Humber Teaching NHS Foundation Trust

Visiting Policy
(N-071)

Version Number:	1.1
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Minor amendments made prior to full review date above (see appended document control sheet for details)	
Date approved by Lead Director:	*QPaS – 1 December 2023*
Date EMT as approving body notified for information:	*December 2023*

Policies should be accessed via the Trust intranet to ensure the current version is used

Contents

1. INTRODUCTION

It is important to recognise the contribution that visiting makes to the wellbeing and the person-centred care of patients; lack of access to visitors causes distress to them and their families.

There is a requirement under Paragraph 26.3 of the Mental Health Act code of practice 2015 for Humber Teaching NHS Foundation Trust to have in place a policy relating to children visiting mental health settings, which this policy incorporates.

This policy should be read in conjunction with the Safeguarding Children, Guidelines and Procedures and the Mental Health Code of Practice 2015 (chapter 19).

The objectives set out in this policy acknowledge that the majority of patients are admitted informally. Most visits by children to patients, whether or not detained are central to the maintenance of normal healthy relationships with parents or other relatives who are in a mental health unit.

2. SCOPE

This Policy applies to all staff working in mental health and learning disability inpatient services, and community hospitals involved in the risk assessment, facilitation, and review of personal visits to patients in inpatient services of the Trust.

It applies to children and young people under the age of 18 years of age visiting mental health units in Humber Teaching NHS Foundation Trust, including CAMHS inpatient units and adult wards.

3. POLICY STATEMENT

The aim of this policy is that personal visits at the Trust hospitals and inpatient units are facilitated flexibly, safely, and effectively, in order to optimise their therapeutic value for both patients and visitors.

Humber inpatient wards and units should ensure that the welfare of patients – mental as well as physical – underpins any decisions taken to limit visits.

To minimise restrictions placed on patients and their relatives, the Trust's approach to visiting is responsive to the prevailing government guidelines, individualised risk assessments and the local picture. This guidance is applicable to inpatient areas. The Trust has one residential unit, Granville Court, which adheres to the national guidance for care homes.

Anyone reported to be experiencing any **symptoms of respiratory (for example influenza, Covid-19) or gastro-intestinal illness** should not visit. Where a face-to-face visit is not practical then virtual visits should be supported and facilitated.

The Trust is committed to ensuring that the best interests and safety of children and young people concerned are always considered and that visits by children and young people are not allowed if they are not in their best interests. However, within this overarching framework, inpatient units should do all they can to facilitate the maintenance of children and young people's contact with friends and family and offer privacy within which that can happen.

The Trust will ensure that:

1. The child's welfare is paramount and takes primacy over the interests of others;
2. The child's welfare is safeguarded and promoted by all staff within the unit at all times;
3. When it is established to be in the best interests, then contact between relatives and children will be actively encouraged by staff.

4. DUTIES AND RESPONSIBILITIES

Chief Executive
The chief executive has overall responsibility to ensure that policies and processes are in place to ensure maximum visiting opportunities for families and friends of patients admitted to one of the Trust Hospitals, and for the visiting of patients by children and young people.

Director of Nursing, Allied Health and Social Care Professionals
The director of nursing, allied health and social care professionals, as the executive director for safeguarding children, has a responsibility to ensure that policies and procedures are in place for the visiting of patients by children and young people.

Chief Operating Officer
The chief operating officer has the responsibility to ensure that all policies are implemented.

Divisional General Managers and Divisional Clinical Leads

- Have responsibility for ensuring that all clinical staff within the Division are familiar with the requirements of the policy and are able to implement them.
- Have responsibility for ensuring staff adhere to this policy and for monitoring their staff's compliance with the Policy.

Matrons
The modern matrons have the responsibility to ensure that all staff working within inpatient areas comply with the policy and ensure it is implemented effectively and safely.

Unit Managers
Managers have a responsibility to ensure that staff are aware of and implement the policy in their area of work.

All inpatient Staff
All staff are responsible for ensuring the policy is used when requests are made to visit patients.

Named Nurse (Safeguarding Children) and Named Doctor (Safeguarding Children)
The Trust has in post a named nurse and named doctor in keeping with statutory requirements placed on NHS providers, who have operational and strategic responsibility for implementing the safeguarding of children within the Trust. They have a responsibility to ensure that policies and procedures are in place and relevant for the visiting of patients by children and young people.

Staff Support and Advice
The role of the named nurse, the named doctor for Safeguarding children and the Trust safeguarding team include the giving of expert advice and support to staff when making decisions relating to children visiting inpatient environments.

5. PROCEDURES AND CONSIDERATIONS PRIOR TO VISITS

5.1. General visiting

5.1.1. Mask wearing:

- The requirement for visitors and individuals accompanying patients to outpatient appointments or urgent treatment centres to wear a mask will be determined according to the local prevalence of circulating respiratory infection as advised by the Trusts Infection Control Team.
- During times of low prevalence, they will not routinely be required to wear a facemask unless this is a personal preference.

5.1.2. Visiting hours - Mental Health / Learning Disability Units:

Visiting hours should not form part of a blanket restriction. The Mental Health Act Code of Practice (2015) states that such restrictions "have no basis in national guidance or best practice; they promote neither independence nor recovery and may breach a patient's human rights".

- Please note that having 'reasonable' visiting times is not classed as a blanket restriction. It allows for planning staff resources, room booking, catering, and the arrangement of effective feedback / update where needed. If the ward had too many visitors to manage at any one time this would compromise the safety of patients and staff.
- The MHA Code of Practice 11.5 states: "Visits should be encouraged and made as comfortable and easy as possible for the visitor and the patient. Reasonable and flexible visiting times, access to refreshments and pleasant surroundings will all contribute to a sense of respect for the patient's entitlement to be visited."
- Set hours should be clearly displayed, with the option to make individual arrangements outside those hours if required. It is seen as good practice for the units to use welcome packs, which state the visiting hours but also inform patients and their carers / families that visiting outside of normal hours can be arranged and be flexible if needed. This information should also be displayed on the visiting hours sign in the reception area.

5.1.3. Visiting hours - Community Hospitals:

Visiting times are between 14.00 hrs – 17.00 hrs and 18.00 – 20.00 hrs. This supports our restricted mealtime policy and allows for patients to take part in the rehabilitation therapy. Visiting where possible may be permitted at other times via prior arrangement with the nurse in charge, when a compassionate approach will be supported. Open visiting is permitted for all patients at end of life / palliative and those with dementia or special needs. The wards do allow visits from children supervised unless any infection present. Therapy dogs are allowed if preorganised.

5.2. Practical considerations to support visiting for all visitors during times when infectious disease is in general circulation:

- **Before visiting** the visitor/s should contact the clinical area to discuss appropriate arrangements. This should include an individual risk assessment. Visitors must agree to follow staff direction at all times to maintain safety. If there are restrictions on visiting this should be explained to the person at this time.
- It may be necessary to deny access to a particular visitor if they refuse to follow requirements as outlined below. We have a duty to protect all patients in our care and in particular those who are extremely vulnerable as they may not be able comply to any form of social distancing etc. A range of solutions for the family members to safely visit their

loved one MUST be offered first as we appreciate how important it is to facilitate visiting. **Anyone showing symptoms of infectious disease should not visit,** even if these symptoms are mild or intermittent, due to the risk they pose to others. This is important for infection prevention and control. This includes consideration of any atypical symptoms. The number of visitors should be determined by the clinical needs of the patient.

- **Visiting times** may be staggered to accommodate visiting for all patients.
- **Visitors should be informed in advance** about what to expect when they see the patient, including practical advice about the PPE requirements (if patient is confirmed as infectious), and bringing items in for the patient.
- **Face coverings**: The requirement for the use of masks will be determined by the local rates of infection and /or the clinical diagnosis of the patient. Additional advice will be provided to the visitor when visiting a patient confirmed or suspected to be infectious.
    - – Visitors, parents, guardians, siblings will be asked to wear a surgical facemask if visiting a high-risk area or a patient with suspected/known infectious disease.
- **Personal belongings -** Visitors should limit the number of personal belongings they bring with them.
- **For patients at end-of-life care** visitors should be informed in advance about what to expect when they see the patient and, be given practical advice about wearing personal protective equipment and handwashing. An individualised approach needs to be taken on a case-by-case basis to manage the balance between compassionate visiting and infection risk management.
- **Where possible, visits can take place outdoors, maintaining social distancing.** The patient will need the appropriate authorisation if detained under the Mental Health Act and have had a risk assessment in relation to meeting visitors outside the unit boundaries.
- **Visiting may be facilitated more easily through**, for example, arranging a visiting space off the ward / unit and limiting the time of visits.
- **Where a face-to-face visit is not practical** then patients should be supported to maintain contact with family and friends through digital means (11.6 Mental Health Act Code of Practice, 2015) (CoP) during periods of high prevalence of communicable disease, when visits may be affected due to the requirement to implement additional measures such as social distancing. As stated in the CoP (chapter 8), patients should have readily accessible and appropriate daytime telephone and internet facilities to enable this.
- **The outcome of all visits** (including those conducted virtually) should be recorded on Lorenzo.

These arrangements will be reviewed in conjunction with the release of any local, regional or national guidance and measures designed to prevent the transmission of infectious disease.

5.3. Local or ward-based outbreak procedures:

Visiting may be restricted by the Organisation management team based on outbreaks in the local area resulting in local restrictions or in response to an outbreak on the unit to be visited. These arrangements will be communicated via the Trust website to visitors and via internal communications for staff and patients.

5.4. Exclusion of Visitors

There may be circumstances where staff may restrict visitors, refuse them entry or require them to leave but these instances should be exceptional. The decision to prohibit a visit by any person whom the patient has requested to visit or has agreed to see should be regarded as a serious interference with the rights of the patient and a blanket restriction may be considered a breach of their article 8 rights. There may be circumstances when a visitor has to be excluded, but these instances should be exceptional, and any decision should be taken only after other means to deal with the problem have been considered and (where appropriate) tried.

The Safeguarding team should be involved in any discussions about excluding visitors. Any such decision should be fully documented and include the reasons for the exclusion, and it should be made available for independent scrutiny by the CQC or service commissioner and explained to the patient. Staff should review the effect on the patient of any decision to restrict visits.

There are two principal grounds which could justify the restriction or exclusion of a visitor: clinical grounds and security grounds.

The decision to restrict or exclude a visitor can be taken proactively, or in response to information received or current presentation. For example, some visits could be detrimental to the safety or wellbeing of the patient, the visitor, other patients, or staff on the ward. In these circumstances, the responsible clinician may make special arrangements for the visit, impose reasonable conditions or if necessary, exclude the visitor. In any of these cases, the reasons for the restriction should be recorded and explained to the patient and the visitor, both orally and in writing (subject to the normal considerations of patient confidentiality). Wherever possible, 24-hour notice should be given of this decision.

Some visitors may need to be excluded on security grounds; examples of such behaviour include:

- apparently under the influence of drugs or alcohol
- incitement to abscond
- smuggling of illicit drugs or alcohol into the hospital or unit
- transfer of potential weapons
- unacceptable aggressive or threatening behaviour
- attempts by members of the media to gain unauthorised access.

A decision to exclude a visitor on the grounds of their behaviour should be fully documented and explained to the patient orally and in writing. Where possible and appropriate, the reason for the decision should be communicated to the person being excluded (subject to the normal considerations of patient confidentiality and any overriding security concerns).

If staff are considering terminating an ongoing visit, they must be aware that this may become a point of disagreement/conflict and consider summoning assistance by activating their personal alarm prior to intervention.

This decision must be shared with senior staff on duty immediately.

For mental health and learning disability units Guidance is available in Chapter 11 of the Mental Health Act Code of Practice.

Any decision to refuse access for a visit or to terminate an ongoing visit will be reported through Datix.

Any refusal by the Trust to allow a visitor to visit a detained patient must be reported to the Mental Health Legislation Team, (see MHA COP 19.12-16).

6. CHILDREN VISITING MENTAL HEALTH AND LEARNING DISABILITY INPATIENT UNITS

This section specifically applies to children and young people under the age of 18 years of age visiting mental health and learning disability units in Humber Teaching NHS Foundation Trust, including CAMHS inpatient units and adult wards.

In order to promote good practice in the area of children visiting patients in mental health / learning disability units, informally or detained under the Mental Health Act in the pursuit of good practice requires that the needs, interests, and welfare of children are paramount and not secondary to the wishes and feelings of others. This should be taken into account when formulating and implementing Care Plans in professional practice and in the provision of facilities for visiting.

It is important to maintain relationships with the family members/friends/carers. A visit by a child should only take place after there has been a multi-disciplinary discussion to ascertain the desirability of contact between the children and patients to identify concerns, assess any risk of harm to a child (see section 5.5.6). Records (safeguarding section) should clearly document decision making on admission, or on subsequent requests for a child to visit, and agreement made that the visit is in the child's best interest.

All staff must ensure that when agreement has been given for a child or young person to visit, appropriate arrangements are made to ensure the safety and comfort of that child and for maintaining the privacy and dignity of other patients on the ward.

A visit by a child should only take place following a decision that such a visit would be in the child's best interest. Decisions to allow such visits should be reviewed regularly., (regular depends on individual assessment of need). Assessment of risk should be completed each time there is a review as circumstances may have changed, this should be recorded in patient records (safeguarding section) .

6.1. Procedures and considerations prior to visit

All staff must ensure that when agreement has been given for a child or young person to visit, appropriate arrangements are made to ensure the safety and comfort of that child and for maintaining the privacy and dignity of other patients on the ward.

6.2. Assessment

The needs of and the arrangements for children involved with the patient should be considered by all agencies involved with the patient as an integral element within the assessment and could result in recommendations being made and any contact restrictions considered. Any information regarding child/young person visitors should be communicated to the unit and recorded in the patient's notes.

When a visit by a child/young person is requested, an assessment should be carried out; this will efficiently identify any concerns about a child/young person visiting which may be present (see flow chart Appendix 1).

Patients should only receive visits from children to whom they are closely related. It is not generally appropriate for visitors to bring other children where there is no such relationship.

In the vast majority of cases where no concerns are identified, arrangements should be made to support the patient and child/young person and to facilitate contact.

Decisions to allow such visits should be reviewed regularly and included in the patient's care plan.

6.3. Location of Visits

Staff should think creatively about how to make the visit a positive experience. The location of the visit should be considered carefully. In some cases, it may be better for arrangements to be made for visiting in either another part of the mental health unit or in some cases away from the mental health unit. In the case of detained patients this may require due consideration of the need for leave. Appropriate and sensitive supervision should be provided where appropriate and in line with any contact arrangements set out by the local authority.

Consideration should be given to the development of innovative schemes that will develop best practice in this area.

Visiting areas in secure units should be compliant with the current secure standards. Please refer to Forensic - Personal Visits SOP

6.4. Unannounced Visits

There may be an occasion when a child/young person is presented unannounced for a visit. On such occasions the nurse in charge will undertake the necessary steps in accordance with this policy as to whether the visit is approved or not.

6.5. Concerns about the appropriateness/desirability of a Child/Young Person Visiting

This may arise in a number of cases:

- the response by the child/young person to the patient or his/her mental illness
- the wishes and feelings of the child/young person
- the age and overall emotional needs of the child/young person
- consideration of the child/young person's best interests

- the views of those with parental responsibility
- the patient's history and family situation
- the patient's current mental state (which may differ from an assessment made immediately prior or after admission)
- when assessing current and recent mental state, does the patient have delusional beliefs incorporating the child or a suicidal plan which involves the child/children in question
- the history and presenting behaviour of the patient population on the unit as a whole
- the nature of the unit e.g. medium secure units;

It needs to be considered that a range of options may present themselves when concerns are identified in any of these areas. This need not automatically result in the refusal of visiting or other forms of contact. The available clinical team must aim to obtain a balance between the management of risk and the interests of patients and children/young persons. In some situations, it may be appropriate for visiting to take place with the support and supervision of mental health unit staff or other agencies. In other situations, alternative forms of contact such as letter, telephone or digital technology may be appropriate.

6.6. Decision to Refuse Visits

Family/carers must be made aware that on occasions, it may be decided that on arrival at the unit, a decision may have been made to refuse the visit, e.g. the mental state of the patient may have changed since the visit was arranged; e.g. the patient is very agitated or aggressive. If it is felt necessary to cancel/refuse a visit, then the reasons why must be clearly documented in the patient's records (safeguarding section).

Decisions to refuse visits, which will only be taken in exceptional circumstances, should be given in writing as well as orally and will need to be supported by clear evidence of concerns e.g. reported from the family or noted by staff that the child was obviously upset during the previous visit.

There may be legal reasons why it has been decided that it is not in the child's best interest to visit the patient. Staff should ascertain whether any court orders relating to contact or any child protection conference decisions that impact on visiting arrangements. Contact may be prohibited, or it may have to take place under supervision from an officer determined by the Court or Child Protection Plan. It is essential that all staff are aware if children are on a child protection plan and liaise with the relevant Children's Social Care team prior to planning the visit.

The patient who has been refused a visit by a child/young person may become upset and require additional staff support.

The child who has been refused a visit with the patient may also require further support. If this is the case then the first source of support should be from the adult accompanying the child. If further support is required, advice can be sought by the safeguarding team.

It is important that it is clearly recorded in records if the patient should not be in receipt of visits from children. This must be clearly visible to all staff.

The steps to be taken in making the decision to refuse visiting include:

- consulting on concerns with the patient, the child/young person (depending on age and understanding), those with parental responsibility, advocates, and where relevant the local children's social care team
- communicate the decision to the patient, other family members, child and those with parental responsibility
- review any decisions and means of communicating this to the patient, advocate or other person or agency involved in the decision
- possible actions to be taken to allow future visits
- crèche facilities or care arrangements so adult visiting can take place.

These steps will be taken in consultation with the local authority where relevant and will be congruent with the policies and approach of the Hull Safeguarding Children Partnership, East Riding Safeguarding Children Partnership and North Yorkshire Safeguarding Children Partnership Guidelines and Procedures.

6.7. Supervision of Visits

If the child/children are subject of a Child Protection Plan or "looked after" by the local authority, and a multi-agency decision has been made that it is appropriate for a child visit to go ahead, staff should discuss with the social worker what resources will need to be put in place in terms of supervision of the visit. If it is required that contact is supervised by the local authority, this decision will have been made by the local authority previously. This should be established at the point of contact with Social Care and arrangements made if appropriate.

If the child/children are not subject to a Child Protection Plan or "looked after" then all visits will need to be supervised by the carers/family members of the child/children at all times. No visit should take place without this supervision from carers.

6.8. Family/Carers

Unit staff must ensure that family/carers are made aware of the visiting arrangements on admission and of their responsibility to contact the unit before each visit to ensure it is appropriate that the children visit. Staff must make it clear to the family/carer that on no occasion should a child come to visit the unit without prior arrangement.

6.9. Consent

Young people (aged 16 or 17) are presumed to have sufficient capacity to choose and consent to undertake a visit, unless there is significant evidence to suggest otherwise.

Likewise, any young person or adult over the age of 16 years are presumed to have the capacity to consent to receiving visitors, unless there is evidence to suggest they don't have capacity to make this decision.

If the patient has parental responsibility for the visitor, they will be able to contribute to any decision making regarding this however, if there is a conflict between parents or a contact order in force there may be a need to resolve this in court.

6.10. Young Carers

A 'young carer' is defined in section 96 of the Children and Families Act 2014 as: '…a person under 18 who provides or intends to provide care for another person'. This relates to care for any family member who is physically or mentally ill, frail elderly, disabled or misuses alcohol or substances.

The key principle is that: 'Children should not undertake inappropriate or excessive caring roles that may have an impact on their development. A young carer becomes vulnerable when their caring role risks impacting upon their emotional or physical well-being and their prospects in education and life'.

If you believe the child maybe a young carer, please discuss this with the Humber Safeguarding Team and consider a referral to the Local Authority for assessment.

7. HUMAN RIGHTS ACT

In the light of the Human Rights Act, Article 8 (Right to Family Life) and Article 11 (Freedom of Assembly), this policy is established from the perspective that visiting is allowed unless there are exceptional circumstances prohibiting this. The Human Rights Act came into effect in October 2000; consequently, the Trust and its staff, along with its supporting agencies, are seen as a public authority having an obligation to respect the convention rights. Staff must understand these rights and take them into account when carrying out this policy and procedure.

8. EQUALITY AND DIVERSITY

This policy ensures that people in receipt of our services will be offered services that are safe and effective and led by the needs of the person, ensuring the best interests and safety of children and young people.

An Equality and Diversity impact Assessment has been carried out on this document using the trust approved EIA. The impact on staff, children, young people and families is a positive one, the emphasis being on ensuring the safety of children and young people.

9. IMPLEMENTATION

This policy will be disseminated by the method described in the Document Control Policy.

10. MONITORING AND AUDIT

Matrons will monitor that the policy is being adhered to within their inpatient area.

In respect of mental health and learning disability inpatient services the Mental Health Legislation Team will monitor and report on any exceptions, non-compliance of policy in respect of exclusion of visitors (for any reason) as required by the Code of Practice. Exceptions will be reported via the Mental Health Legislation Steering group and the Committee.

Any subsequent recommendations will be fed back through the Mental Health Legislation Steering Group in order for action plans to be implemented and disseminated through the Divisions.

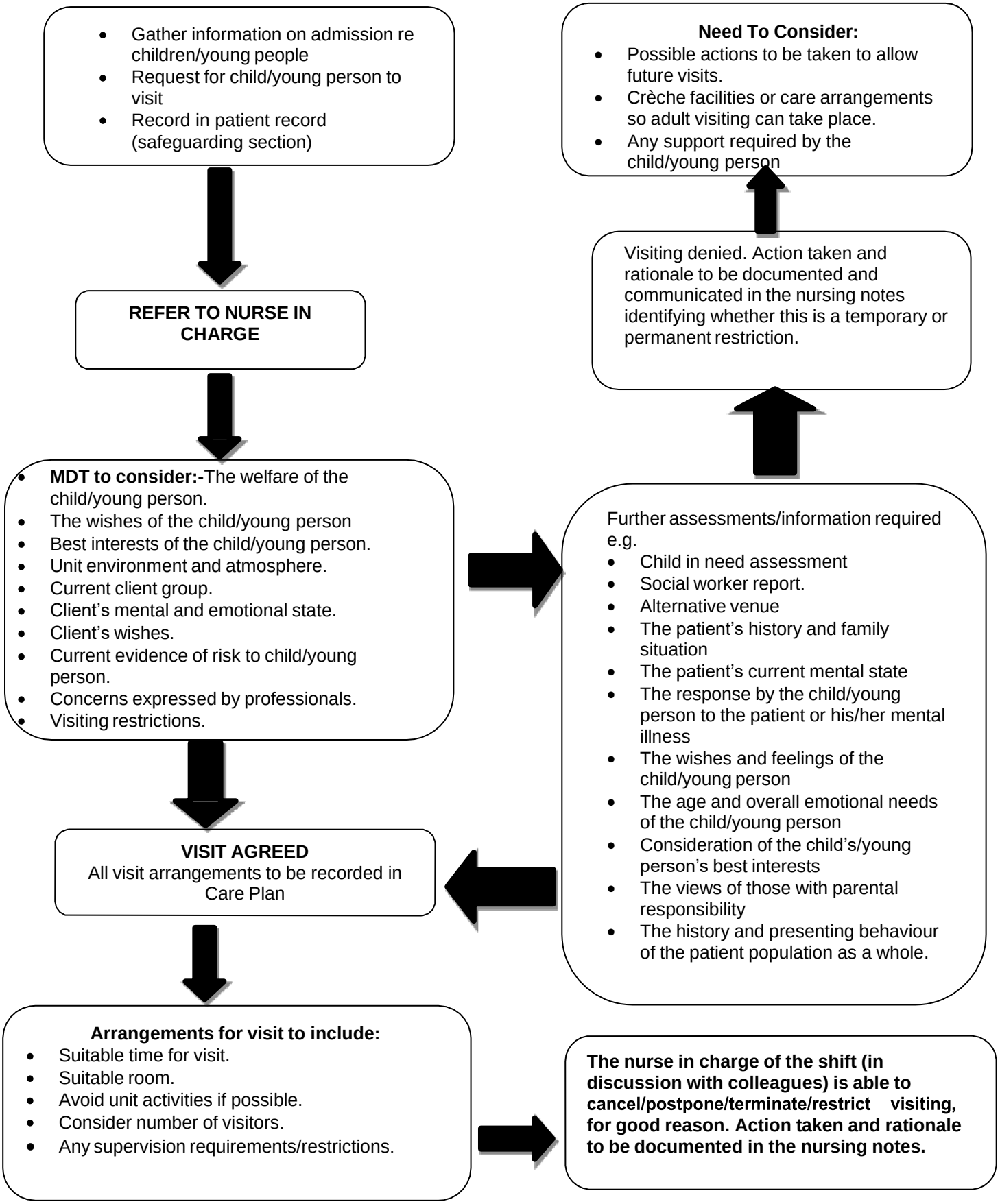
Divisional managers and divisional clinical leads will be responsible for ensuring that any system or practice changes are implemented and for lessons learnt to be shared to all clinicians working to this policy.

In respect of the children and young people visiting units section of this policy the monitoring will be via the Trust safeguarding team. An audit of its effectiveness based on any area of concern that may arise will be undertaken with the support of the mental health unit safeguarding link person.

11. REFERENCES/EVIDENCE/GLOSSARY/DEFINITIONS

Mental Health Code of Practice 2015
Mental Capacity Act 2005
Mental Health Act 1983
East Riding Safeguarding Children's Partnership Guidelines and Procedures
Hull Safeguarding Children's Board Guidelines and Procedures
North Yorkshire Safeguarding Children's Board Guidelines and Procedures
Guidance on the visiting of Psychiatric Patients by Children (HSC 1999/222: LAC (99)32) to NHS Trusts, Health Boards and local authorities.

Appendix 1: Flowchart: Child/Young Person Visiting Policy



Appendix 2: Document Control Sheet

This document control sheet must be completed in full to provide assurance to the approving committee.

Document Type	Policy		
Document Purpose	The aim of this policy is that personal visits at the Trust hospitals and inpatient units are facilitated flexibly, safely and effectively, in order to optimise their therapeutic value for both patients and visitors.		
Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates	15.11.2023	Mental Health Legislation Steering Group	
Approving Committee:(V1.0)	EMT	Date of Approval:	14 Feb 2023
Ratified at:	Trust Board	Date of Ratification:	29 Mar 2023
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*		Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [✓]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the Author:*		
	This policy will be disseminated by the method described in the Document Control Policy Documents.		
Monitoring and Compliance:	Matrons will monitor policy compliance within their inpatient area. In respect of mental health and learning disability inpatient services the Mental Health Legislation Team will monitor and report on any exceptions, non-compliance of policy in respect of exclusion of visitors (for any reason) as required by the Code of Practice. Exceptions will be reported via the Mental Health Legislation Steering group and the Committee. Any subsequent recommendations will be fed back through the Mental Health Legislation Steering Group in order for action plans to be implemented and disseminated through the Divisions. Divisional managers and divisional clinical leads will be responsible for ensuring that any system or practice changes are implemented and for lessons learnt to be shared to all clinicians working to this policy. In respect of the children and young people visiting units' section of this policy the monitoring will be via the Trust safeguarding team. An audit of its effectiveness based on any area of concern that may arise will be undertaken with the support of the mental health unit safeguarding link person.		

Document Change History: (please copy from the current version of the document and update with the changes from your latest version)			
Version number/name of procedural document this supersedes	*Type of change, e.g. review/legislation*	*Date*	*Details of change and approving group or executive lead (if done outside of the formal revision process)*
1.0	*New policy*	*Feb 2023*	*This Policy replaces the Visiting Guidance (G412 V16) and the Safeguarding Children and Young People Visiting Patients in Mental Health Units and CAMHS Inpatient Unit Policy (N-035). updates made to reflect the local changes in visitor mask wearing section 5.1 and 5.2. Additional information regarding exclusion of visitors. Approved at EMT (14 February 2023) and ratified at Board (29 March 2023).*
1.1	*Review*	*Dec 2023*	*Minor amends. Removed statement about Covid-19 on page 3, removed the need for completion of child visiting forms at section 6, and amended visiting times to community hospital visiting on page 5 and 6.* *Approved at QPaS 1-Dec-2023*

Appendix 3: Equality Impact Assessment

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or Process or Service Name: **Visiting Policy**
2. EIA Reviewer (name, job title): **Michelle Nolan, Mental Health Act Clinical Manager**
3. Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other? **Policy**

Main Aims of the Document, Process or Service

The aim of this policy is that personal visits at the Trust hospitals and inpatient units are facilitated flexibly, safely and effectively, in order to optimise their therapeutic value for both patients and visitors. It includes children visiting mental health settings and aims to promote good practice in the area of children visiting patients detained in mental health units, informally or under the Mental Health Act.

Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma

Equality Target Group	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?	How have you arrived at the equality impact score?
1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender Reassignment	Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	Low	The age of the child visiting the mental health unit will be taken into account within the individual risk assessment and care plan for the patient.
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental Health (including cancer, HIV, multiple sclerosis)	Low	The Trust is committed to promoting awareness of sensitivity to and appropriate consideration of any special needs or requirements relating to any form of disability.
Gender	Men/Male Women/Female	Low	As above
Marriage/Civil Partnership		Low	Applicable regardless of partnership status.
Pregnancy/ Maternity		Medium	Visitors who are pregnant will have this taken into account within the risk assessment and management plan prior to visiting.
Race	Colour Nationality	Low	The Trust is committed to promoting awareness of sensitivity to and appropriate

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
	Ethnic/national origins		consideration of any special needs or requirements relating to any preferences, needs or requirements related to race or ethnicity. This policy is consistent in its approach regardless of race. It is acknowledged however that for any patient whose first language is not English, as information needs to be provided and understood, staff will follow the Trust interpretation procedure.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	Low	The Trust is committed to promoting awareness of sensitivity to and appropriate consideration of any preferences, needs or requirements related to religious or other belief systems.
Sexual Orientation	Lesbian Gay Men Bisexual	Low	The Trust is committed to promoting awareness of sensitivity to and appropriate consideration of any preferences, needs or requirements related to sexual orientation.
Gender Re-assignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	Low	This procedure is consistent in its approach regardless of the gender the individual wishes to be identified as. We recognise the gender that people choose to live in hence why the terms gender identity and gender expression ensure we are covering the full spectrum of LGBT+ and not excluding trans, gender fluid or asexual people. Specific guidance is given in relation to gender and trans. As a guiding principle, everyone will be treated as an individual and gender should not be a barrier.

Summary

Please describe the main points/actions arising from your assessment that supports your decision above.

The standards and principles described within the policy prompt the clinician to have regard to individual holistic risk assessment of all inpatients in relation to having free access to their visitors.

Any audit/monitoring outcomes of related policy would continue to inform any changes to the Equality Impact Assessment in relation to any of the equality target group characteristics and impact of any restrictions or exclusions of visitors.

This policy does not focus on any one group, any one race, gender or religious or philosophical belief, but reflects the revised guidance for all patients and staff.

Additional consideration and planning will be made regarding very young children or pregnant visitors.

EIA Reviewer: **Michelle Nolan**	
Date completed: **November 2023**	Signature **Michelle Nolan**