legal to possess, but is handed over by the patient for safe-keeping, must be stored and the patient allowed to have access to it in accordance with the MHA Code of Practice Ch 8.24

6.2.4 Please refer to the relevant policies for the management of property that is illegal to possess, such as illicit substances, (Managing Substance Misuse and Harmful Substances on Inpatient Wards Policy) and offensive weapons (Security Policy). Seek advice from the Local Security Management Specialist with regard to other potentially illegal items, such as extreme pornographic materials.

6.2.5 Do not destroy or dispose of any property without specific permission from a relevant Director or, in their absence, Associate Director

6.2.6 An incident form must be completed to record the handing over of property for disposal by others, or the granting of permission to destroy or dispose of property by Trust staff

6.3 Exceptions permitted by the CQC in its 'Brief Guide for Inspectors'

6.3.1 The CQC Brief Guide for Inspectors states that banning the following 'prohibited' or 'contraband' items SHOULD NOT BE CHALLENGED as a Blanket Restriction:

- Alcohol and drugs or substances not prescribed
- Items used as weapons (firearms, real or replica; knives; other sharps; bats)
- Fire hazard items (flammable liquids; matches; incense)
- Pornographic material
- Material that incites violence or racial/cultural/religious/gender hatred
- Clingfilm; foil; chewing gum; blu-tack; plastic bags; rope; metal clothes hangers
- Laser pens
- Animals
- Equipment that can record moving or still images

[1] *Cheshire West and Chester Council v P* [2014] UKSC 19, [2014] AC 896

- Smoke-free policies are deemed to be justifiable blanket restrictions

6.3.2 Additional Permitted Exceptions - Secure Settings:
- Mobile phones
- Computers; Tablets; games Devices with hard drives or sharing capabilities
- Items with voice recording capabilities
- Other items with enabled WiFi/internet capabilities
- Items considered an escape aid
- Restrictions on access to money will be part of the security fabric of the ward
- Restrictions on take away food may be in place to ensure therapeutic activity of the ward is not undermined

6.3.3 The CQC Brief Guide also refers to searching:
- General Acute Wards: Random or routine searching permitted if there is specific cause
- Psychiatric Intensive Care Units (PICU): Random or routine searching backed by policy which includes clear rationale on the purpose of any search
- Low Secure Wards: Random searching likely; routine searching at times in response to specific issues.

6.4 Identification and Documentation of Blanket Restrictions

6.4.1 Each service area will hold a local register of the blanket restrictions in place in that location. The patient will be informed of these restrictions as part of the process of explaining their rights under the MHA, and a record made that they have received this information (Record of Conversation) will be held on their electronic care record.

6.4.2 Each area will maintain a local register of any blanket restrictions over and above theTrust-wide blanket restrictions

6.4.3 All blanket restrictions will be supported by a clear and concise rationale for applying for the restriction utilising the Restraint Reduction Networks 4R's - Rule, Reason (risk), Rights, Review, and Impact for the blanket restriction.

6.4.4 Trust wide Blanket restrictions approved by the Director of Nursing and Clinical Director / Head of Nursing will be available alongside this policy on Jarvis.

6.4.5 Each area must review its practices and existing blanket restrictions at least quarterly (July, October, January, April) via its governance/business meetings in order to identify and minimise the use of blanket restrictions. A record of these reviews is to be documented in the minutes of the meeting and held by that service area.~~E~~

6.4.6 A formal review of each service area register will be completed on a 12-monthly basis by the service and the Patient Safety Team.

6.4.7 In the event that a practice is newly identified as a blanket restriction the register must be updated as soon as practicable, including the rationale and justification for the restriction utilising the Restraint Reduction Networks 4R's - and submitted to the Clinical Director or the Head of Nursing for review and temporary implementation. The Clinical Director or the Head of Nursing will inform the Director of Nursing and seek approval.

6.4.8 If it <u>is not immediately necessary</u> to apply the restriction in a blanket fashion, ensure that it is only applied to the patient/s whose presentation warrants the restriction

6.4.9 If it <u>is immediately necessary</u> for risk-management purposes to impose the

restriction in a blanket fashion, this must be authorised by the Clinical Director or the Head of Nursing.

6.4.10 The imposition of an immediately necessary blanket restriction or any change to the register must be reported by completion of an incident form

6.4.11 All patients should be informed that the restriction is in place and why (as far as possible, having due regard to any issue of confidentiality)

6.4.12 The updated version of the register must be provided to the Clinical Director, or the Head of Nursing or his/her deputy as soon as is practicable.

6.5 Issues specifically relating to secure services (MHA Code of Practice Ch 8.8)

Within secure service settings some restrictions may form part of a broader package of physical, procedural and relational security measures associated with an individual's identified need for enhanced security in order to manage high levels of risk to other patients, staff and members of the public.

The individual's need for such security measures should be justified to meet the admission criteria for any secure service. In any event, the application of security measures should be based on the needs of and identified risks for individual service users, and impose the least restriction possible.

Where individual service users in secure services are assessed as not requiring certain security measures, consideration should be given to relaxing their application, where this will not compromise the overall security of the service. Where this is not possible, consideration should also be given as to whether the service user should more appropriately be managed in a service that operates under conditions of lesser security.

SHSC has a low secure unit (Forest Lodge), a locked Psychiatric Intensive Care Unit (PICU - Endcliffe Ward) and locked intensive rehabilitation provision at Forest Close.

Each of these areas has specific criteria for admission and protocols for discharge which conform to the requirements of the Code of Practice in respect of the need for the care of an individual patient to be delivered in conditions of enhanced security

6.6 Governance Arrangements

6.6.1 In addition to the local arrangements described in sections 6.4, each directorate should put in place processes for identifying and appropriately responding to blanket restrictions within its service areas.

6.6.2 Any blanket restriction identified by the CQC during inspections or MHA monitoring visits will be addressed by the resulting Trust action plan or the ward's Provider Action Statement (PAS), respectively

6.6.3 CQC action plans are monitored by the Care Standards Team and reported into Quality Assurance Committee and the Board

6.6.4 MHA PAS are monitored by the MHA Committee, and reported into EDG, QAC and Board

6.6.5 The Least Restrictive Practice Oversight Group (LRPOG) will maintain oversight of all blanket restrictions and will include details in Quarterly reports to Quality Assurance Committee and the Board. The LRPOG has the authority to agree or otherwise a blanket restriction, however responsibility and accountability lay with the Directorate Leadership team. If following review, a blanket restriction is not agreed, the blanket restriction must be immediately terminated. If a blanket restriction is agreed, how the need for the ongoing restriction will be monitored will be agreed by the LRPOG as will the plan to how

the blanket restriction can be safely terminated. Blanket restrictions should be routinely reported from LRPOG to the Quality Assurance Committee.

6.6.6 The Quality Assurance Committee will hold responsibility for the organisational register receiving a report on a quarterly basis from the RPOG and amending the register contained within this policy.

6.7 Communication

Details of prohibited items will be communicated to staff and patients by a range of means including verbally, posters, leaflets, booklets, letters and in-patient forums.

The existence of Trust-wide blanket restrictions and service area blanket restrictions willbe communicated to staff at induction/preceptorship, staff meetings and by e mail.

7. Development, Consultation and Approval

- Reviewed against the Restraint Reduction Network guidance.
- A 'big conversation' regarding blanket restrictions was held in May 2022 with presentations on Human Rights and the CQC prior to discussing.
- Champions were identified on each ward to review their own restrictions.
- A service user evaluation was completed using the Restraint reduction Network evaluation form.
- Inpatient ward managers reviewed their own blanket restrictions.
- This policy was virtually consulted on by the Reducing Restrictive Practice Oversight Group. This policy was reviewed by the Human Rights Officer in summer 2024

8. Audit, Monitoring and Review

Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Directorates to be assured that policy is being followed in their service areas	Audit	Clinical Director, the Head of Nursing Directorate Leadership team	Annual	The Restrictive Practice Group	Restrictive Practices group	The Restrictive Practice Group

- Each ward will send their updated list to the Director of Nursing and/or Clinical Director and /or Head of Nursing every time it changes.

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- The register should be reviewed every 6 months, by the IPQR and received at LRPOG. If local registers have not been reviewed then IPQR and or LRPOG will intendent report via ULYSSES.

9. Implementation Plan

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust website.	Director of Corporate Governance	Within 5 working days of ratification	
A communication will be issued to all staff via all staff e mail	Director of Corporate Governance	Within 5 working days of ratification	
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	Within 5 working days of ratification	
Directorate Leadership team will be responsible for ensuring disseminations and implementation and inclusion in Directorate governance meetings	Directorate Leadership team		

10. Dissemination, Storage and Archiving (Control)

The policy will be made available to all staff via the Intranet and Trust website. A communication will be issued to all staff via the Communication Digest immediately following publication

11. Training and Other Resource Implications

There is no specific training implication for this policy. However, it is an expectation that consideration may be given to it in other SHSC mandatory training (specifically Mental Capacity Act, Deprivation of Liberty Safeguards, Mental Health Act and RESPECT training).

12. Links To Other Policies, Standards And Legislation (Associated Documents)

Mental Health Act 1983 (MHA) and MHA Code of Practice (2015)
Human Rights Act 1998
Mental Capacity Act 2005 (MCA) and MCA Code of Practice
Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) and DoLS Code of Practice
SHSC Managing Substance Misuse and Harmful Substances on In-Patient Wards (2020)
SHSC Security Policy (2018)
SHSC Personal Search Policy (2020)

13. Contact Details

Title	*Name*	*Phone*	*Email*
Head of Mental Health Legislation	Jamie Middleton	0114 27 18110	Jamie.Middleton@shsc.nhs.uk
Human Rights Officer	Tallyn Gray	0114 2263666	Tallyn.Gray@shsc.nhs.uk
Professional Lead for RESPECT/ Lead for Restrictive Practice	Greg Hughes		Greg.Hughes@shsc.nhs.uk
Head of Nursing	Emma Highfield		Emma.Highfield@shsc.nhs.uk
Head of Nursing	Christopher Wood		Christopher.Wood@shsc.nhs.uk

14. References

Mental Health Act 1983 (MHA) and MHA Code of Practice (2015)
Human Rights Act 1998
Mental Capacity Act 2005 (MCA) and MCA Code of Practice
Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) and DoLS Code of Practice
Cheshire West and Chester Council v P [2014] UKSC 19, [2014] AC 896
Care Quality Commission, Brief guide: the use of ‘blanket restrictions’ in mental health wards<
20191125_900767_briefguide-blanket_restrictions_mental_health_wards_v3.pdf (cqc.org.uk)>

The template below is the template that all services should use when compiling their local blanket restrictions register:

NOTE: This is a Trust wide list indicating if a restriction is in place on a ward or not. Each individual ward MUST have its own localised register, available to all of its staff in which the '4Rs' formula is used to explain the rule, reason, rights and review elements that restriction.

The following items are subject to a Trust wide prohibition and do not need to be justified using the '4 Rs' on wards individually: Alcohol, illegal and unprescribed drugs, weapons (firearms (real or replica) knifes, and other sharps, bats), Fire hazards(lighters and matches, incense), illegal pornography, material that incites of violence, racial/cultural/religious gender hatred) clingfilm, foil chewing gum , plastic bags , rope , metal clothes hangers, laser pens animals. SHSC is a 'smoke free' Trust, thus smoking is not permitted in /on any part of Trust premises.

	Blanket Restriction	Areas Applicable to	Description of Blanket Restriction (**Rule**)	Identification and/or Justification for Restriction (**Reason**)	Linked SHSC Policy/ Code of Practice (**Rights**)	Record when implemented, reviewed, the plan to remove and where these actions are evidenced. (**Review**)
			.			Implemented : 17/05/2018 Last Review: April 2022 as part of policy update Plan to remove: Where can evidence for this be accessed:

Appendix A – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

Jamie Middleton, Head of MH Legislation and Tallyn Gray, Human Rights Officer, August 2024.

This policy does not impact on staff, patients or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.
DISABILITY	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.
GENDER REASSIGNMENT	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.
PREGNANCY AND MATERNITY	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.
RACE	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.
RELIGION OR BELIEF	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.

SEX	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.
SEXUAL ORIENTATION	No specific impact identified.	No further action identified.	Due consideration given in developing policy, particularly in relation to the Mental Health Act 1983 Code of Practice, 2015 and the Mental Capacity Act, 2005.

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)

Please delete as appropriate: Policy Amended

Impact Assessment Completed by (insert name and date)

Jamie Middleton, Head of MH Legislation and Tallyn Gray, Human Rights Officer, August 2024.

Appendix B - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?

X **Yes. No further action needed.**

2. On completion of flow diagram – is further action needed?

X **No, no further action needed.**

☐ **Yes, go to question 3**

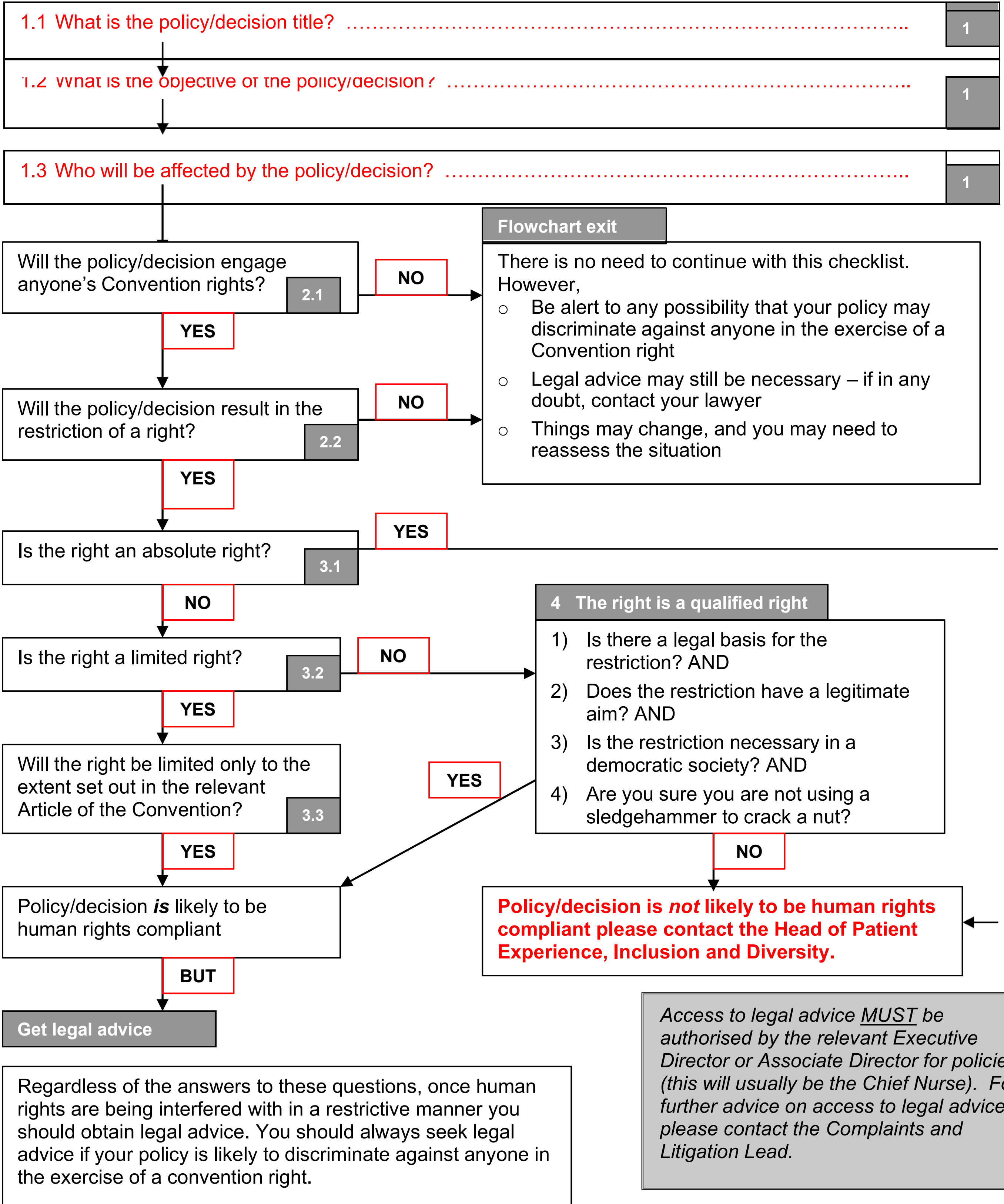
3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



Appendix C

Review/New Policy Checklist

This checklist to be used as part of the development or review of a policy and presented to the Policy Governance Group (PGG) with the revised policy.

		Tick to confirm
	Engagement	
1.	Is the Executive Lead sighted on the development/review of the policy?	X
2.	Is the local Policy Champion member sighted on the development/review of the policy?	X
	Development and Consultation	
3.	If the policy is a new policy, has the development of the policy been approved through the Case for Need approval process?	N/A
4.	Is there evidence of consultation with all relevant services, partners and other relevant bodies?	X
5.	Has the policy been discussed and agreed by the local governance groups?	X
6.	Have any relevant recommendations from Internal Audit or other relevant bodies been taken into account in preparing the policy?	N/A
	Template Compliance	
7.	Has the version control/storage section been updated?	X
8.	Is the policy title clear and unambiguous?	X
9.	Is the policy in Arial font 12?	X
10.	Have page numbers been inserted?	X
11.	Has the policy been quality checked for spelling errors, links, accuracy?	X
	Policy Content	
12.	Is the purpose of the policy clear?	X
13.	Does the policy comply with requirements of the CQC or other relevant bodies? (where appropriate)	X
14.	Does the policy reflect changes as a result of lessons identified from incidents, complaints, near misses, etc.?	X
15.	Where appropriate, does the policy contain a list of definitions of terms used?	X
16.	Does the policy include any references to other associated policies and key documents?	X
17.	Has the EIA Form been completed (Appendix 1)?	X
	Dissemination, Implementation, Review and Audit Compliance	
18.	Does the dissemination plan identify how the policy will be implemented?	X
19.	Does the dissemination plan include the necessary training/support to ensure compliance?	X
20.	Is there a plan to i. review ii. audit compliance with the document?	 X X
21.	Is the review date identified, and is it appropriate and justifiable?	X