

Our Ref: NG/RM/25226
Date: 16th July 2025

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Deputy Director of Governance
North Staffordshire Combined Healthcare NHS Trust
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ST4 8HH

Reception: 0300 123 1535

Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 24th June 2025. Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:

I am writing under the Freedom of Information Act 2000 to request information regarding your Trust's use of restorative justice or restorative practices, particularly in the context of sexual safety incidents and patient complaints, and your interpretation and implementation of the NHS England Sexual Safety in Healthcare Charter (2023).

Definitions and Context

Restorative justice (RJ) refers to voluntary, facilitated processes that bring together those harmed and those responsible for harm to acknowledge what happened, understand its impact, and agree on steps to repair it. Common restorative practices include apology meetings, restorative conferences or circles, and dialogue-based resolution procedures. NHS Resolution's Being Fair guidance (2019) encourages such restorative approaches as part of developing a "just and learning culture" in healthcare settings.

Request

Please respond to the following questions:

1. NHS Sexual Safety in Healthcare Charter

a) Has your Trust signed up to the NHS England *Sexual Safety in Healthcare Charter* (2023)? **Yes**

b) If yes:

- Please confirm the date of adoption. **July 2024**
- Provide any internal implementation plans, policy updates, or cultural change programmes associated with the Charter. **Please see Appendix 1 attached.**

c) Does your Trust interpret the Charter's emphasis on person-centred and trauma-informed approaches as including or supporting the use of restorative practices?

The Trust's Civility and Respect (including restorative just and learning culture) cultural transformation programme includes members who represent Patient Safety, which includes the Patient Safety Incident Response Framework aligned to a compassionate and restorative just and learning approach, and Trauma Informed Care from a psychology perspective.

2. Restorative Practices in Complaint Resolution

a) Does your Trust use dialogue-based or restorative approaches in patient complaints more generally (e.g., apology meetings, mediation, facilitated dialogue)?

Yes, facilitated dialogues are encouraged including staff counselling. It mostly sits with the managers to hold meetings (apology meeting or 1 to 1 meeting depending on the approach). These are mostly related to patient complaints not staff process.

b) If yes, please describe the approach and provide any supporting documents.
Please see Appendix 2 attached.

3. Use of Restorative Justice or Restorative Practice

a) Has your Trust ever used restorative justice or restorative practices in the context of:

- Sexual harassment, assault, or misconduct involving staff or patients?
Yes, the informal fact-finding approach used if there is potential misconduct of staff includes applying the original NHSE Just Culture guide principles (the approach is under review after being replaced nationally by the Being Fair Tool).
- Patient complaints involving interpersonal harm or conflict?

Yes - as part of safeguarding, PIPOT meetings, disciplinary investigations depending on the approach, shared learning with any changes to practices.

b) If yes to either, please provide:

- A brief description of the approach used. **Please see Appendix 2 attached.**
- Any relevant policies, procedures, or internal guidance.

Please see Appendices 3-9 attached

The Trust also uses the Being Fair Tool which can be found here [Being Fair Guidance](#)

- Any staff training materials relating to restorative practice.

1. **The Trust's Civility and Respect (including restorative just and learning culture) Cultural Transformation Programme has involved the following training:**

- Trust leaders attending external training on a restorative just and learning culture led by Mersey Care NHS Foundation NHS Trust in partnership with Northumbria University,
- External speakers have attended the Trust's Leadership Academy or development sessions, such as Roger Kline (focused on EDI) and Doctor Chris Turner focused on (Civility Saves Lives).
- A Civility Awareness e-learning package has been developed and launched through the Trust's Learning Management System for all employees.
- A Civility and Respect (including restorative just and learning culture) toolkit is currently being drafted for our staff.

2. **Disciplinary training for Investigation Officers.**

3. **Organisational or personal development.**

- Carrying our workplace investigations
- Disciplinary Panel course

- Any available summary evaluations or outcome reports without any identifying details included. **Due to confidentiality, it is unlikely to share the disciplinary reports even after redacting. Therefore, The Trust is applying Section 40 (2) exemption to this question as its disclosure would contravene one or more of the data protection principles under the Data Protection Act 2018**

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely



Nicola Griffiths
Deputy Director of Governance

Sexual Safety Charter Delivery and Communications Plan

The NHS Sexual Safety Charter aims to foster a safe, respectful, and supportive environment for all patients and staff within the NHS. This delivery plan outlines the strategic approach to implementing and embedding the Charter's principles across the Trust.

1. Initial/Launch Period (First 3-6 Months) Objectives: <ul style="list-style-type: none"> Announce the launch of the NHS Sexual Safety Charter. Raise awareness among staff. Establish a foundation for ongoing communication and engagement. 	Lead	Delivery / Completion Date	Progress / comments
1. Internal planning and communication:			
i. Create a Task and Finish Group: Create Trust task and finish group to develop a plan to benchmark against the charter and develop a plan of action for implementation	█	November 2023- Completed	Benchmarking against current working and action plan created to address gaps and areas of development.
ii. Designated role	█	November 2023- completed	█ subject matter expert/ OD lead of charter implementation.
iii. Launch Event: Organise a virtual or in-person launch event to introduce the NHS Sexual Safety Charter to all staff. Include senior leadership to underscore the importance of the initiative.	ICB task and finish group	02.10.2024	
iv. Staff Briefings: Conduct department-level briefings to explain the Charter's importance, what it entails, and how it will impact daily operations. Provide clear guidance on reporting mechanisms.	Trust task and finish group		Agenda item for next task and finish group. 24.09.2024
v. Intranet: Create a dedicated section on the Trust's intranet with resources, FAQs, and details about the Sexual Safety Charter. Ensure this is updated.	█	25/07/2024- Completed	
vi. Email letter to all staff: Email staff to advise of the Charter.	█	31/07/2024- Completed	
vii. Policy development Review Existing Policies Conduct a comprehensive review of current policies related to sexual safety and harassment. Identify gaps and areas for improvement to align with the Charter's principles.	Trust task and finish group		Policies to be reviewed Patient Sexual safety- completed. Staff Domestic Abuse- ongoing. Staff Bullying and Harassment- ongoing
viii. Metrics	Trust task and finish group		Staff Survey- review on results on sexual safety questions to be explore further. Incident reporting- monthly incident go to CSIG- these do not include staff to staff incidences. Staff

			to patient incident are allegations and managed through a process. Annual report produced for sexual safety trust incidences to go to CSIG 16/09/2024. Went to safeguarding group on the 7/09/2024. HR investigations- Data to be looked into at next task and finish group. FSU- No evidence of any concerns coming via FSU.
i. Develop Training Programs Content: Include modules on sexual safety, reporting mechanisms, and support services. Delivery: Offer mandatory training for all staff, with specific training for those in leadership and HR roles. Patient and Public Education Create educational materials for patients and the public to raise awareness about their rights and how to report concerns	Trust task and finish group		NHSE- leading on resources to trust to use. To discuss at the next task and finish group. Launch event on the 02/10/2024. Looking at introduction to trust induction and preceptorship programme. Sexual safety awareness was introduced in inpatient wards in supervision.
2. External Communication:			
i. Social Media: Utilise the Trust's social media channels to share the news and direct followers to resources. Use engaging content, including infographics to explain the Charter.	Trust task and finish group		Agenda item for next task and finish group. 24.09.2024
ii. Patient and Public Information: Display posters and leaflets in public areas of Trust facilities explaining the Charter and what it means for patients. Update the Trust's website with relevant information and contact points for concerns.	Trust task and finish group		Agenda item for next task and finish group. 24.09.2024
3. Stakeholder Engagement:			
i. Co-production: Engage with staff groups, managers , and senior leaders to discuss the Charter and seek their input on how to best support its implementation.	Trust task and finish group		Agenda item for next task and finish group. 24.09.2024
2. Years 1-2 Objectives: <ul style="list-style-type: none"> Embed the Charter's principles into the Trust's culture and operations Monitor the implementation and gather feedback Ensure continuous engagement with stakeholders 	Lead	Delivery / Completion Date	Progress / comments
1. Ongoing Internal Communication:			
i. Updates: Provide updates via the intranet and Newsround on the progress of the Charter's implementation, sharing success stories.			

ii.	Workshops and Refresher Training: Continue to offer workshops and refresher training sessions on sexual safety, emphasising the importance of the Charter and how staff can contribute to a safer environment.			NHSE resources are being developed.
iii.	Feedback Loops: Promote anonymous feedback channels for staff to share their experiences, concerns, and suggestions regarding the Charter's implementation.			FSU Dear Buki Further considerations to be discussed in task and finish group.
2. External Communication:				
i.	Public: Raise awareness on Trust's website and social media channels.			
3. Stakeholder Engagement:				
i.	Surveys: Conduct surveys with staff to assess the effectiveness of the Charter's implementation and identify areas for improvement.			

3. Years 3-5 Objectives: <ul style="list-style-type: none"> Ensure the sustainability and continuous improvement of the Charter's implementation Maintain high levels of awareness and commitment among all stakeholders Regularly review and adapt the communications strategy based on feedback and changing needs 		Lead	Delivery / Completion Date	Progress / comments
1. Long-Term Internal Communication:				
i.	Annual Reports: Publish an annual report summarizing the year's progress, challenges faced and plans for the future.			
ii.	Continuous Training: Integrate sexual safety and the Charter's principles into the regular training curriculum for all new staff and offer advanced training for existing staff.			
iii.	Recognition Programs: Develop programs to recognise and reward departments or individuals who excel in promoting and maintaining a sexually safe environment.			
2. Ongoing External Communication:				
i.	Regular Updates: Continue to provide updates through the ICS and NHSE meetings			
ii.	Case Studies: Share case studies or testimonials from staff and patients who have benefited from the Charter.			
3. Stakeholder Engagement:				
i.	Review and Adaptation: Regularly review feedback to adapt and improve the implementation of the Charter. Use insights to refine policies and communication strategies.			
ii.	Partnership Strengthening: Strengthen partnerships with staff networks, ensuring they remain involved in the ongoing dialogue about sexual safety within the Trust.			

iii.	Benchmarking and Best Practices: Engage with other NHS Trusts to share best practices and benchmark the Trust’s progress against national standards.			ICS group has been formed. NHSE meetings attended.
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A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

- Please note:**
- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
 - **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
 - **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
 - **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - **Q1. deliberate harm test**

1a. Was there any intention to cause harm?



Yes

Recommendation: Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual.

END HERE

No go to next question - **Q2. health test**

2a. Are there indications of substance abuse?



Yes

Recommendation: Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier.

END HERE

2b. Are there indications of physical ill health?



Yes

Recommendation: Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier.

END HERE

2c. Are there indications of mental ill health?

if **No to all** go to next question - **Q3. foresight test**

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?



If No to any

Recommendation: Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual.

END HERE

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

if **Yes to all** go to next question - **Q4. substitution test**

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?



If Yes to any

Recommendation: Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual.

END HERE

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. Were there any significant mitigating circumstances?



Yes

Recommendation: Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients.

END HERE

if **No**

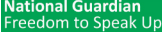
Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients.

END HERE

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:



Document level: Trust
Code: 1.70
Issue number: _____

Managing Safeguarding Allegations Against Staff

Lead executive	Executive Director of Nursing and Quality
Authors details	Head of Safeguarding

Type of document	Policy
Target audience	All individuals employed by the Trust including contractors, voluntary workers, students, locums, agency, and bank staff.
Document purpose	To ensure safe working systems are in place to protect service users, the relatives, and the public and support staff in managing allegations.

Approving meeting	Quality Committee	Meeting date	7 th March 2024
Implementation date		Review date	31 st March 2025

Trust documents to be read in conjunction with	
5.32	Serious Incident Policy
3.1	Disciplinary Procedures
4.01	Safeguarding Children and Young People Policy
1.12a	Adult Safeguarding Policy
4.26	Listening, Responding, and Improving – PALS and Complaints

Document change history		Version	Date
What is different?	Updated in line with policy review schedule and to reflect current guidance.	3	Sept 2020
Appendices / electronic forms	Appendix A added to provide clarity on process for investigating allegations	3	Sept 2020
What is the impact of change?	Changes made reflect diversity of roles within the workforce and clarify roles of senior members of staff.	3	Sept 2020

Training requirements	Safeguarding Children & Adults Level 1&2 is mandatory training for all staff. Awareness of this policy and the roles and responsibilities of individual staff groups is made explicit during this training.
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Document consultation	
Directorates	
Corporate services	
External agencies	

Financial resource implications	
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External references
<ol style="list-style-type: none"> 1. Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board Adult Protection Procedures 2. Stoke on Trent and Staffordshire Safeguarding Children Board Child Protection Procedures 3. Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019) 4. Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) 5. HM Government, Working Together to Safeguard Children (2018) 6. The Care Act (2014) 7. Guide to the General Data Protection Regulation (2018) 8. Data Protection Act (2018) 9. The Human Rights Act (1998)

Monitoring compliance with the processes outlined within this document	<p>Awareness of this policy and the roles and responsibilities of individual staff groups is made explicit during mandatory level 1 and 2 safeguarding training.</p> <p>The effectiveness of this policy will be monitored through the trust Safeguarding Group which meets quarterly.</p>
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Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Less favourable / More favourable / Mixed impact
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– Age (e.g. consider impact on younger people/ older people)	no	
– Disability (remember to consider physical, mental and sensory impairments)	no	
– Sex/Gender (any particular M/F gender impact; also consider impact on those responsible for childcare)	no	
– Gender identity and gender reassignment (i.e. impact on people who identify as trans, non-binary or gender fluid)	no	
– Race / ethnicity / ethnic communities / cultural groups (include those with foreign language needs, including European countries, Roma/travelling communities)	no	

<ul style="list-style-type: none"> – Pregnancy and maternity, including adoption (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples) – Sexual Orientation (impact on people who identify as lesbian, gay or bi – whether stated as ‘out’ or not) – Marriage and/or Civil Partnership (including heterosexual and same sex marriage) – Religion and/or Belief (includes those with religion and /or belief and those with none) – Other equality groups? (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups) 	no	
	no	
	no	
	no	
<p>If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.</p> <p>Enter details here if applicable</p> <p>If you have identified potential negative impact:</p> <ul style="list-style-type: none"> - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? <p>Can the impact be reduced by taking different action?</p> <p>N/A</p>		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	Yes / No	
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	Yes / No	
N/A		
<p>Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact.</p> <p>For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk</p>		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

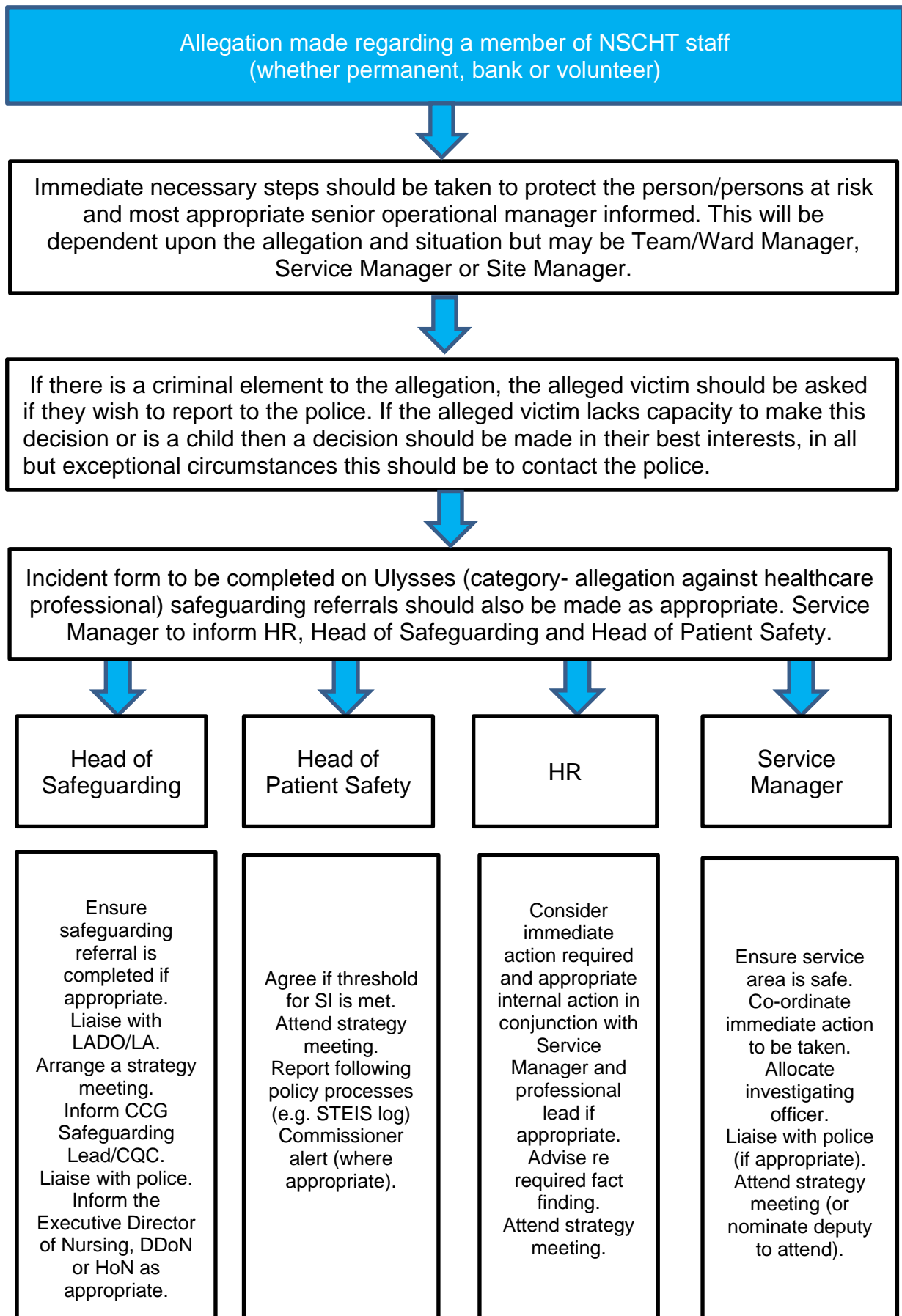
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1. Quick Reference Flowchart

REPORTING SAFEGUARDING ALLEGATIONS AGAINST STAFF

This process **must** be followed should an allegation be made:



2. Introduction/Background

North Staffordshire Combined Healthcare NHS Trust (NSCHT) is committed to promoting the welfare of children, young people and adults and to protecting them from risks of harm. NSCHT recognises its responsibility to ensure that safe working systems are in place. The Trust is committed to creating a climate in which allegations or concerns can be raised without fear or recrimination to the reporter.

The purpose of this Policy is to provide a framework for managing cases where allegations are made about NHS staff (including agency workers, bank staff and contractors) and volunteers or other unpaid personnel working within the Trust, that indicate that children, young people or adults with care and support needs are believed to have suffered, or are likely to suffer, significant harm.

Concern may also be raised if the staff member is behaving in a way which demonstrates unsuitability for working with children, young people or adults with care and support needs, in their present position, or in any capacity. The allegation or issue may arise either in the employee's/professional's work or private life.

Working Together to Safeguard Children and Young People (2018) and The Care Act (2014) both set out expectations for all statutory organisations to have a procedure for managing safeguarding allegations made against staff.

This policy applies to all areas of NSCHT and all individuals employed by or engaged to work within the Trust including contractors, voluntary workers, students, locums, agency and bank staff.

3. Policy Synopsis

The Policy provides a framework for managing allegations made about staff that indicate that children, young people or adults with care and support needs are believed to have suffered, or are likely to suffer, significant harm or are considered at risk, in their present position, or in any capacity. The allegation or issue may arise either in the person's work or private life.

4. Managing an Allegation

Allegations of abuse can be identified via a number of routes these include, but are not limited to:

- Complaints
- Incident Reporting
- Safeguarding referrals
- PALS
- Disclosures from service user and or their relatives/friends
- Alerts from other agencies

- Freedom To Speak Up processes

All allegations made against members of staff are to be dealt with in accordance with this policy to ensure openness and transparency and adequate protection for service users and staff.

Allegations may be contemporary in nature, historical or both. Even where concerns are clearly historical, they should be responded to in accordance with this policy.

Advice and support can be sought from the Safeguarding Team at any point during the process.

4.1 Process for managing allegations against a member of staff

All allegations of abuse should be logged via the Trust incident reporting system (Ulysses in accordance with the incident reporting policy).

In addition to this, the allegation should be reported through existing line management structures. If this method is compromised i.e. the allegation is against the line manager then alternative line management oversight should be sought from the immediate line manager of the member of staff about whom the allegation has been made.

Once an allegation is received by a line manager, this must be escalated to the service manager.

Upon the receipt of an allegation the service manager is responsible for ensuring that following are informed:

- Associate Director.
- Head of Patient and Organisational Safety.
- Head of Safeguarding.

Following notification of an allegation the Head of Safeguarding is responsible for ensuring that a safeguarding referral has been generated in accordance with multi-agency policies and procedures and co-ordinating the required strategy/ fact finding meeting.

Where the incident involves an adult with care and support needs in our care, the Head of Safeguarding must ensure that the Commissioning Safeguarding Adult Lead is informed as well as notifying the CQC where appropriate. This will be done by including the identified CQC Inspector and CCG Adult Lead into the strategy meeting invite. This is enable oversight and assurance of robust Trust procedures for managing safeguarding allegations.

The Safeguarding Team will convene a strategy meeting within 72 hours of the incident being reported. This meeting may be face to face or virtual. This meeting will usually include as a minimum the Head of Safeguarding (or deputy), the Head of Patient Safety (or deputy), Service Manager, HR representation and identified line manager dealing with the incident.

The line manager identified as managing the incident should bring initial fact finding including an account taken from person raising the allegation to the strategy meeting.

Following the strategy discussion, the responsibility for informing the employee/volunteer of any restrictions to their duties rests with the operational line management structure, supported and advised by Human Resources. At this point the member of staff should not be informed of the detail of the allegation; only that a safeguarding allegation has been made.

It should be made clear to the member of staff that the investigative process is a neutral process with an aim of establishing the facts regarding the allegation and not any indication or presumption of guilt.

A named person will be appointed, by the line manager with support from the relevant Human Resources Advisor, to provide support to the staff member concerned.

There are three strands to be considered when dealing with an allegation:

- A police investigation of a possible criminal offence.
- Social care enquiries regarding an adult with care and support needs and / or assessment about whether a child is at risk.
- Possible disciplinary action by an employer.

Where a criminal offence is believed to have possibly occurred as a result of a safeguarding allegation this should be reported to the police and necessary actions taken to preserve evidence and not interfere with potential witnesses.

In some cases it will not be appropriate for a member of staff to remain at work whilst an investigation is being undertaken. After consideration of the circumstances it may be possible, as an alternative to suspension, to transfer the staff member concerned to a different work area or setting. For members of bank staff this would be a temporary withdrawal of the offer of shifts. This decision will be taken by the relevant Service Manager, Associate Director and Human Resources Advisor, where appropriate guidance may be sought from the Head of Safeguarding and the Executive Director of Nursing and Quality or their deputies.

Suspension will be considered in any case where:

- there is cause to suspect a child/adult is at risk of significant harm;
- the allegation warrants investigation by the police;
- the allegation is so serious that it might be grounds for dismissal.

Should suspension be decided upon it should be made clear to the member of staff that this like the overall investigation process is a neutral act and designed to protect both the member of staff, alleged victim and other service users from any further incident or allegation.

Factors that may influence the decision to suspend include the presence of evidence that indicates the allegation is unfounded (suspension may not be necessary), or the

presence of evidence that corroborates the allegation in any way (suspension is likely to be necessary).

Where the allegation involves the member of staff's family e.g. domestic abuse, consideration must be given to the safety of the family members.

The Head of Patient Safety and Head of Safeguarding should be aware of all decisions made as a result of a safeguarding allegation. This includes the outcome of disciplinary processes which may continue after safeguarding and patient issues have been resolved.

4.2 Police Involvement

In the event of an allegation of a criminal nature the Police must be informed at the point of disclosure. All police/criminal investigations take precedence over other internal/ external lines of inquiry; however the strategy meeting still needs to be held within the appropriate timescales and police should be invited to this meeting.

4.3 Out of Hours

In the event that an allegation is received out-of-hours disciplinary procedures should be used where appropriate, however not all allegations will fall into this category. A decision will be taken, which is proportionate to the potential risk, by the Site Manager as to whether there is a need to take immediate remedial action. If an allegation is received out of hours, notification to those listed should occur as soon as possible the next working day.

5. Confidentiality

The managing allegations process is a confidential process managed under the General Data Protection Regulation 2018, Data Protection Act 1998, Human Rights Act 1998, and employment legislation. All information regarding an allegation relating to both the alleged perpetrator and the victim should be treated as confidential outside of those immediately involved in the managing allegation process and strategy meetings.

The nature and details of allegations **should not** be discussed at team meetings, during handovers, on work premises or outside of work in social settings.

6. Duties and Responsibilities

6.1 Lead Professional Roles

6.1.1 Local Authority Designated Officer (LADO)

The LADO is responsible for overseeing individual cases of allegations concerning children and providing advice and guidance to employers and voluntary organisations.

They will ensure that decisions are made as objectively as possible and monitor the progress of cases to ensure that they are dealt with as quickly as possible in a consistent, thorough and fair process.

6.1.2 Executive Director of Nursing and Quality

The Executive Director Nursing and Quality is the executive lead for safeguarding and should be informed about all allegations of abuse made against members of staff. They are responsible for providing assurance that any concerns are addressed with the LADO/DASM at an inter-agency level where this process is required.

6.1.3 Head of Safeguarding

The Head of Safeguarding is responsible for providing advice and guidance within their organisation and liaising with other agencies as necessary. They should monitor the progress of cases to ensure they are dealt with as quickly as possible, consistent with a thorough and fair process.

6.1.4 Head of Patient and Organisational Safety

The Head of Patient and Organisational Safety is responsible for reporting the incident as a serious incident where the threshold for a safeguarding investigation has been met and in accordance with the incident reporting policy and is required to attend the strategy meeting.

6.1.5 Human Resources

Human resources will offer advice in accordance with HR Policies and Processes including the disciplinary processes and procedures where applicable. A representative from HR is required to attend the strategy meeting. Records relating to any disciplinary action will be kept by the HR department in accordance with the disciplinary policy.

6.2 Additional Roles

6.2.1 Clinical Directors

It is the responsibility of the Clinical Directors to ensure that this policy is enforced. Clinical Directors will enact any necessary referrals to registering bodies as appropriate to their role and as required following outcomes of investigations.

6.2.2 Associate Directors

Associate Directors are responsible for ensuring this policy is distributed and enacted within their service areas.

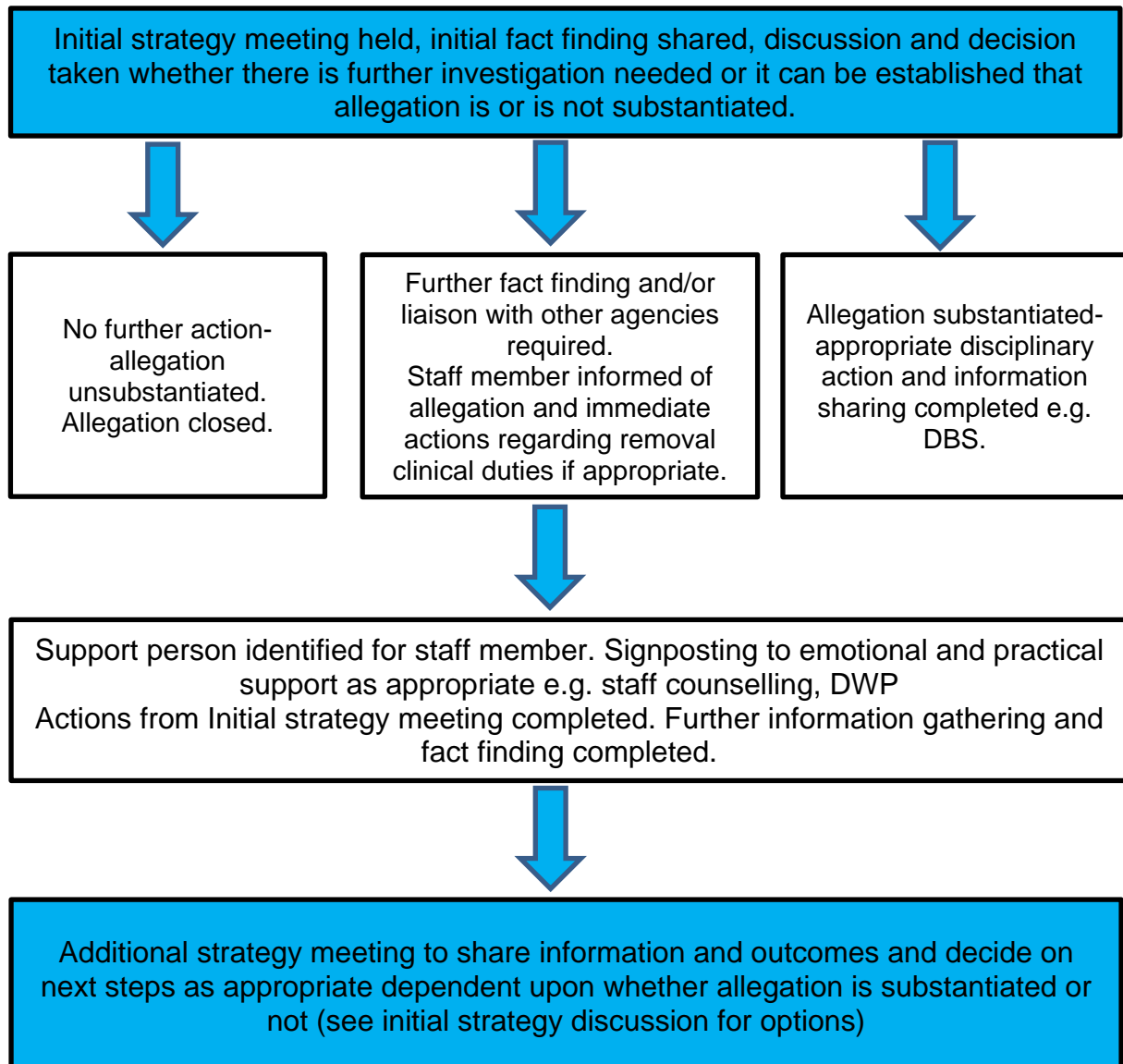
6.2.3 Human Resources Advisors

Human Resources Advisors are responsible for supporting and facilitating the sharing of information pertaining to staff as requested by the LADO and Trust Designated Head of Safeguarding, and advising on any action in accordance with the Trust's Disciplinary Procedure Policy (3.01)

6.2.4 All staff

All staff are responsible for reporting **any** concerns they may have regarding the conduct or actions of a colleague, visitor or volunteer. They should ensure that any allegation against another member of staff is brought to the attention of line managers and reported correctly in order for it to be addressed through this policy.

7. Appendix A: Managing Safeguarding Allegation Process



***Please note this process may be paused or delayed in order for police investigations to take precedence over internal investigations**

8. APPENDIX B: Training Needs Analysis

Please tick as appropriate

There is no specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	
There is specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required- link with learning and development department.	✓

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/face to face/ e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Career Grade Doctor	✓	3yearly	e-learning levels 1 and 2, face to face level 3	✓
Training Grade Doctor	✓		e-learning levels 1 and 2, face to face level 3	✓
Locum medical staff	✓		e-learning levels 1 and 2, face to face level 3	✓
Inpatient Registered Nurse	✓		e-learning levels 1 and 2, face to face level 3	✓
Inpatient Non-registered Nurse	✓		e-learning levels 1 and 2, face to face level 3	✓
Community Registered Nurse	✓		e-learning levels 1 and 2, face to face level 3	✓
Community Non Registered Nurse / Care Assistant	✓		e-learning levels 1 and 2, face to face level 3	✓
Psychologist / Pharmacist	✓		e-learning levels 1 and 2, face to face level 3	✓
Therapist	✓		e-learning levels 1 and 2, face to face level 3	✓
Clinical bank staff regular worker	✓		e-learning levels 1 and 2, face to face level 3	✓
Clinical bank staff infrequent worker	✓		e-learning levels 1 and 2, face to face level 3	✓
Non-clinical patient contact	✓		e-learning levels 1 and 2	✓
Non-clinical non patient contact	✓		e-learning levels 1 and 2	✓

Please give any additional information impacting on identified staff group training needs (if applicable)

Levels 1&2 are a joint eLearning training package available on the LMS with no limit on access to the training package.

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Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

All levels of children and young people safeguarding training meets the requirements set out in Safeguarding Children & Young People: Roles and Competencies for Healthcare Staff Intercollegiate Document (2019)

Adult safeguarding training is developed in accordance with The Care Act (2014), the Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) and Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 Safeguarding service users from abuse and improper treatment.

Any other additional information

Training compliance levels by directorate are reported quarterly to safeguarding group and Quality Committee and monthly at SLT.

Completed by		Date	16/09/2020
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Document level: Trustwide

Code: 1.75

Issue number: _____

Domestic Abuse Policy

Lead executive	Executive Director of Nursing and Quality
Authors details	Head of Safeguarding Deputy Director of Nursing & Quality

Type of document	Policy
Target audience	All individuals employed by the Trust including contractors, voluntary workers, students, locums, agency, and bank staff.
Document purpose	To ensure safe working systems are in place to protect service users, relatives, staff, and the public.

Approving meeting	Quality Committee Trust Board	Meeting date	3 rd November 2022 10 th November 2022
Implementation date	30 th November 2022	Review date	30 th November 2025

Trust documents to be read in conjunction with	
4.01	Safeguarding Children and Young People Policy.
1.89	Safeguarding Adults at Risk Policy.

Document change history		Version	Date
What is different?	Updated policy		
Appendices / electronic forms			
What is the impact of change?	Ensure NSCHT is compliant with current legislation and best practice guidance in line with NHS England recommendations.		

Training requirements	
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Document consultation	
Directorates	Consultation has been sought through the Safeguarding Group, Nursing and Quality Policy Group and Human Resources Policy Group.
Corporate services	
External agencies	

Financial resource implications	
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External references

1. Domestic Abuse Act 2021
2. Government's Mandate to NHS England for 2018-19
3. Honour Based Violence - Crown Prosecution Service, 2018
4. Forced Marriage - Home Office, 2018
5. World Health Organisation, Female Genital Mutilation, 2014
6. Female Circumcision Prohibition Act 1985
7. Female Genital Mutilation Act 2003
8. Serious Crime Act 2015
9. Family Law Act 1996, Section 63(1)
10. Care Act 2014
11. Bowstead, 2015
12. Association of Directors of Adult Social Services, 2015
13. Radford et al 2011
14. UNICEF 2017
15. Edleson et al 2007
16. Stannard 2009
17. Working Together to Safeguard Children, 2018
18. Sidebotham et al 2016
19. Children's Act 1989 and 2004
20. Department for Education 2017
21. Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' August 2013
22. Data Protection Act (2018)
23. General Data Protection Regulations (2016)
24. Striking the Balance, Practical Guidance on the Application of Caldicott Guardian Principles to Domestic Abuse and MARAC (Department of Health 2012)
25. NICE Guidance ph50: Domestic Abuse – Multiagency Working (2014)13,
26. NICE Quality Standard QS116 (2016)10

Monitoring compliance with the processes outlined within this document

Equality Impact Assessment (EIA) - Initial assessment

Yes/No

Less favourable /
More favourable /
Mixed impact

Does this document affect one or more group(s) less or more favourably than another (see list)?

<ul style="list-style-type: none"> – Age (e.g. consider impact on younger people/ older people) – Disability (remember to consider physical, mental and sensory impairments) – Sex/Gender (any particular M/F gender impact; also consider impact on those responsible for childcare) – Gender identity and gender reassignment (i.e. impact on people who identify as trans, non-binary or gender fluid) – Race / ethnicity / ethnic communities / cultural groups (include those with foreign language needs, including European countries, Roma/travelling communities) – Pregnancy and maternity, including adoption (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples) – Sexual Orientation (impact on people who identify as lesbian, gay or bi – whether stated as ‘out’ or not) – Marriage and/or Civil Partnership (including heterosexual and same sex marriage) – Religion and/or Belief (includes those with religion and /or belief and those with none) – Other equality groups? (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups) 	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>More favourably</p> <p>More favourably</p> <p>More favourably</p> <p>More favourably</p> <p>More favourably</p> <p>More favourably</p> <p>More favourably</p> <p>More favourably</p> <p>More favourably</p> <p>More favourably</p>
<p>If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.</p>		
<p>Anyone can be a victim of Domestic Abuse, however, certain group within the protected characteristics may be more likely to be a victim of serious DA and may have additional barriers for accessing support. For example those with a disability may have Increased vulnerabilities. For LGBTQ+ individuals that may be victims of DA, may also face additional barriers to prevent disclosure or access of support. Research demonstrates that Women who are pregnant have increased risk of DA. There may be additional barrier within certain ethnic groups that make disclosure more difficult and there may be barriers to assessing support. This policy does not discriminate against any protected characteristics Individuals who receive our services require support for various reasons and it is recognised there is a relationship between adversity, trauma and support</p>		
<p>If you have identified potential negative impact:</p> <ul style="list-style-type: none"> - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? <p>Can the impact be reduced by taking different action?</p>		
<p>Enter details here if applicable</p>		

Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	Yes / No
Enter details here if applicable	
<p>Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact.</p> <p>For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk</p>	
Was a full impact assessment required?	No
What is the level of impact?	Low

Training Needs Analysis for the policy for the development and management of Trustwide procedural / approved documents

Please tick as appropriate

There is no specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	
There is specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	✓

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Career Grade Doctor	✓	3 yearly	E-Learning	✓
Training Grade Doctor	✓	3 yearly	E-Learning	✓
Locum medical staff	✓	3 yearly	E-Learning	✓
Inpatient Registered Nurse	✓	3 yearly	E-Learning	✓
Inpatient Non-registered Nurse	✓	3 yearly	E-Learning	✓
Community Registered Nurse	✓	3 yearly	E-Learning	✓
Community Non Registered Nurse / Care Assistant	✓	3 yearly	E-Learning	✓
Psychologist / Pharmacist	✓	3 yearly	E-Learning	✓
Therapist	✓	3 yearly	E-Learning	✓
Clinical bank staff regular worker	✓	3 yearly	E-Learning	✓
Clinical bank staff infrequent worker	✓	3 yearly	E-Learning	✓
Non-clinical patient contact	✓	3 yearly	E-Learning	✓

Non-clinical non patient contact	Optional	Optional	E-Learning	✓
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Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

NICE Guidance ph50: Domestic Abuse – Multiagency Working (2014)¹³, and the NICE Quality Standard QS116 (2016)¹⁰ outline the recommendations for training for different professional groups.

Any other additional information

Completed by	Head of Safeguarding	Date	09/09/2022
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1. Executive Summary

North Staffordshire Combined HealthCare NHS Trust (NSCHT) Domestic Abuse Policy has been developed to provide a clear framework in relation to recognising, reporting, recording and responding to domestic abuse.

Domestic abuse is a Human Rights violation in relation to right to life, health, personal freedom and security, and the right not to be torture or exposed to other inhuman, cruel or degrading treatment.

2. Scope

- 2.1 This policy applies to all employees of NSCHT and all other individuals employed by the Trust including contractors, voluntary workers, students, and locum and agency staff.
- 2.2 This policy provides a framework to ensure that there is a cohesive and coordinated approach to supporting those experiencing domestic abuse. As a result service users who have experienced, or who are experiencing domestic abuse will receive the recognition, information and support. This policy does cover domestic abuse in relation to staff.
- 2.3 This policy acknowledges that domestic abuse can affect anyone regardless of sex/gender, sexual orientation, religion/belief, age, disability, race, marital status, gender reassignment or maternity/pregnancy. NSCHT does not discriminate against any individual in this policy but acknowledges factors which may increase risk.

3. Roles and responsibilities

The duties including levels of responsibility for the Domestic Abuse Policy and procedure for staff working within adult and children's services are outlined below.

- 3.1 The Chief Executive has overall responsibility for the strategic and operational management of the Trust, including ensuring that the Trust complies with all legal, statutory and good practice requirements. The Chief Executive is responsible for ensuring that there are safe and effective systems in place to deliver high quality care to the persons who use our services.
- 3.2 The Trust Board has overall responsibility for ensuring that the organisation complies with all legal, statutory and good practice requirements by the provision of up to date, evidence-based policies.
- 3.3 The Trust Safeguarding Team will provide expert advice, guidance and leadership regarding domestic abuse in the context of children and adults at risk.
- 3.4 Human Resources will provide guidance and support to managers who have staff experiencing domestic abuse, either as victim or perpetrator.

- 3.5 Practitioners are accountable for their actions and omissions and must use their clinical judgement and skills to justify their actions and work in accordance to their Professional Code of Practice.
- 3.6 It is the responsibility of all staff working NSCHT to be familiar with the content of this document, follow the guidance contained within it and report any adverse experience to their line manager.
- 3.7 NICE Domestic Violence and Abuse: Multi-Agency Working ph-50 (2014) states that all frontline staff should be able to ask relevant questions to help people disclose their past or current experiences of such violence or abuse. The enquiry should be made in private on a one-to-one basis in an environment where the person feels safe, and in a kind, sensitive manner. Staff trained in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, mental health, children's and vulnerable adults' services ask service users whether they have experienced domestic violence and abuse. This should be a routine part of good clinical practice, even where there are no indicators of such violence and abuse.

4. Introduction

- 4.1 Domestic abuse is not a single incident or even a series of incidents. It is essentially a pattern of behaviour designed to achieve power and control over a current or ex-partner or other family member, which is achieved through the use of physical, sexual, psychological and economic abuse, or through movement restriction and/or social isolation. It is usually a combination of all of these and is widespread throughout every socio-economic group and frequently co-exists with child abuse.
- 4.2 Domestic abuse has a major impact on the health, social, emotional and intellectual development of an unborn baby, child or young person, witnessing (including hearing) domestic abuse should be considered child abuse.
- 4.3 The UK government's definition of domestic abuse is;

“Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are personally connected to each other. The abuse can encompass, but is not limited to:

- *psychological, emotional or other abuse.*
- *physical or sexual abuse.*
- *economic abuse.*
- *violent or threatening behaviour.*

It may also include destructive criticism, pressure tactics, disrespect, breaking trust, isolation, stalking and harassment“.

- 4.4 The Domestic Abuse Act 2021 changed the definition to consider those who are “personally connected”, and not simply those people in an “intimate relationship”.

Personally connected refers to the following:

- those who are, or have been, married to each other.
- those who are, or have been, civil partners of each other.
- those who have agreed to marry one another (whether or not the agreement has been terminated).
- those who have entered into a civil partnership agreement (whether or not the agreement has been terminated).
- those who are, or have been, in an intimate personal relationship with each other.
- those who each have, or there has been a time when they each have had, a parental relationship in relation to the same child.
- those who are relatives.

- 4.5 People can experience DA regardless of their social group, class, age, race, disability, sexuality, and lifestyle. Abuse can begin at any time in a person's life – young people, adolescents, the elderly, and frail can all be victims and perpetrators. It is rarely a one-off event. Physical and sexual abuse tends to increase in frequency and severity over time, and the pattern of abuse must be disrupted to prevent further harm or devastating consequences.
- 4.6 The majority of the population access the healthcare system at some point so healthcare professionals are in a unique position to help people who experience DA get the support they need. Health professionals also play a key role in identifying and supporting those effected by DA who may be at increased risk due to being a child, or an adult with care and support needs.
- 4.7 NSCHT supports the view that all NHS Trusts should be helping to identify violence and abuse earlier and supporting victims to get their lives back sooner, as defined in the Government's Mandate to NHS England for 2018-19. As such NSCHT recognises that domestic abuse is a criminal act which adversely affects the health and wellbeing of individuals, families, and communities.
- 4.8 NSCHT also recognises that there are a range of equality issues to be considered around domestic abuse including the following:
- Whilst anyone can experience domestic abuse, there is evidence that women are the most likely victims of high-risk incidences and men are the most likely perpetrators.
 - Because of the gendered cultural differences surrounding domestic abuse, it can be difficult for men to disclose that they are victims of domestic abuse.
 - Some people in same sex relationships may experience concerns relating to the dual disclosure of sexual orientation and domestic abuse.
- 4.9 NSCHT is committed to ensuring that, as far as is reasonably practicable, the way we treat staff who raise a concern about domestic abuse, or perpetrate domestic abuse, does not discriminate against individuals or groups on the grounds of any protected characteristic. The aim of this policy is to ensure that victims of domestic abuse receive a high standard of care irrespective of age, race, culture, sexuality, religion or ability and equality underpins all its service provision.

5. Definitions

- 5.1 Controlling Behaviour: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
- 5.2 Coercive Behaviour: an act or a pattern of acts of assault, threats, humiliation or other abuse that is used to harm, punish, or frighten their victim. Both control and coercive behaviours can involve threats re; children/contact with children
- 5.3 Physical Abuse: shaking, smacking, punching, pushing, kicking, biting, starving, tying up, stabbing, suffocation, throwing things, using objects as weapons, female genital mutilation, 'honour violence'. The physical effects can often be on areas of the body that are covered and hidden (i.e. chest and abdomen).
- 5.4 Sexual Abuse: forced sex, sexual exploitation, pressuring an individual to participate in non-consensual sexual activities, sexual insults, coerced nudity, taking of explicit photographs under duress, distributing or placing explicit photographs or videos online, sexual violence, non-consensual acts during intercourse including strangulation, beating, restraint and marking. The perpetrator may refuse to use protection and knowingly expose the victim to infection or pregnancy.
- 5.5 Psychological Abuse: intimidation, insulting, isolating the victim from friends and family, criticising, denying the abuse, treating them as inferior, threatening to harm children or take them away, forced marriage, controlling behaviour including obsessive checking of texts and whereabouts. In the Lesbian, Gay, Bisexual and Transgender, (LGBTQ+) community, sometimes the threat of 'outing' (threatening to divulge the nature of someone's sexuality to family friends or employers) is used to intimidate individuals.
- 5.6 Economic Abuse: not letting a victim work, undermining efforts to find work or study, refusing to give money, asking for an explanation of how every penny is spent, making them beg for money, not paying bills. The victim may have no access to cash or cards and have their accounts or access to money tightly controlled.
- 5.7 Emotional Abuse: swearing, undermining confidence, making racist remarks, making the victim feel unattractive, calling them stupid or useless, and eroding their independence. Controlling or threatening behaviour.
- 5.8 Honour Based Violence: the terms "honour crime" or "honour-based violence" (HBV) or "izzat can be described as a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour.) this can include assault, imprisonment and murder where the person is being punished by their family or community. Such violence can occur when perpetrators perceive that a relative has 'shamed' the

family and/or community by breaking their 'honour'. It can be distinguished from other forms of violence, as it is often committed with some degree of approval and / or collusion from family and or community members (Crown Prosecution Service, 2018).

5.9 Forced Marriage: A forced marriage is where one or both people do not (or in cases of people with learning disabilities or reduced capacity, cannot) consent to the marriage as they are pressurised, or abuse is used, to force them to do so. It is recognised in the UK as a form of domestic or child abuse and a serious abuse of human rights (Home Office, 2018). This is now legislated as an offence and is recognised in the UK as a form of violence against women and men, domestic/child abuse and a serious abuse of human rights. An arranged marriage (not considered abuse) will become 'forced' if either or both parties withdraw consent and are pressured to continue with the marriage. The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they are bringing shame on their family).

5.10 Female Genital Mutilation (FGM): is linked to domestic abuse and includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons (World Health Organisation, Female Genital Mutilation, 2014). FGM has been illegal in England, Wales and Northern Ireland since the Female Circumcision Prohibition Act 1985 came into force. In 2003 the Female Genital Mutilation Act additionally stipulated that it was an offence to:

- perform FGM.
- assist in the carrying out of FGM.
- assisting a female to carry out FGM on herself in the UK or abroad.

A person found guilty of any of the above offences would be liable to receive a maximum sentence of 14 years imprisonment.

The Serious Crime Act 2015 then extended the realms of the previous Act to include making it an offence for; *"any person with parental or caring responsibility for a girl to fail to protect her from FGM."*

5.11 Relative: A relative is defined by section 63(1) of the Family Law Act 1996. This could be a father, mother, stepfather, stepmother, son, daughter, stepson, stepdaughter, grandmother, grandfather, grandson or granddaughter, brother, sister, uncle, aunt, niece, nephew or first cousin.

5.12 Independent Domestic Violence Advisor (IDVA): the main purpose of independent domestic violence advisors is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children.

5.13: Independent Sexual Violence Advisor (ISVA). An independent sexual violence advocate offers confidential advice and support to all victims of recent or historic sexual violence. This support is offered in differing format depending on risk levels – e.g. low risk support is in the format of an outreach worker

6 Management of Disclosure

- 6.1 Following a disclosure of domestic abuse it is essential that the practitioners' response is sympathetic, supportive and non-judgemental. It is important to gain consent to discuss the information with a third party, e.g. Domestic Abuse Support Services and Children's Services (unless there is a need to share that information without consent e.g. protecting children from significant harm).
- 6.2 An assessment of the immediate danger the victim and his/her child/children are in needs to be made based on the information disclosed. A Safe Lives Risk Identification Checklist needs to be completed. If 14 or more positive responses are made, then referral to the Multi Agency Risk Assessment Conference (MARAC) needs to be discussed with the client. Where it is considered that discussing a referral to MARAC would place the victim and his/her children at greater risk then the referral may be made without discussion or gaining consent. A referral may also be made on professional judgement if the nature of what has been disclosed is of serious concern, in this instance the referral should be discussed with the Safeguarding Team
- 6.3 The safety of the child/children needs to be considered. Frontline staff should access the threshold document from your Local Safeguarding Board or Partnership, this can be used to help you identify the level of need or risk. If you are unsure, you can discuss this with the Safeguarding Team within the Trust. It is good practice to inform the person that you are going to refer. There are however specific circumstances where this is not appropriate such as when there is an increased risk to you, the victim or the child if you inform them.
- 6.4 Adults who meet the criteria of Adults at Risk under the Care Act (2014) also need to be considered and safeguarding referrals made if there is a risk to the 'victim' being unable to protect themselves from the abuse. Consideration should be given on whether there is an adult in the home with needs for care and support who may also be at the risk.
- 6.5 All disclosures should be recorded as accurately as possible and using persons own words where possible. Records can be requested as part of criminal proceedings. A copy of the Risk Identification Checklist should also be uploaded to the patient or service user records.
- 6.6 **Adult Safeguarding**
 - 6.6.1 If an adult makes a disclosure the professional should consider whether they are an adult with care and support needs and refer as appropriate (see trust1.89 Safeguarding Adults at Risk Policy).
 - 6.6.2 Healthcare staff should consider domestic abuse as an alternative diagnosis for unexplained or suspicious injuries, substance misuse and mental health issues. 70% of victims of domestic abuse also misuse drugs and/or alcohol and 50% of men and 60% of women with mental health issues have suffered with domestic abuse (Bowstead, 2015).
 - 6.6.3 Mental capacity should be considered as those at high or serious risk of harm can affect an individual's ability to safeguard themselves and others (Association of

Directors of Adult Social Services, 2015), therefore this can lead to a lack of recognition around risk and can prevent them from being able to safeguard themselves.

- 6.6.4 Domestic abuse is a category of abuse under the Care Act (2014). If a service user is experiencing domestic abuse, then an adult safeguarding referral should be completed if the criteria for adult safeguarding are met.

Criteria for adult safeguarding is as follows:

- The adult must have care and support needs (regardless of whether these are these are being met).
- They must be at risk of or experiencing abuse or neglect.
- As a result of their care and support needs, they are unable to protect themselves from abuse or neglect.

This does not negate the need to refer high risk cases to MARAC, however, does allow for interventions and safety planning for those cases that do not meet MARAC threshold.

6.7 Safeguarding Children

- 6.7.1 Around 1 in 5 children have been exposed to domestic abuse (Radford et al 2011). Children who are exposed to violence in the home are denied their right to a safe and stable home (UNICEF 2017). Infants and small children who are exposed to violence in the home are 15 times more likely to be physically or sexually assaulted than the national average (Edleson et al 2007). Domestic abuse threatens the brain development of young children and can later affect their physical and emotional functioning (Stannard 2009). Where domestic abuse exists there are often issues around alcohol and drug misuse which increases the likelihood the child will experience abuse or neglect (Working Together to Safeguard Children, 2018). Domestic abuse is a factor in over half of Serious Case Reviews (Sidebotham et al 2016). The Children's Act 1989 was amended in 2004 to recognise the "*see and hearing the ill-treatment of others*" as a form of emotional abuse.

- 6.7.2 Where it is known that a child is living with domestic abuse a safeguarding referral should be considered. Advice can be sought from the Safeguarding Team. Where a practitioner is working with a young person that discloses, they are in an abusive relationship it should be considered whether there is also a risk of Child Sexual Exploitation (CSE). CSE is a form of sexual abuse that can occur when there is an unbalance of power to coerce, manipulate or deceive a child or young person, under the age of 18 years, to engage in sexual activity (Department for Education 2017).

7. **Multi Agency Risk Assessment Conferences (MARAC)**

- 7.1 The aim of the MARAC is to share multi agency information to increase the safety, health and wellbeing of high-risk victims and their children who have scored 14 or above positive responses on the Safe Lives Risk Identification Check (RIC) or from professional judgement of the risks to the victim and children.

- 7.2 Information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors. After sharing all relevant information, they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a coordinated action plan.

The primary focus of the MARAC is to safeguard the adult victim. The MARAC will also make links with other agencies to safeguard children and manage the behaviour of the perpetrator. At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim does not attend the meeting but is normally represented by an IDVA who speaks on their behalf.

The aims of MARAC are to:

- Safeguard victims.
- Make links with other public protection arrangements in relation to children, perpetrators and vulnerable adults.
- Safeguard agency staff.
- Address the behaviour of the perpetrator.

This is achieved by a multi-agency, risk focused, information sharing, and action planning process developed at the MARAC meeting. This is facilitated by the MARAC Chair who ensures that cases are usually managed within 20 minutes.

7.3 What Information to Share at MARAC?

Only proportionate, accurate information that is directly relevant to the safety of the victim should be shared by the attending agencies. This falls into four main categories:

- Basic demographic information including any pseudonyms used and whether there are any children and their ages.
- Information on key risk factors and any relevant information about the victim and any children; also, the alleged perpetrator's circumstances and their behaviour and including where appropriate, professional opinion.
- Any relevant history of domestic violence or other associated behaviour (child abuse, sexual assault) by the perpetrator or victim.
- The 'views' of the victim or the perpetrator. Typically, the IDVA or another support agency should represent the perspective of the victim on the risks s/he faces, and how best to address them.

Information sharing at MARAC is strictly limited to the aims of the meeting.

7.4 After the Meeting

Invitations to MARAC meetings will be sent to Care Co-ordinators if it is identified by the Safeguarding Team that a person to be discussed at MARAC is open to our services (this includes the victim, perpetrator and children). Information will be shared by the Safeguarding Team on an electronic platform for open and closed cases.

It is important that practitioners document the invite and the outcome of the meeting. This is to inform that there has been a referral to MARAC, which not only provides awareness from a therapeutic point of view but will identify if there is any ongoing risk to them, professionals and the public. It may be appropriate to stop any home visits if the risk is high. Risk assessments should be updated accordingly.

MARAC information cannot be shared with the alleged perpetrator of abuse and cannot be disclosed under any circumstance.

Careful consideration should be given not to record confidential information about other parties' i.e., detailed criminal history of partner.

- 7.5 It is the responsibility for practitioners to update any Care Plan or Risk Assessments in relation to the information they have received following MARAC. For example, a victim may be offered further appointment opportunities if they have previously not attended.
- 7.6 Practitioners who identify or receive a disclosure of domestic abuse can access the Safe Lives RIC on Appendix 1 or by contacting the trust safeguarding team.

8. Domestic Homicide Reviews

- 8.1 A Domestic Homicide Review (DHR) is defined as:

A review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:-

- a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- a member of the same household as the victim.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for Coroners and the criminal courts.

- 8.2 A duty to undertake Domestic Homicide Reviews was implemented by the Home Office through statutory guidance in April 2011. The 'Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews' was then revised in August 2013. This states that a person establishing or participating in a Domestic Homicide Review must have regard to the statutory guidance and if they decide to depart from it, have clear reasons for doing so.

This is reflected locally by the commitment of statutory and voluntary organisations, of which NSCHT is one, across Staffordshire and Stoke-on-Trent to learning lessons from the tragic deaths of victims of domestic violence and abuse. This is in order to improve the way in which organisations and practitioners can individually and collectively develop support mechanisms, procedures, resources and interventions with the aim of avoiding future incidents of domestic homicide and violence.

NSCHT is represented at DHR by a senior manager, usually the Safeguarding Lead. Clinical staff may need to be interviewed by a senior representative of the Trust as part of the information gathering and report writing process.

- 8.4 DHRs generally conclude with recommendations for partner agencies involved. These recommendations will be reviewed by the relevant directorates within NSCHT and implemented where applicable. There will be oversight of each individual DHR within the NSCHT Safeguarding Group.

9. Information Sharing

- 9.1 The Data Protection Act (2018) has been amended in line with General Data Protection Regulations (2016)

“Does not prohibit the collection and sharing of personal information. It does, however, provide a framework to ensure that personal information about a living individual is shared appropriately. In particular, the Act balances the right of the information subject (the individual whom the information is about) and the need to share information about them”.

- 9.2 Information relating to domestic abuse is likely to be very sensitive and should be kept confidential. Information should only be shared where there is a legal basis, examples could include: sharing information with the police for the prevention or detection of crime, where an individual is a risk of serious harm. Staff should always ensure information is shared in line with information governance policies and if in doubt seek advice.
- 9.3 If you believe that an individual may be a victim of neglect or physical, sexual or emotional abuse, and that they lack capacity to consent to disclosure, staff must give information promptly to an appropriate responsible person or authority (NSCHT Safeguarding Team). If, for any reason, you believe that disclosure of information is not in the best interests of a neglected or abused individual, you should discuss the issues with an experienced colleague. Your decision to disclose or not discloses information should be documented in the patient's record alongside what you have shared. If you have not shared information your justification for this should also be recorded. You should be prepared to justify your decision.
- 9.4 Sharing information should be used to increase a victim's safety and that of their children; however, only information that is relevant should be shared. Consent to share information should be gained from the victim when disclosing this must be documented. In the event it is not possible to gain consent from the victim but sharing would be in their best interest's advice must be sought from the Safeguarding Team, or Information Governance.
- 9.5 The Striking the Balance, Practical Guidance on the Application of Caldicott Guardian Principles to Domestic Abuse and MARAC (Department of Health 2012) aids to assist those involved in sharing information between agencies in relation to Domestic Abuse.

The Caldicott Principles are as follows:

- Justify the purpose(s).
- Don't use personal confidential unless it is absolutely necessary.
- Use the minimum necessary personal confidential data.
- Access to personal confidential data should be on a strict need-to-know basis.
- Everyone with access to personal confidential data should be aware of their responsibilities.
- Comply with the law.
- The duty to share information can be as important as the duty to protect patient confidentiality.

9.6 Fears of sharing information must not stand in the way of the need to safeguard and promote the welfare of children, young people, and adults at risk of abuse and neglect. Sharing information between organisations can be essential for effective identification, assessment, risk management and service provision.

10 Support and Supervision for Staff

- 10.1 Practitioners supporting clients who are suffering from domestic abuse should have safeguarding supervision to support them in delivering good practice. Safeguarding supervision is a requirement for staff and is delivered by the Safeguarding Team in accordance with the NSCHT Safeguarding Supervision Framework.
- 10.2 Practitioners working with adults and or children who require supervision or advice regarding domestic abuse and/or safeguarding children should contact the Safeguarding Team.
- 10.3 Staff who have experienced domestic abuse in their own lives, currently or historically, may obtain advice and/or support from the Safeguarding Support Team.

11. Safety Planning

- 11.1 Initial safety planning to protect the victim and children following disclosure:
- Encourage to ring 999 in an emergency.
 - Plan where to go in an emergency and have an alternative route.
 - If an argument occurs move to an area of lower risk (room with an outside exit).
 - Plan escape routes and have window / door keys readily available.
 - Put handbags/ keys / money in a safe accessible place or with someone they can trust.
 - Let friends / neighbours that are trusted know about the situation and ask them to call the Police if they hear suspicious noises.
 - Teach the children, if and when appropriate, to call for help. They should never use a phone in front of the abuser as this may endanger them further.
 - Create code words or a phrase for friends and children so that they know when to call for help and or leave danger areas.
 - Pack a survival kit (keep safe with a trusted friend or relative) if need to leave in a hurry. This should include a change of clothes, extra house / car keys,

money, birth certificates, marriage certificates, passports, any legal documents (e.g., immigration status), medication and any documents related to the children.

- Choose a place to go – talk to a close trusted friend or relative about the abuse and discuss staying with them in an emergency.
- Call in a police station for help if necessary.
- Keep 24-hour helplines easily accessible.
- Encourage to make careful notes about what is happening including times, dates, any professionals seen, and any injuries received. These notes can assist in accessing legal and welfare rights should they ever be needed.

12. Training

- 12.1 Online Domestic Abuse Awareness training is available on LMS. This is essential to role training for those who have direct contact with patients and service users but can be accessed by anyone in the trust.
- 12.2 NICE Guidance ph50: Domestic Abuse – Multiagency Working (2014)¹³, and the NICE Quality Standard QS116 (2016)¹⁰ outline the recommendations for training for different professional groups.

Process for Managing Domestic Abuse

Ask

Frame the topic first then ask a direct question. Examples:

Framing: *"As violence in the home is so common, we now ask contacts about it routinely"*

Direct Question: *"Are you in a relationship with someone who hurts or threatens you?"*
"Did someone cause these injuries to you?"

Action

Be aware of your local domestic violence agency, how to contact local independent Domestic violence advisor (IDVA), offer leaflet and suggest referral.

Action any local safeguarding procedures.

Assess

(Use SafeLives Risk Identification Checklist)

Assess contacts safety:

"Is your partner here with you?"

"Where are the children?"

"Do you have any immediate concerns?"

"Do you have a place of safety?"

Document

Consider safety and confidentiality when recording information in patient notes.

Be aware of appropriate Read-codes to use.

Medical records can be used by survivors in future criminal justice proceedings and may be called on to be used in MARAC.

Validate

Validate what's happening and send important messages to the contact:



"You are not alone".




"You are not to blame for what is happening to you".



"You do not deserve to be treated in this way."




Appendix 2





Domestic Abuse Services Locally and Nationally



<u>Service</u>	<u>Opening Hours</u>	<u>Contact</u>	<u>What is Offered</u>
Forced Marriage Unit 		<p>Telephone 020 7008 0151</p> <p>Email fm@fcdo.gov.uk</p> <p>Website https://www.gov.uk/guidance/forced-marriage#contact</p>	<p>The Forced Marriage Unit (FMU) is a joint Foreign, Commonwealth and Development Office (FCDO) and Home Office unit which leads on the government's forced marriage policy, outreach and casework. It operates in the UK where support is provided and also overseas where consular assistance is provided to British nationals (including dual nationals)</p> <p>A public helpline to provide advice and support to:</p> <ul style="list-style-type: none"> - Victims and potential victims of forced marriage - Professionals dealing with cases - Provide assistance when an unwanted spouse is due to move to the UK - <p>Assistance in repatriation of victims held against their will overseas where possible</p>
Galop (Previously Broken Rainbow) 	<p>Helpline Mon, Tue, Fri 10:00-5:00pm Wed and Thur 10:00-08:00pm</p> <p>Webchat Wed and Thur 5:00-8:00pm</p>	<p>Helpline 0800 999 5428</p> <p>Webchat via main website https://galop.org.uk</p>	<p>Support for individuals of the LGBT+ community who are victims of sexual abuse, sexual violence, hate crime, 'conversion therapies', honour-based abuse, forced marriage, and other forms of abuse</p>



<p>Glow Domestic Abuse Services</p> 	<p>Domestic Abuse Helping 9:00-5:00pm Monday to Friday</p> <p>Safe Accommodation Services 24/7</p>	<p>Domestic Abuse Helpline 0330 0945 559</p> <p>Stoke-On-Trent Safe Accommodation 01782 817055</p> <p>Newcastle-Under-Lyme Safe Accommodation 01782 713737</p> <p>Staffordshire Moorlands Safe Accommodation 01538 267093</p> <p>Website: https://findtheglow.org.uk/our-services/</p>	<p>Safe accommodation services (with specialist DA support for both victims and their children)</p> <p>Healthy relationship programmes in schools</p> <p>DA Recovery group programmes</p> <p>DA Housing Advocacy</p> <p>Perpetrator behavioural change programme (NEWCASTLE-UNDER-LYME, STAFFORDSHIRE MOORLANDS AND STOKE-ON-TRENT ONLY)</p> <p>1:1 CYP support (referral from Newcastle under Lyme schools; NEWCASTLE-UNDER-LYME ONLY)</p>
<p>Grange Park</p> 		<p>Helpline 0800 970 0372</p> <p>Website: https://grangepark.org.uk</p>	<p>Located in Stoke-On-Trent providing forensic, counselling, and aftercare services to people who have experienced rape or sexual assault whether this is recent or non-recent</p> <p>Crisis worker support, forensic medical examination, emergency contraception, pregnancy testing, sexual health screening, referrals to other supporting agencies</p>
<p>Karma Nirvana</p> 	<p>Helpline Mon-Fri 9:00-5:00pm</p>	<p>Helpline 0800 5999 247</p> <p>Online form, request a call back https://karmanirvana.org.uk/about/contact-us/</p> <p>Website: https://karmanirvana.org.uk</p>	<p>Confidential and free service for victims of Honour Based Abuse including but not limited to: child marriage, forced marriage, FGM</p> <p>Training frontline professionals about Honour Based Abuse so that they can respond to victims and save lives</p>



<p>National Centre for Domestic Violence</p>  <p>National Centre for Domestic Violence A Community Interest Company</p> <p>Violence</p>		<p>Helpline 0800 970 2070</p> <p>Text NCDV to 60777</p> <p>Email office@ncdv.org.uk</p> <p>Website https://www.ncdv.org.uk</p>	<p>Support survivors of domestic violence and abuse obtain protection against an abuser</p> <p>Free, fast and effective support to survivors of domestic violence and abuse, helping individuals obtain injunctions from their local county court</p> <p>A free service regardless of financial circumstances, sexual orientation, race, gender, age, political religious belief or otherwise</p> <p>Free injunction service, injunctions often within 24 hours, legal aid, emergency non-molestation and occupation orders, direct links with local authorities, health centres, refuges and women's aid centres</p>
<p>New Era Domestic Abuse Service (for victims)</p> 	<p>24/7, 365 days a year confidential telephone helpline</p> <p>24/7, 365 days a year Live Webchat facility</p>	<p>Free, confidential helpline and live webchat facility</p> <p>Call 0300 303 3778</p> <p>Website: www.new-era.uk</p> <p>Agency Referrals: New-era@victimsupport.cjsm.net</p> <p>Adult general enquiries: new-era@victimsupport.org.uk</p> <p>Children and Young People enquiries: new-eraCYP@victim support.org.uk</p>	<p>Free confidential support for victims aged 4 years and above.</p> <p>Prioritised safety and recovery support, whether incidents are reported to the police or not.</p> <p>One to one and group support, advocacy, assistance with non-molestation and other orders, housing, help with access to refuge and emergency accommodation with specialist advisors for LGBTQ+, BAMER and male victims.</p> <p>All levels of risk supported from standard to high risk (MARAC).</p> <p>Training for communities, businesses and professionals through</p>


			Eventbrite. Domestic Abuse in the Workplace Training.
New Era Domestic Abuse Service (for perpetrators) 	9:00-5:00pm Monday to Friday	Free confidential helpline for those wishing to change their abusive behaviour 01785 904770 Agency Referrals: New-era@justice.gov.uk General enquiries: new-era@justice.gov.uk Website: www.new-era.uk	Free confidential support for Perpetrators of Domestic Abuse wishing to change their abusive behaviour. One-to-one and group work support for Adults and Children via voluntary participation through accredited programmes of intervention between 10 sessions and 30 sessions weekly.
Pathway Domestic Abuse Vitcmin Services 	24/7 365 days a year	Free and confidential 24 hour helpline 01543 676800 Email between 08:30 and 15:00 Mon-Fri talktoeve@pathway-project.co.uk Professional enquiries: wendyd@pathway-project.co.uk (Head of Operations) or jackieh@pathway-project.co.uk (Refuge Manager) Website: https://www.pathway-project.co.uk	Free confidential support for victims of domestic and sexual abuse via one to one and group support. Specialist economic abuse support, peer mentoring, counselling services and legal clinic. ISVA, CHISVA and Young Women and Girls Worker. Refuge accommodation (one refuge staffed 24/7). Outreach support for male victims. (LICHFIELD AND TAMWORTH ONLY)
Refuge 	Helpline 24/7 Web chat Mon-Fri 03:00-10:00pm	Helpline 0808 2000 247 Live chat available via www.nationaldahelpline.org.k Website https://www.refuge.org.uk	Supporting women and children who have been a victim of domestic violence Provide emergency/temporary accommodation for women and children Access to specialist services to help victims' access safety

<p>Refuge and National Domestic Violence Helpline</p>  <p>For women and children. Against domestic violence.</p>	<p>Helpline 24/7</p> <p>Live Chat Mon-Fri 3:00- 10:00pm</p> <p>BSL Helpline Mon-Fri 10:00- 6:00pm</p>	<p>Helpline 0808 2000 247</p> <p>Live Chat and BSL Helpline via main website: https://www.nationaldahelpline.org.uk/</p>	<p>The helpline can help women and children find a refuge vacancy</p> <p>Support in accessing specialist services in your community</p>
<p>Respect (Domestic abuse perpetrators)</p> 	<p>Helpline Mon-Thurs 10:00- 8:00pm Friday 10:00- 5:00pm</p> <p>Email Mon-Friday 9:00- 8:00pm</p> <p>Webchat Thursday 2:00- 4:00pm</p>	<p>Helpline 0808 8024 040</p> <p>Email Support info@respectphoneline.org.uk</p> <p>Webchat Support via main website: https://respectphoneline.org.uk/</p>	<p>A confidential helping, email and webchat service for domestic abuse perpetrators and those supporting them</p> <p>Support men and women who are using abuse in relationships, same-sex or heterosexual from anywhere in the UK</p> <p>Provide information around domestic abuse intervention programmes where available</p>
<p>Respect Men's Advice Line (Male victims of domestic abuse)</p> 	<p>Helpline Mon-Fri 10:00- 8:00pm</p> <p>Email Mon-Fri 09:00- 8:00pm</p> <p>Webchat Wed 10- 11:30am And 2:30- 4:00pm</p>	<p>Helpline 0808 8010 327</p> <p>Email info@mensadviceline.org.uk</p> <p>Webchat via main website https://mensadviceline.org.uk/contact-us/</p>	<p>Support for male victims of domestic abuse and those supporting them</p> <p>A free and confidential service</p> <p>Advice, emotional support, and information on other services to help keep them and/or their children safe</p>
<p>SARAC</p> 	<p>24 hour message line, responses usually within 24 hours</p>	<p>Helpline 01283 517185</p> <p>Online referrals via main website https://sarac.org.uk</p>	<p>Sexual abuse rape advice centre for individuals at risk of, or have experienced, sexual violence and/or rape at any time in their lives</p> <p>Free independent and one-to-one emotional</p>

	Online referrals only accessed during office hours Mon-Fri 09:00-5:00		support, information and advice for everyone over the age of 11 BURTON, LICHFIELD, TAMWORTH, UTTOXETER, SWADLINCOTE and SOUTH DERBYSHIRE
Savana 	Mon-Fri 09:00-05:00	Helpline 01782 433204 Email: info@savana.org.uk Website: https://www.savana.org.uk	Providing free counselling and support services for anyone aged 4+ who have been affected by sexual violence and abuse A dedicated digital youth support service alongside in person support in schools and youth groups Training courses for groups, individuals and professional organisations STOKE-ON-TRENT CATCHMENT AREA
Southall Black Sisters 	Helpline Mon-Fri 09:00-05:00pm (closed for lunch 12:30-1:30pm)	Helpline 0208 571 9595 Email info@southallblacksisters.co.uk Website https://southallblacksisters.org.uk	A service established to meet the needs of Black (Asian and African-Caribbean) women experiencing domestic and gender related violence Empowering individuals to gain more control over their lives, live without fear of violence and assert their human rights to justice, equality and freedom Offer specialist advice, information, casework, advocacy, counselling and self-help support services in several languages
Staffordshire Victim's Gateway	Monday to Saturday 09:30-04:30pm Closed on Sunday	Telephone 0330 0881 339 Email help@staffsvictimsgateway.org.uk Self-refer online	The Victim Gateway offers telephone and one-to-one support to help victims cope and recover from the impact of crime

	<p>Bank Holiday Hours 10:00-3:00pm</p>	<p>https://staffsvictimsgateway.org.uk/contact-svg/</p> <p>Website: https://staffsvictimsgateway.org.uk/</p>	<p>The Contact and Assessment team make contact with individuals who have reported crime to the police by telephone or via letters/email</p> <p>Provide information and guidance around what the individual may need as a victim of crime, alongside emotional support and onward referrals to other services if in agreement</p> <p>Create support plans designed to help build resilience, aid recovery, and help in navigating the Criminal Justice process</p>
<p>Staffordshire Women's Aid Victim Services</p> 	<p>24/7, 365 days a year</p>	<p>Helpline 0300 330 5959</p> <p>Make a referral online referrals@staffordshirewomensaid.org</p> <p>For general enquiries please email enquiries@staffordshirewomensaid.org</p> <p>Website: www.staffordshirewomensaid.org</p>	<p>Free, non-judgemental and confidential support for victims of domestic abuse</p> <p>Refuge Accommodation</p> <ul style="list-style-type: none"> • 12 unit refuge staffed 24/7 for women and children • 4 units of dispersed refuge accommodation (for male and female victims) <p>Resettlement Services</p> <p>Therapeutic counselling, for both adults and children, who have experienced domestic abuse</p> <p>Women's Community Services, including Well-Being Service, Legal Advice Clinic, Food and Clothes Bank, support for women to become digitally and financially empowered and support to access training and employment.</p> <p>A range of group work programmes to aid recovery and build self-esteem and skills.</p> <p>A range of CPD accredited training on</p>

			<p>domestic and sexual violence.</p> <p>(CANNOCK, STAFFORD AND SOUTH STAFFORDSHIRE ONLY)</p>
<p>Survive</p> 		<p>Telephone 01270 253179</p> <p>Email survive156@yahoo.com</p> <p>Website https://survive-abuse.co.uk</p>	<p>Established to relieve the mental, physical and spiritual suffering caused by all types of abuse</p> <p>Specialise in sexual abuse including rape and incest</p> <p>Provide education and training for those working to alleviate the effects of this abuse</p> <p>Art therapy for individuals struggling with anxiety, frustration and/or past trauma</p> <p>Counselling for survivors (14+ years) of childhood sexual abuse, rape, incest and domestic violence</p> <p>CHESHIRE COUNTY AND SOME AREAS OF NORTH STAFFORDSHIRE ONLY</p>
<p>Victim Support</p> 	<p>Helpline 24/7</p> <p>Live chat 24/7</p> <p>Online form response within 3 working days</p>	<p>Helpline 0808 1689 111</p> <p>Online form available via main website</p> <p>Live chat available via main website</p> <p>https://www.victimsupport.org.uk</p>	<p>Support for individuals affected by crime, not only those who have experienced it directly but also their friends, family and any other people involved</p> <p>Free and confidential support 24/7</p> <p>Services include: information and advice, emotional and practical help (immediate and longer term), advocacy, peer support and group work, restorative justice, support around personal safety, help in navigating</p>

			the criminal justice system
Womens Aid 	Web chat Mon-Fri 08:00-06:00pm Sat and Sun 10:00-6:00pm Email responses within 5 working days	Email helpline@womensaid.org.uk Web chat available through main website https://www.womensaid.org.uk/	Specialist support services for women and children experiencing domestic abuse

Appendix 3

Agency MARAC risk assessment & referral form

Risk Identification Checklist for use by IDVA's and other agencies for MARAC case identification when domestic abuse, 'honour' - based violence and / or stalking are disclosed

There are four ways in which an agency can identify a high risk victim of domestic abuse for MARAC. The referral types are:

- A CAADA '**RIC (Risk Identification Checklist) assessment**'. Submitted to MARAC when completed with a score of 14 positive responses.
- The '**Escalation**' assessment is used when the number of incidents being discussed or reported is increasing, within a 12 month period. This is used to identify cases where there is not a positive identification of a majority of the risk factors on the list, but where abuse appears to be escalating and where it is appropriate to assess the situation more fully by sharing information at MARAC.
- A '**Professional opinion**' assessment will be based upon the given facts that are being presented by the victim and the level of professional concern is high. There will be occasions where the particular context of a case gives rise to serious concerns even if the victim has been unable to disclose the information that might highlight their risk more clearly. This could reflect extreme levels of fear, cultural barriers to disclosure, immigration issues or language barriers particularly in cases of 'honour'-based violence. This judgement would be based on the professional's experience and/or the victim's perception of their risk.
- A '**Repeat case**' is defined as a case which has been previously referred to MARAC and at some point in the twelve months from the date of the last referral and a further incident has been identified. Any agency may identify this further incident (regardless of whether it has been reported to the police). A further incident includes any one of the following types of behaviour, which, if reported to the police, would constitute criminal behaviour:
 - Violence or threats of violence to the victim (including threats against property), or
 - A pattern of stalking or harassment, or
 - Rape or sexual abuse

Where a repeat victim is identified by any MARAC agency, that agency should refer the case back to the MARAC, regardless of whether the behaviour experienced by the victim meets the local referral threshold of visible high risk, escalation or professional judgement. To identify repeat victims of domestic abuse regardless of to whom it is reported, all MARAC agencies should have the capacity to 'flag and tag' their files following the latest referral so that they are aware if a service user/client experiences a repeat incident.

Risk Identification Checklist for use by IDVA's and other non-police agencies for MARAC case identification when domestic abuse, 'honour' - based violence and / or stalking are disclosed

Victims name: Agency case ref. number:

Please explain that the purpose of asking these questions is for the safety and protection of the individual concerned.	Yes	No	Don't	
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Tick the box if the factor is present <input checked="" type="checkbox"/> . Please use the comment box at the end of the form to expand on any answer. It is assumed that your main source of information is the victim. If this is <u>not the case</u> please indicate in the right hand column	(tick)	(tick)	Know (tick)	State source of info if not the victim e.g. police officer
1. Has the current incident resulted in injury? (Please state what and whether this is the first injury.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Are you very frightened? Comment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. What are you afraid of? Is it further injury or violence? (Please give an indication of what you think perpetrator might do and to whom, including children) Comment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Do you feel isolated from family/friends i.e. does perpetrator try to stop you from seeing friends/family/doctor or others? Comment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Are you feeling depressed or having suicidal thoughts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Have you separated or tried to separate from perpetrator within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Is there conflict over child contact?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Does perpetrator constantly text, call, contact, follow, stalk or harass you? (Please expand to identify what and whether you believe that this is done deliberately to intimidate you? Consider the context and behaviour of what is being done.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Are you pregnant or have you recently had a baby? (within the last 18 months)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Is the abuse happening more often?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Is the abuse getting worse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Does perpetrator try to control everything you do and/or are they excessively jealous? (In terms of relationships, who you see, being 'policed at home', telling you what to wear for example. Consider 'honour'-based violence and specify behaviour.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Has perpetrator ever used weapons or objects to hurt you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Has perpetrator ever threatened to kill you or someone else and you believed them? (If yes, tick who.) You <input type="checkbox"/> Children <input type="checkbox"/> Other (please specify) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

15. Has perpetrator ever attempted to: Strangle <input type="checkbox"/> Choke <input type="checkbox"/> Suffocate <input type="checkbox"/> Drown <input type="checkbox"/> you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Does perpetrator do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? (If someone else, specify who.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Is there any other person who has threatened you or who you are afraid of? (If yes, please specify whom and why. Consider extended family if HBV.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Do you know if perpetrator has hurt anyone else? (Please specify whom including the children, siblings or elderly relatives. Consider HBV.) Children <input type="checkbox"/> Another family member <input type="checkbox"/> Someone from a previous relationship <input type="checkbox"/> Other (please specify) <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Has perpetrator ever mistreated an animal or the family pet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Are there any financial issues? For example, are you dependent on perpetrator for money/have they recently lost their job/other financial issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Has perpetrator had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life? (If yes, please specify which and give relevant details if known.) Drugs <input type="checkbox"/> Alcohol <input type="checkbox"/> Mental Health <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Has perpetrator ever threatened or attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. Has perpetrator ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children? (You may wish to consider this in relation to an ex-partner of the perpetrator if relevant.) Bail conditions <input type="checkbox"/> Non Molestation/Occupation Order <input type="checkbox"/> Child Contact arrangements <input type="checkbox"/> Forced Marriage Protection Order <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Do you know if perpetrator has ever been in trouble with the police or has a criminal history? (If yes, please specify.) DV <input type="checkbox"/> Sexual violence <input type="checkbox"/> Other violence <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<div>Total 'Yes' responses</div>				

<p>For consideration by professional: Is there any other relevant information (from victim or professional) which may increase risk levels? Consider victim's situation in relation to disability, substance misuse, mental health issues, cultural/language barriers, 'honour'- based systems and minimisation. Are they willing to engage with your service? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Describe:</p> <p>Consider abuser's occupation/interests-could this give them unique access to weapons? Describe:</p>	
<p>What are the victim's greatest priorities to address their safety?</p>	
<p>Do you believe that there are reasonable grounds for referring this case to MARAC? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, have you made a referral? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Signed: _____ Date: _____</p>	
<p>Do you believe that there are risks facing the children in the family? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please confirm if you have made a referral to safeguard the children: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Date referral made:</p> <p>Agency referral made to:</p> <p>Case worker name:</p>	
<p>Referring practitioner:</p> <p>Signature:</p>	<p>Date:</p>

MARAC Referral Form

Please complete this referral form, once completed please email to the relevant Harm Reduction Hub

Cannock – HRH.Cannock@staffordshire.police.uk
 East Staffs – HRH.Burton@staffordshire.police.uk
 Lichfield – HRH.Lichfield@staffordshire.police.uk
 Moorlands – HRH.Moorlands@staffordshire.police.uk
 Newcastle – HRH.Newcastle@staffordshire.police.uk
 South Staffs – HRH.SouthStaffs@staffordshire.police.uk
 Stafford – HRH.Stafford@staffordshire.police.uk
 Stoke North – HRH.StokeNorth@staffordshire.police.uk
 Stoke South – HRH.StokeSouth@staffordshire.police.uk
 Tamworth – HRH.Tamworth@staffordshire.police.uk

<p>Referring agency: Address:</p>	<p>Referring practitioner:</p>
---------------------------------------	--------------------------------

Tel:	Email:
------	--------

Date of incident:	Date of RIC:	Date referral made:
RIC referral: <input type="checkbox"/>	Professional referral: <input type="checkbox"/>	Escalation referral: <input type="checkbox"/>
Case Number:	Repeat MARAC*:	Date of last MARAC:

Victim details

Name:	DOB: Between 16-17 years old? Yes/No:	Ethnicity: BME: LGBT: Disabled: (Mark N/A if not applicable)
Occupation:		
Address:		Post Code:
Home tel:	Mobile:	

Perpetrator details

Name:	DOB: Between 16-17 years old? Yes/No:	Ethnicity:
Occupation:		
Address:		Post Code:
Home tel:	Mobile:	

Children's details

Child 1:	DOB:	Ethnicity:
Living with Victim: Yes <input type="checkbox"/> No <input type="checkbox"/>	Living with Perpetrator: Yes <input type="checkbox"/> No <input type="checkbox"/>	

Address:		Post Code:
Child 2:	DOB:	Ethnicity:
Living with Victim: Yes <input type="checkbox"/> No <input type="checkbox"/>	Living with Perpetrator: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Address:		Post Code:
Child 3:	DOB:	Ethnicity:
Living with Victim: Yes <input type="checkbox"/> No <input type="checkbox"/>	Living with Perpetrator: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Address:		Post Code:
Child 4:	DOB:	Ethnicity:
Living with Victim: Yes <input type="checkbox"/> No <input type="checkbox"/>	Living with Perpetrator: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Address:		Post Code:
Additional Details		

Reasons for referral <small>(relevant to current case)</small>
Background and risk issues

Is victim aware of MARAC referral? Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes have they given their consent? <input type="checkbox"/>
If victim is aware of MARAC referral and it's safe to contact them please consider the following questions:
Who is the victim afraid of?

Who does the victim believe is safe to talk to?

Who does the victim believe it is not safe to talk to?

Ensure it is safe to ask:

- Consider the environment
- Is it conducive to ask?
- Is it safe to ask?
- Never ask in the presence of another family member, friend, or children over the age of 2
- Create the opportunity to ask the question
- Use an appropriate professional interpreter if required, never use a family member.

Domestic Abuse Suspected

Is it safe to explore this further?

No

Create/Plan an opportunity to ask

Yes

ASK

Is the response that there is abuse?

No

Ongoing monitoring

Yes

VALIDATE

ASSESS risk by using the SafeLives RIC

Are any risks identified?
Including to children
consider child
safeguarding referral

No

Yes- Refer to
Safeguarding

Refer to MARAC

Assessment score above 14 or professional
judgement of high risk or escalation of
incidents

Assessment score below 14

OR

Develop a
safety plan

Consent gained
to refer for
support?

Yes

Refer to Local Domestic Abuse service- New Era

No

Ongoing
monitoring

NSCHT Safeguarding Team and Support for Staff
01782 441644

Document level: Trustwide
Code: 1.87
Issue number: _____

Sexual Safety and Responding to Sexual Violence Policy

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

Type of document	Policy
Target audience	All individuals employed by the Trust including contractors, voluntary workers, students, locums, agency, and bank staff.
Document purpose	To ensure safe working systems are in place to protect service users, relatives, staff, and the public.

Approving meeting	Quality Committee Trust Board	Meeting date	3 rd November 2022 10 th November 2022
Implementation date	30 th November 2022	Review date	30 th November 2025

Trust documents to be read in conjunction with	
	1.70 Managing Safeguarding Allegations Against Staff Policy. 4.01 Safeguarding Children and Young People Policy. 1.89 Safeguarding Adults at Risk Policy. 3.09 Freedom to Speak Up (FTSU) Policy

Document change history		Version	Date
What is different?	Added reference to British Psychological Society Guidance and to Trust Sexual Safety Patient Leaflet.	V2	14/4/2020
	Major changes.	V3	17/09/2022
Appendices / electronic forms			
What is the impact of change?	Improved access to other sexual safety tools.		

Training requirements	Safeguarding Children & Adults Level 1&2 is mandatory training for all staff. Domestic Abuse and Sexual Violence Training is provided for all appropriately identified staff. Awareness of this policy and the roles and responsibilities of individual staff groups is made explicit during this training.
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Document consultation	
Directorates	
Corporate services	
External agencies	

Financial resource implications	
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External references
<ol style="list-style-type: none"> 1. Government's Mandate to NHS England for 2018-19, Department of Health and Social Care (2018). 2. Ending Violence against Women and Girls Strategy 2016-2020 HM Government (2016). 3. Strategic Direction for Sexual Assault and Abuse Services; Lifelong care for victims and survivors: 2018 – 2023.NHS England. (2018). 4. The Equality Act. Her Majesty's Stationery Office. (2010). 5. World Report on Violence and Health. World Health Organisation. (2002). 6. Crown Prosecution Service, Department of Health and Home Office. Provision of therapy for child witnesses prior to a criminal trial: practice guidance. Crown Prosecution Service (2001). 7. Crown Prosecution Service, Department of Health and Home Office. Provision of therapy for vulnerable or intimidated witnesses prior to a criminal trial: practice guidance. Home Office Communications Directorate. (2002). 8. New South Wales Health. Sexual Safety – Responsibilities & Minimum Requirements for Mental Health Services. New South Wales Government. (2013). 9. British Psychological Society. Capacity to Consent to Sexual Relations. The British Psychological Society. (2019). 10. Domestic Abuse Act (2021).

Monitoring compliance with the processes outlined within this document	This will be monitored via the Safeguarding Group, Clinical Safety Improvement Group and the Weekly Incident Group.
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Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Less favourable / More favourable / Mixed impact
Does this document affect one or more group(s) less or more favourably than another (see list)?		
– Age (e.g. consider impact on younger people/ older people)	No	
– Disability (remember to consider physical, mental and sensory impairments)	No	
– Sex/Gender (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– Gender identity and gender reassignment (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– Race / ethnicity / ethnic communities / cultural groups (include those with foreign language needs, including European countries, Roma/travelling	No	

<p>communities)</p> <ul style="list-style-type: none"> – Pregnancy and maternity, including adoption (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples) – Sexual Orientation (impact on people who identify as lesbian, gay or bi – whether stated as ‘out’ or not) – Marriage and/or Civil Partnership (including heterosexual and same sex marriage) – Religion and/or Belief (includes those with religion and /or belief and those with none) – Other equality groups? (May include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups) 	<p>No</p> <p>No</p> <p>No</p> <p>No</p>	
<p>If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.</p>		
<p>Whilst the policy does not discriminate against any particular group additional consideration has been given to the additional complexities faced by individuals from some minority groups and increased complications of a disclosure of experiencing sexual violence also meaning a disclosure of sexual orientation, gender identity or gender reassignment for some individuals. However, the compassionate response, support and signposting to specialist services should be of the same standard regardless of the aforementioned issues.</p>		
<p>If you have identified potential negative impact:</p> <ul style="list-style-type: none"> - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? <p>Can the impact be reduced by taking different action?</p>		
<p>N/A</p>		
<p>Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?</p>	<p>No</p>	
<p>If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason</p>	<p>N/A</p>	
<p>N/A</p>		
<p>Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact.</p>		
<p>For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk</p>		
<p>Was a full impact assessment required?</p>	<p>No</p>	
<p>What is the level of impact?</p>	<p>Low</p>	

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1. Introduction/Background

Sexual safety is defined as the recognition, maintenance and mutual respect of the physical, psychological, emotional and spiritual boundaries between people. The Trust supports the view that all service users have the right to feel safe whilst in hospital and NHS Trusts should be helping to identify sexual harassment, violence and abuse earlier and supporting victims to get their lives back sooner, as defined in the Government's Mandate to NHS England for 2018-19. To support this the Trust has produced a sexual safety leaflet which is available in clinical areas.

As such the Trust recognises that any form of sexual harassment or violence is a criminal act which adversely affects the health and wellbeing of individuals. It occurs across society, regardless of age, gender, race, sexuality, wealth and geography. NHS organisations should be working towards the recommendations of the Care Quality Commission's report Sexual Safety on Mental Health Wards (2018) and therefore this policy reflects these recommendations.

People with mental health conditions have just as much right as everyone else to have safe and fulfilling sexual relationships. However, people affected by mental ill health can at times act in disinhibited ways or lack the mental capacity to make sound decisions about relationships. They may have experienced abuse in the past, contributing to their mental ill health, which might leave them at risk of exploitation from others. These factors make it more likely that people affected by mental ill health may engage in sexual behaviour or make them vulnerable to sexual abuse.

2. Policy Synopsis

The purpose of this policy is to:

- Inform staff of best practice when responding to disclosures of sexual harassment or sexual violence, whether current or historical.
- Improve safety and improve health by recognising sexual safety as a serious issue which has an adverse impact upon the health of individuals, families and communities.
- Increase awareness and understanding of sexual safety across the Trust.
- Ensure that all departments are clear within their roles in tackling and responding to issues surrounding sexual safety.
- Provide support for our staff that are experiencing sexual harassment or sexual violence.
- To ensure that processes are in place to support service users following a disclosure.

3. Definitions

- 3.1 Sexual incidents:** Any behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable or afraid. It also extends to being spoken to using sexualised language or observing other people behaving in a sexually disinhibited manner, including nakedness and exposure. Sexual incidents may also include the unwanted exposure to pornography or child sexual abuse images.

3.2 Sexual safety: Responsibilities & Minimum Requirements for Mental Health Services (2013) defines sexual safety as the respect and maintenance of an individual's physical (including sexual) and psychological boundaries. Core elements of sexual safety in a mental health service include:

- A safe physical environment, including consideration of how the service environment could be improved, including eliminating mixed sex accommodation.
- Recognition of the rights of service users to physical and psychological safety.
- Assessment of the service user's vulnerability or potential to harm others.
- Identification of the service user's past experience of sexual assault or harassment.
- Monitoring of professional boundaries and appropriate mechanism's for reporting concerns.
- Management of sexually disinhibited behaviour and prevention of sexual activity in an inappropriate context or setting.
- Provision of professional development for staff.
- Appropriately responses to sexual assault and harassment.
- Proper reporting, recording and investigation of sexual safety incidents and feeding of root cause analysis into safety improvement processes at an organisational and local level.

For the purposes of this policy sexual safety incidents can be divided into three types of incident; sexual violence and harassment, consensual sexual activity in an inappropriate context/setting and sexually disinhibited behaviour.

Feeling safe from sexual harm means feeling free from being made to feel uncomfortable, frightened, or intimidated in a sexual way by patients or staff.

3.3 Sexual wellbeing: Defined as feeling and being sexually safe in and being free from unwanted sexual activity, sexual harassment, and sexual assault.

3.4 Sexual abuse: this includes rape and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

3.5 Sexual assault: This definition is adapted from The Crown Prosecution Service: 'Is when a person is coerced or physically forced to engage in sexual activity against their will, or when a person (of any gender) touches another person sexually without their consent. Touching can be done with any part of the body or with an object'. Sexual assault does not always involve physical violence, so physical injuries or visible marks may not be seen.

3.6 Sexual consent: Where an individual has the freedom and capacity to agree to sexual activity with other persons. It is important to note that individuals with mental health and or a learning disability conditions may appear to consent to activity, but may lack the capacity due to their mental health or learning disability condition.

3.7 Sexual harassment: Sexual harassment includes any behaviour that is characterised by inappropriate sexual remarks, gestures or physical advances which are unwanted and make a person feel uncomfortable, intimidated or degrade their dignity. Verbal and non-verbal sexual gestures or behaviours are categorised as sexual harassment (including staring, leering, and suggestive comments/jokes).

These unwanted behaviours may only happen once or be an ongoing series of events. Sexual harassment also includes exposure to body parts and/or self-stimulation and exposure to unwanted online sexual activity (use of the internet, text, audio, video), and this includes unwelcome sexual advances or unwelcome requests. Sexual harassment may also include unwanted or non-consenting exposure to pornography.

- 3.8 Grooming:** Grooming is a process offenders use to abuse and exploit children. It can happen online and in person. Learning more about grooming can help you spot signs and know what to do if you have concerns. Adults at risk can also experience the process of grooming.
- 3.9 Other:** This category is for sexual incidents where an individual may have witnessed or experienced something of a sexual nature that does not fit in to the categories of sexual harassment or assault, and which made the person feel uncomfortable and/or sexually unsafe.
- 3.10 Sexually Disinhibited Behaviour:** Sexually disinhibited behaviour is the inability to restrain sexual impulses and involves behaviour or talk which is considered inappropriate for the environment. This behaviour may arise for a variety of reasons that may include mental illness or disorder, dementia or the side effects of medication.

Sexually disinhibited behaviour may present itself in one of the following ways:

- An increase in sexual thoughts.
- Engaging in indiscriminate sexual activity.
- Being hypersexual e.g. masturbating in public.
- Sexualised demeanour and general disinhibition.
- Being overly familiar or touching others.
- Wearing overly revealing clothing.
- Removing clothes when not appropriate.

Sexually disinhibited behaviour can be embarrassing, distressing and potentially dangerous for the person exhibiting the behaviour as well as for those that may be exposed to it. It can also negatively impact on existing relationships and be extremely distressing for those that have experienced a prior incident of sexual assault or harassment. For some people being exposed to this behaviour can trigger strong feelings of fear and anxiety. Service users exhibiting this behaviour are also more vulnerable to experiencing sexual assault or harassment and this should be risk assessed and appropriate measures put in place to protect both them and other parties.

These definitions are not exhaustive and any disclosures or behaviours which cause concern should be discussed with the nurse in charge, line manager or the safeguarding team as appropriate.

4. Sexual Safety and Equality

- 4.1** There are a range of equality issues to be considered around sexual safety including consideration of the following:

- Anyone can experience sexual harassment or violence; it can be perpetrated by members of same sex as well as the opposite sex and relates to power and control.
- Due to the gendered cultural differences surrounding sexual violence, it can be difficult for men to disclose that they are victims.
- People who are LGBTQ+ may have concerns relating to the dual disclosure of sexual orientation and the sexual violence or harassment.

This policy aims is to ensure that victims of sexual violence or harassment receive a high standard of care irrespective of age, race, culture, sexuality, religion or ability and equality underpins all its service provision.

Mental health service users can be more vulnerable to sexual violence particularly when they are acutely unwell, for a number of reasons, such as:

- Low self-esteem and confidence.
- Social isolation and loneliness.
- Poor social and communication skills.
- Impaired judgement, due to their mental illness, medication(s) prescribed for their illness or drug and alcohol abuse, or a combination of these.
- Interruption of usual developmental stages due to onset of mental illness combined with limited education regarding relationships, appropriate sexual behaviour and sexual safety.

4.2 There is also evidence to suggest that the prevalence of people with a mental illness who have been exposed to or have experienced personal trauma, including sexual abuse and violence, is high. This highlights the need for greater awareness of the sexual vulnerability of people with a mental illness, and the link between mental health issues and prior sexual assault and violence to be recognised and addressed as part of trauma informed care. Consideration should also be given to the individual's capacity to consent to sexual relations. The British Psychological Society produced guidance in 2019 to support with assessments of capacity specifically relating to sexual activity <https://www.bps.org.uk/news-and-policy/capacity-consent-sexual-relations>.

4.3 In relation to staff, the Trust is committed to ensuring that, as far as is reasonably practicable, the way we treat staff that raise a concern about sexual harassment or violence, or are alleged to perpetrate sexual harassment or violence, does not discriminate against individuals or groups on the grounds of any protected characteristic.

5. Responding to a Disclosure or Suspicion of Sexual Violence or Harassment

5.1 Disclosing an incident of sexual assault or harassment can be a traumatic process, the fear of not being believed is an issue for many who are assaulted and this may be heightened for people with a mental health problem. The stigma that still surrounds mental health problems can result in service user's feeling their experiences are not legitimate. It is therefore important that staff respond to disclosures in an appropriate manner.

5.2 Disclosure is:

- telling another person about an incident of sexual abuse, sexual assault, or sexual harassment, whether the incident is recent, past or ongoing;
- distinct from making a report or allegation (even if sometimes they are one and the same event);
- about support-seeking, while reporting to Police and making allegations are ways of formally bringing the incident to the attention of the criminal justice system.

5.3 In the event of a disclosure the service user should be taken to a quiet and private area. When dealing with a disclosure it is important to try and put the individual at ease. Giving clear and simple messages such as:

- They are not to blame or responsible for what has happened.
- Help is available; you can put them in touch with specialist support services if they want this.
- You are concerned about their wellbeing and safety.
- Telling someone about what is happening is an important step in helping them get support and be safe.
- Explain limits of confidentiality and that if they give details regarding the alleged perpetrator that allow them to be identified such as name, address or date of birth there is a duty to share this with the police if it is identified that children or adults with care and support needs may be at risk.
- Discuss options available to the service user.(See Appendix 2).

In cases where the service user is from a refugee or asylum seeker status consideration should be given to previous experiences, such as previous political persecutions or torture, contributing to a lack of trust in authorities.

Disclosures, where the alleged perpetrator is a Trust employee, must be notified to the relevant manager and managed in accordance with Trust policies (See Managing Safeguarding Allegations Against Staff Policy).

An interpreter should be made available for service users who have experienced a sexual assault and have communication difficulties, such as English as a second language or are deaf.

An assessment of the service user's clinical mental state must be carried out by a senior clinician (in the event they are directly involved in the allegation an alternative clinician should be sought) within 24 hours.

At times a service user may retract the disclosure and this can be for a number of reasons, such as a fear of not being believed or being placed under pressure by the alleged perpetrator. Retraction does not necessarily mean that an incident of sexual assault or harassment did not occur and support should still be offered.

The decision whether or not to inform the police is the victims choice and their decision regarding this should be respected. Exceptions to this are where the service user making the disclosure is aged under 18 years old or where the service user is deemed not to have capacity to make this decision, in the case of lack of capacity the

responsible clinician has a duty of care to act in their best interests.

- 5.4 Following a disclosure it is important that the disclosure is recorded accurately, in the service user's own words including the responses given by the staff member; and discuss with the individual the next steps and choices available to them. If the service user states they do not want the police involved at this time, they may later change their mind and a first disclosure may well become important evidence in any subsequent criminal investigation and trial. Therefore the accurate recording of this disclosure remains vital.

If possible, the member of staff to whom the disclosure is made should establish whether the service user continues to have contact with the alleged perpetrator and if they are aware if the alleged perpetrator has any contact with children. Where the alleged perpetrator can be identified because details such as name, date of birth/age, address etc. are known, and the disclosure relates to childhood sexual abuse this information should be reported to the Police. This should be done without informing and / or gaining consent, in line with Safeguarding procedures.

A service user making a disclosure should be asked if they would like the support of an Independent Sexual Violence Advisor (ISVA). The role of an ISVA is to provide practical support, including but not limited to; support with housing, benefits, education and the criminal justice system including guidance from the point of considering making a report through to any potential Court appearance and beyond. At no point will an ISVA put pressure on an individual to pursue criminal charges or report an offence. (See Appendix 2)

6. Procedure for Reporting Sexual Harassment or Sexual Violence

Any incidents of sexual harassment or sexual violence should be reported to the Nurse in Charge/Ward Manager, who must inform their Senior Manager on call immediately if this has occurred in an inpatient setting. If the disclosure of sexual assault takes place in the community it should be reported to the Team Manager as soon as possible.

The incident must be reported on the electronic incident reporting system and must be submitted as soon as practicable; when assessing the level of severity consideration must be given to the psychological impact of the incident on the victim alongside any physical injuries.

When the service user requests the involvement of the police, they should be contacted immediately; providing the service user's mental state does not preclude this as a relevant action. The police will then arrange for the service user to attend the Sexual Assault Referral Centre (SARC).

If the service user does not want to inform the police, then information should be given to the service user regarding self-referral to the Sexual Assault Referral Centre (SARC). The SARC will provide advice and support, including preservation of evidence in case the individual changes their mind regarding informing the police.

For service users aged 18 years and over there are two referral routes to access the

SARC service, via the police or the self-referral route. For Children and Young People there will be an automatic referral to Children's Social Care and the police and they will co-ordinate accessing the SARC.

Information should be given on local support services the details of which are contained within appendix 2 and a referral made if this is requested by the service user.

A factual, comprehensive record of the disclosure and steps taken should be recorded in the service user's electronic care records. It is important to bear in mind this record may be used as evidence in a subsequent criminal trial.

7. Safeguarding Children and Young People

If during the course of an adult service user's disclosure it becomes apparent that children or young people under the age of 18 years may be at risk a referral for child safeguarding must be made.

If the service user making the disclosure is a child or young person under the age of 18 years a child safeguarding referral must be made.

In both cases a referral is needed so that further enquiries can be made; assessments conducted and appropriate safeguarding action taken. A child protection referral needs to be made in accordance with Trust policy and this should be recorded in the patient's electronic records. An alert should also be placed on the electronic record to ensure other practitioners within the organisation are aware of the referral.

A referral to Children's and Families Social Care can create anxiety and stress for victims. It is important to reassure the individual that Children's and Families Social Care will work with them so that they and any other children at risk can be protected and safe.

8. Safeguarding Adults with Care and Support Needs Who Are at Risk

Sexual abuse is a category of abuse under the Care Act (2014). If a service user is experiencing sexual harassment or sexual violence then an adult safeguarding referral should be completed if the criteria for adult safeguarding are met. The criteria for adult safeguarding as defined by the Care Act (2014) are as follows:

- The adult must have care and support needs (regardless of whether these are being met).
- They must be at risk of or experiencing abuse or neglect.
- As a result of their care and support needs, they are unable to protect themselves from abuse or neglect.

If an adult safeguarding referral is made it needs to be made in accordance with Trust policy and this should be recorded in the patient's electronic records. An alert should also be placed on the electronic record to ensure other practitioners within the organisation are aware of the referral.

9. Provision of Therapy Prior to a Criminal Trial

Concern has long been expressed that witnesses, including vulnerable or intimidated adult witnesses, have been denied therapy pending the outcome of a criminal trial for fear that their evidence could be tainted and the prosecution lost. This fear may conflict with the need to ensure that vulnerable or intimidated adult victims are able to receive, as soon as possible, immediate, and effective treatment to assist their recovery.

Discussions prior to a criminal trial with or between all types of witnesses have been held by the courts in a number of cases to give rise to the potential for:

- Witnesses giving inconsistent accounts of the events in issue in the trial.
- Fabrication, whether deliberate or inadvertent, such as becoming aware of gaps or inconsistencies in their evidence, perhaps when compared with that of others or becoming more convinced, or convincing, in their evidence. The key issue with regard to pre-trial discussions of any kind is the potential effect on the reliability, actual or perceived, of the evidence of the witness and the weight which will be given to in court.

It is recognised that the recovery of the individual must be a priority alongside the criminal prosecution and as a result there are recommendations for pre-trial therapy (PTT) good practice:

- The Crown Prosecution Service (CPS) should be informed of any PTT taking place.
- PTT should begin after the client has given their statement of evidence to the police.
- Detailed factual records of therapy should be kept and made available to the CPS as required.
- PTT should focus on the client's current responses and coping, rather than on the original abuse, utilising person-centred types of therapy to support this kind of 'current' focus.
- The CPS should focus on the welfare of the client, rather than simply on the pending court case.

Further detailed advice and guidance can be sought from the Safeguarding Team.

10. Supporting Staff Experiencing Sexual Violence

The Trust aims to respond sympathetically, effectively, and confidentially to any member of staff who discloses sexually harassment or sexual violence and are committed to supporting our staff. The Trust will work with the member of staff, and where agreed other agencies, to identify what actions can be taken to increase their personal safety as well as address any risks there may be to colleagues. The Trust will not discriminate against anyone who has been subjected to sexual harassment or violence in terms of their existing employment or career development.

Members of staff who experience sexual harassment or sexual violence may choose to disclose, report to or seek support from a staff side representative, a manager, or colleague. Members of staff who receive information from staff about sexual

harassment or sexual violence will not counsel victims, but can offer a listening ear, information, workplace support, and signpost to other organisations that may provide help and support. (See appendix 2)

Both the Named Doctor and Named Nurse for Safeguarding are also available to provide support for members of staff. They can also provide guidance for managers and staff side representatives.

Employee's right to confidentiality and discretion around personal details of employees will be respected (addresses, telephone numbers, work locations, shift times). However, cases where there are believed to be safeguarding concerns either relating to children or adults with care and support needs at risk of abuse there is a statutory obligation upon the Trust to share this information and confidentiality cannot be guaranteed.

11. Duties and Responsibilities

11.1 Chief Executive and Other Executive Directors

It is the responsibility of the Executive Directors to ensure that this policy is enforced.

11.2 Line Managers, Senior Medical Staff, Senior Nursing Staff, Senior Managers

It is the responsibility of senior members of staff to ensure that the policy is implemented.

11.3 Safeguarding Team

The Safeguarding Team will provide information and support to clinical staff working with service users who have disclosed sexual violence or harassment.

11.4 Professional Registered Clinical Staff

All professionally registered clinical staff have a responsibility to appropriately support service users and report incidents in line with Trust policy.

11.5 All Members of Staff

All members of staff have a duty to respond appropriately to disclosures of sexual violence or harassment and should access available training as appropriate to their role.

Managing Sexual Incidences on the Ward

Ensure safety of those involved

- Consider the observation levels of the patients
- Consider introducing zonal observations
- Considered whether either person could be moved to a different ward
- Seek advice from safeguarding and or Patient Safety Team.

Assess what happened

- Speak separately to all patients involved. Consider whether you feel patients involved had capacity, assess/ request assessment as soon as practicable after the incident and clearly document in electronic records.
- If a sexual assault has taken place, you can seek advice immediately from The Grange (SARC) for adults: 0800 970 0372 –self referral line, 01782 980380- office number for professional advice. West Midlands Paediatric Sexual Assault Service: 24/7 0800 953 4131- Do not attempt to physically examine the patient yourself.
- The patient can report the assault to the police at any point but we have a duty of care to complete third party reporting if they don't want to.
- Consider making a safeguarding referral

Consider exposure

- It is important to know whether those involved are HIV or hepatitis B/C positive.
- Screening kits can be sought from <https://sh24.org.uk/> for testing of Sexually transmitted infections and in cases where patients cannot be taken to the sexual health clinic.

Contraception

- Consider whether you need to prescribe emergency contraception. There are three options:
 - 1 X Levonorgestrel 1.5mg tablet - can be taken up to 3 days (72 hours) after unprotected sex, but ideally should be taken within 12 hours. BMI greater than 26kg/m or body weight greater than 70kg, or the woman is taking enzyme inducing medicines, then two tablets should be given.
 - 1 X Ulipristal 30mg tablet - can be taken up to 5 days (120 hours) after unprotected sex.
 - Emergency intrauterine device (effective up to 5 days/120 hours). This is more effective but the patient will need to visit a sexual health clinic.

Documentation

- Document your assessment and any discussions on the patient record. Complete a separate entry for each patient involved. Make sure you mention discussions about capacity, consent, screening and contraception.
- If a sexual assault has taken place, make sure you document what happened in the patient's words. Take accurate and contemporaneous notes. Seek advice and support (See Appendix 2)
- Update the Risk Assessment, care plan and complete incident form and safeguarding referral if appropriate.
- Handover what has happened and any outstanding tasks to the nurse in charge so they are aware.

Appendix 2

Resources

Local Services:

- Grange Park (SARC) for adults: 0800 970 0372: self-referral line, 01782 980380 office number for professional advice.
- West Midlands Paediatric Sexual Assault Service: 24/7 0800 953 4131. Please note this service has a paediatrician on call 24 hours a day. Referrals for children are usually made via the police or social care, so that safeguarding issues are dealt with in parallel with the SARC provision.
- If you are unsure about whether or not to refer a child/young person to the West Midlands Paediatric Assault Service for a medical, please contact: 0800 953 4131 for a case discussion with the on-call paediatrician.
- Staffordshire Women's Aid are commissioned to support people in North Staffordshire who have experienced sexual abuse by their Survive service providing counselling and ISVA services. Contact on: on 03003305959 or email referrals@staffordshirewomensaid.org
- Savanna are commissioned to support people in Stoke-on-Trent and provide 1:1 and group counselling, take referrals from 4 years of age, ISVA services: 01782 433205, 24 hour message line: 01782 433204.

National Support:

- The Survivors Trust: 0808 801 0818
- Safeline, the National Male Survivor Helpline: 0808 800 5005
- Rape Crisis: 0808 802 9999

Appendix 3

Savana Referral Form

Name of Referral.....

Area

Postcode

Tel: Home **Mobile**

Is it ok to leave a message on above number/s: **Yes / No**

D.O.B...... **Age**

Has consent been given to contact the client: **Yes / No**

Brief details of Referral.....

.....

.....

.....

Name of Referrer

Agency.....

Tel:

Email:

Appendix 4

Training Needs Analysis

For the development and management of Trust wide procedural/approved documents.

There <u>is no</u> specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	
There <u>is</u> specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	✓

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trustwide learning programme for this staff group (✓ if yes)
Career Grade Doctor	✓		eLearning/Face to face	✓
Training Grade Doctor	✓		eLearning/Face to face	✓
Locum medical staff	✓		eLearning/Face to face	✓
Inpatient Registered Nurse	✓		eLearning/Face to face	✓
Inpatient Non-registered Nurse	✓		eLearning/Face to face	✓
Community Registered Nurse	✓		eLearning/Face to face	✓
Community Non Registered Nurse / Care Assistant	✓		eLearning/Face to face	✓
Psychologist / Pharmacist	✓		eLearning/Face to face	✓
Therapist	✓		eLearning/Face to face	✓
Clinical bank staff regular worker	✓		eLearning/Face to face	✓
Clinical bank staff infrequent worker	✓		eLearning/Face to face	✓
Non-clinical patient contact	✓		eLearning	✓

Non-clinical non patient contact		✓		
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Please give any additional information impacting on identified staff group training needs (if applicable)

All front line clinical staff will be required to complete sexual violence awareness training.
The Training Department will maintain records of training and report on levels of compliance.

Please give the source that has informed the training requirement outlined within the policy
i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information

Completed by	Head of Safeguarding	Date	13/09/2022
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Document level: Trust
Code: 1.89
Issue number: V3

Safeguarding Adults at Risk Policy

Lead executive	Executive Director of Nursing and Quality
Authors details	Head of Safeguarding

Type of document	Policy		
Target audience	All individuals employed by the Trust including contractors, voluntary workers, students, locums, agency and bank staff.		
Document purpose	To ensure safe working systems are in place to protect service users, relatives, staff and the public.		
Approving meeting	Quality Committee Trust Board	Meeting date	02 February 2023 09 February 2023
Implementation date	15 th February 2023	Review date	28 th February 2026

Trust documents to be read in conjunction with	
	Managing Safeguarding Allegations Policy (Trust Policy 1.70) Safeguarding Children and Young People Policy (Trust Policy 4.01) Prevent Policy (Trust Policy 4.43) Domestic Abuse Policy (Trust Policy 1.75) Sexual Safety and Responding to Sexual Violence Policy (Trust Policy 1.87).

Document change history		Version	Date
What is different?	Updated document, change of title, enhanced content to reflect this document being utilised as an operational policy within the Trust.	V3	August 2019
Appendices / electronic forms			
What is the impact of change?			

Training requirements	Safeguarding Children & Adults Level 1&2 is mandatory training for all staff. Face to Face Level 3 Adult Safeguarding training is mandatory for all professionally qualified staff. Domestic Abuse and Sexual Violence Training is also provided for all appropriately identified staff. Awareness of this policy and the roles and responsibilities of individual staff groups is made explicit during this training.
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Document consultation	
Directorates	
Corporate services	
External agencies	
Financial resource	

implications	
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External references
<ol style="list-style-type: none"> 1. The Care Act (2014). The Stationery Office Limited (2014). http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf 2. Safeguarding Adults, Pocket Guide. (2017).NHS England. https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf 3. Safeguarding in Light of the Care Act (2015). Research in Practice for Adults. 4. The Modern Slavery Act. (2015). http://www.legislation.gov.uk/ukpga/2015/30/contents/enacted 5. The Sexual Offences Act. (2003). The Crown Prosecution Service. https://www.cps.gov.uk/legal-guidance/rape-and-sexual-offences-chapter-2-sexual-offences-act-2003-principal-offences-and 6. Domestic Violence Disclosure Scheme (DVDS) Guidance (2016). The Home Office. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575361/DVDS_guidance_FINAL_v3.pdf 7. Staffordshire and Stoke-on-Trent Adult Safeguarding Enquiry Procedures, V4 (2016). https://www.ssaspb.org.uk/Guidance/SSASPB-Adult-Safeguarding-Enquiry-Procedures.pdf 8. The Government's revised mandate to NHS England for 2018-19. (2018). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/803111/revised-mandate-to-nhs-england-2018-to-2019.pdf

Monitoring compliance with the processes outlined within this document	This will be monitored via the Safeguarding Group, Clinical Safety Improvement Group and the Weekly Incident Group.
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Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Less favourable / More favourable / Mixed impact
Does this document affect one or more group(s) less or more favourably than another (see list)?		
– Age (e.g. consider impact on younger people/ older people)	No	
– Disability (remember to consider physical, mental and sensory impairments)	No	
– Sex/Gender (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– Gender identity and gender reassignment (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– Race / ethnicity / ethnic communities / cultural groups (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– Pregnancy and maternity, including adoption (i.e.	No	

<p>impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)</p> <ul style="list-style-type: none"> – Sexual Orientation (impact on people who identify as lesbian, gay or bi – whether stated as ‘out’ or not) – Marriage and/or Civil Partnership (including heterosexual and same sex marriage) – Religion and/or Belief (includes those with religion and /or belief and those with none) – Other equality groups? (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups) 	No	
	No	
	No	
<p>If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.</p>		
<p>Whilst the policy does not discriminate against any particular group additional consideration has been given to the additional complexities faced by individuals from some minority groups and increased complications for an individual when a disclosure of abuse or neglect also means a disclosure of sexual orientation, gender identity or gender reassignment or any other protected characteristic. However the compassionate response, support and signposting to specialist services provided by all employees of the Trust should be of the same standard regardless of the aforementioned issues.</p>		
<p>If you have identified potential negative impact:</p> <ul style="list-style-type: none"> - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? <p>Can the impact be reduced by taking different action?</p>		
<p>As above</p>		
<p>Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?</p>	No	
<p>If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason</p>	N/A	
<p>N/A</p>		
<p>Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact.</p>		
<p>For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk</p>		
<p>Was a full impact assessment required?</p>	No	
<p>What is the level of impact?</p>	Low	

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1. Introduction/Background

Adult safeguarding is everyone's responsibility. NHS England describes adult safeguarding as a fundamental part of patient safety and wellbeing and of the outcomes expected of the NHS. This is outlined in the Government's revised mandate to NHS England for 2018-19, particularly objective 2 of the mandate: To help create the safest, highest quality health and care service (Department for Health and Social Care, 2018). Safeguarding adults relates to providing additional measures for those least able to protect themselves from harm or abuse. NHS organisation's statutory responsibilities are defined within the Care Act (2014). The Care Act replaced numerous previous laws in response to national reviews and learning in order to provide a statutory and coherent approach to adult safeguarding in England.

The Care and Support Statutory Guidance issued under the Care Act (2014) replaced No Secrets Act (2000) from April 2015. The following adult safeguarding principles have been incorporated into the Care Act 2014. These are:

- Empowerment – People being supported and encouraged to make their own decisions and informed consent. "I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."
- Prevention – It is better to take action before harm occurs. "I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help".
- Proportionality – The least intrusive response appropriate to the risk presented. "I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed".
- Protection – Support and representation for those in greatest need. "I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want".
- Partnership – Local solutions through services working with their communities.
- Communities have a part to play in preventing, detecting and reporting neglect and abuse. "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me".
- Accountability – Accountability and transparency in delivering safeguarding. "I understand the role of everyone involved in my life and so do they".

Another key principle throughout the Care Act is making safeguarding personal; this means an individualised approach to safeguarding which involves putting the person in control of their life and the outcomes they want from adult safeguarding investigations. This is designed to empower people to speak freely and to be supported to make informed choices (with support where necessary) and this principle is inseparable from dignity and the human right to a quality of life. Therefore, the primary focus/point of decision-making must be as close as possible to the adult and they must be supported to make their own choices.

In adult safeguarding situations the adult must be involved at the earliest opportunity (unless doing so would put them at greater risk of harm) and they must be kept

involved throughout the process to ensure that safeguarding is more person centred and more outcome focused.

Professionals should clearly record within electronic care records their rationale as to why they did or did not raise a concern and this should be consistent with safeguarding principles, especially the principle of proportionality.

The Care Act (2014) has also placed adult safeguarding and adult safeguarding boards on a statutory basis, with duties to co-operate over the supply of information and rights to access to advocacy.

Section 42 of the Care Act requires Local Authorities, on behalf of adults who fit the criteria, to carry out Statutory Enquiries. Local Authorities may also cause others to do so, on their behalf. The Care Act (2014) also makes provision for non-statutory enquiries, these may be carried out in circumstances where the threshold for adult safeguarding is not met, but there remains concerns of abuse or neglect (including self-neglect) where the framework of an adult safeguarding enquiry may help to manage or minimise risk.

The Care Act (2014) has also created a duty of candour on providers in respect of failings in hospital and care settings with a new offence for providers of supplying false or misleading information, in the case of information they are legally obliged to provide.

This policy should be read in conjunction with the policies and procedures of Staffordshire and Stoke on Trent Adult Safeguarding Partnership Board (SSASPB) as displayed on their website (<https://www.ssaspb.org.uk/Home.aspx>).

2. Policy Synopsis

The purpose of this policy is to:

- Inform staff of best practice when responding to concerns or disclosures of adult safeguarding.
- Reduce the risk of harm and improve outcomes for the most vulnerable members of society by recognising adult safeguarding as a serious issue which has an adverse impact upon the health and wellbeing of individuals, families and communities.
- Increase awareness and understanding of adult safeguarding across the Trust.
- Ensure that all departments are clear within their roles in tackling and responding to issues surrounding adult safeguarding.
- Provide support for our staff that may be experiencing adult safeguarding concerns in the personal life.
- To ensure that processes are in place to support service users following a concern being raised or a disclosure.

3. Definitions of Adult Safeguarding

Adult safeguarding criteria is defined by the Care Act (2014) as being met when the following are present:

- the adult has care and support needs (regardless of whether these are these are being met by the local authority);
- the adult is at risk of or experiencing abuse or neglect;
- and as a result of their care and support needs they are unable to protect themselves from abuse or neglect.

The categories of abuse as defined by the Care Act (2014) are:

- Physical
- Sexual
- Psychological
- Financial
- Neglect/Acts of Omission
- Self Neglect
- Domestic Abuse
- Discriminatory
- Organisational
- Modern Slavery

3.1 Physical Abuse

Physical abuse can include assault (e.g. hitting, slapping, pushing, pinching or kicking) the misuse of medication, being locked in a room, inappropriate sanctions or force-feeding, inappropriate methods of restraint and unlawfully depriving a person of their liberty.

3.2 Sexual Abuse

Sexual abuse includes inappropriate looking or touching, subjection to pornography or witnessing sexual acts, sexual teasing or innuendo, sexual photography/filming, indecent exposure and sexual assault, rape or sexual acts to which the adult has not consented or was pressured into consenting.

It includes penetration of any sort and situations where the person causing harm touches the abused person's body (e.g. breasts, buttocks, genital area), exposes their genitals (possibly encouraging the abused person to touch them) or coerces the abused person into participating in or looking at pornographic videos or photographs.

Any sexual relationship that develops between adults where one is in a position of trust, power or authority may also constitute sexual abuse.

The Sexual Offences Act (2003) also provides protection for persons with a mental disorder. There are three categories of offences for vulnerable persons, they are:

- Offences against persons with a mental disorder impeding choice;
- Offences where there are inducements etc. to persons with a mental disorder; and
- Offences by care workers against persons with a mental disorder.

In all these offences, mental disorder is defined as set out in section 1 of the Mental Health Act 1983, as amended by the Mental Health Act 2007, as 'any disorder or disability of the mind'. As well as including serious mental illness this definition ensures the protection of those with a lifelong learning disability and persons who develop dementia in later life.

The legislation draws a distinction between those persons who have a mental disorder impeding choice, persons whose mental functioning is so impaired at the time of the sexual activity that they are unable to make any decision about their involvement in that activity, i.e. they are 'unable to refuse', those who have the capacity to consent to sexual activity but who have a mental disorder that makes them vulnerable to inducement, threat or deception; and those who have the capacity to consent to sexual activity but who have a mental disorder and are in a position of dependency upon the carer.

The denial of a sexual life to consenting adults is also considered abusive practice.

3.2 Psychological Abuse

Psychological abuse includes 'emotional abuse' and takes the form of threats of harm or abandonment, deprivation of contact, humiliation, rejection, blaming, controlling, intimidation, coercion, indifference, harassment, verbal abuse (including shouting or swearing), cyber bullying, isolation or withdrawal from services or support networks. Psychological abuse is the denial of a person's human and civil rights.

It includes preventing the adult from using services that would otherwise support them and enhance their lives. Psychological abuse also includes removing choice and opinion, privacy and dignity, being unable to follow one's own spiritual and cultural beliefs, sexual orientation and the intentional and/or unintentional withholding of information (e.g. information not being available in different formats/languages etc.).

3.3 Financial Abuse

Financial abuse includes theft, fraud, internet scamming or coercion in relation to an adult's financial affairs or arrangements. This includes wills, property, inheritance or financial transactions and the misuse or misappropriation of property, possessions or benefits.

3.4 Neglect/Acts of Omission

This includes ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, social care or educational services, and the withholding of the necessities of life such as medication, adequate nutrition and heating.

Neglect also includes a failure to intervene in situations that are dangerous to the person concerned or to others, particularly when the person lacks the

mental capacity to assess risk for themselves.

Neglect and poor professional practice may take the form of isolated incidents or pervasive ill treatment and gross misconduct.

3.5 Self Neglect

Self neglect covers a wide range of behaviour, including neglecting to care for one's personal hygiene, health or surroundings and behaviour such as hoarding.

Self neglect is also defined within the Care Act as the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the individual and sometimes to their community.

3.6 Domestic Abuse (including Female Genital Mutilation)

The Home Office (2013) describe domestic abuse as;

“Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, emotional abuse”.

Many people think that domestic abuse is about intimate partners, however domestic abuse includes abuse by other family members such as: mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family and much adult safeguarding work that occurs at home is, in fact is concerned with domestic abuse. This confirms that domestic abuse approaches and legislation can be considered safeguarding responses in appropriate cases.

In circumstances where an identified perpetrator of domestic abuse is known to be in or starting a new relationship the police may use their common law powers in the prevention of crime to make a disclosure to the potential victim, this is known as a domestic violence disclosure or ‘Clare’s law’ disclosure.

For further advice information and resources regarding domestic abuse please see the Trust domestic abuse policy (policy number 1.75).

Female genital mutilation (FGM) involves procedures that intentionally alter or injure female genital organs for non-medical reasons. The procedure has no health benefits for girls and women. The Female Genital Mutilation Act (FGMA) was introduced in 2003 and came into effect in March 2004. The act makes it illegal to practise FGM in the UK or to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in another country. It also makes it illegal to aid, abet, counsel or procure the carrying out of FGM abroad.

3.7 Discriminatory Abuse

This includes discrimination on the grounds of race, faith or religion, age, disability, gender, sexual orientation and political views. It also includes not responding to dietary needs and not providing appropriate spiritual support along with racist, sexist, homophobic or ageist comments or jokes, or comments and jokes based on a person's disability or any other form of harassment, slur or similar treatment.

Hate crime can be viewed as a form of discriminatory abuse, although will often involve other types of abuse as well.

Excluding a person from activities on the basis they are 'not liked' is also discriminatory abuse.

3.8 Organisational Abuse

Organisational abuse is the mistreatment, abuse or neglect of an adult by a regime or individuals in a setting or service where the adult lives or that they use. This includes both neglect and poor care practice. Organisational abuse violates the person's dignity and represents a lack of respect for their human rights.

The failure to appropriately raise concerns regarding alleged organisational abuse means that you are complicit in the abuse; therefore inaction on the part of staff who are not active participants in the abuse is also an adult safeguarding concern.

3.9 Modern Slavery

Modern slavery is the recruitment, movement, harbouring or receiving of children or adults through the use of force, coercion, and abuse of vulnerability, deception or other means for the purpose of exploitation.

Someone is in slavery if they are forced to work (through mental or physical threat); owned or controlled by an 'employer', usually through mental or physical abuse or the threat of abuse; dehumanised, treated as a commodity or bought and sold as 'property'; physically constrained or has restrictions placed on his/her freedom of movement.

There are estimated to be at least 13,000 modern slaves in the UK at any one time. Some common signs to look out for within healthcare settings are people who may present as; withdrawn, avoiding eye contact, reluctant to seek help, lacking health care/dental care, malnourished, signs of physical and/or sexual abuse, physical restraint, confinement, or torture, not being allowed to travel on their own, rarely interacting with others, unfamiliar with their neighbourhood or where they work, appear under the control of others, as having few or no personal possessions, are not in control of their own money or documents, not allowed or able to speak for themselves (a third party may insist on being present and/or translating), wearing the same clothes day in day out or clothes be inappropriate for the weather.

In community settings common signs may also include; living and working at the same place, overcrowded accommodation, poor living conditions, dirty cramped environment, poor living conditions and being dropped off and collected on a regular basis either very early or late at night.

In addition to raising adult safeguarding concerns certain statutory agencies have a duty to notify the Home Office in suspected/confirmed cases of modern slavery, this includes local authorities, therefore when completing a referral for adult safeguarding under this category a notification will be made to the Home Office. The information provided will be used to build a better picture of modern slavery in England and Wales. NHS Trusts are not named as authorities as to whom the statutory duty to notify applies. Voluntary notifications can however be made if appropriate by NHS organisations, this should be considered on a case by case basis and advice may be sought from line managers or the Safeguarding Team.

3.10 Prevent

Although not a category of abuse under the Care Act (2014) preventing someone from becoming a terrorist or supporting terrorism is no different from safeguarding individuals from other forms of exploitation.

There is no obvious profile of a person who is likely to become involved in terrorist-related activity, or single indicator of when a person might move to support extremism.

Vulnerable individuals may be exploited in many ways by radicalisers and this could be through direct face to face contact, or indirectly through the internet, social networking or other media. For further information and guidance please refer to the Prevent Policy (Trust Policy 4.43).

4. Responding to a Concern or Disclosure of Abuse or Neglect

In the event of a disclosure the service user should be taken to a quiet and private area. When dealing with a disclosure it is important to try and put the individual at ease. Giving clear and simple messages such as:

- They are not to blame or responsible for what has happened.
- Help is available; you can provide further support or put them in touch with other support services if they want this.
- You are concerned about their wellbeing and safety.
- Telling someone about what is happening is an important step in helping them get support and be safe.
- Explain limits of confidentiality, particularly if it is identified that children or other adults with care and support needs may be at risk.
- Discuss options available; include in this discussion immediate steps that can be taken to help them to feel safer.
- Explore with the person any immediate communication or care needs that may need addressing, particularly if the alleged perpetrator is their primary or sole carer.

In cases where the service user is from a refugee or asylum seeker status consideration should be given to previous experiences, such as previous political persecutions or torture, contributing to a lack of trust in authorities.

Disclosures, where the alleged perpetrator is a Trust employee, must be notified to the relevant manager and managed in accordance with Trust policies.

The Staffordshire and Stoke-on-Trent Adult Safeguarding Enquiry procedures (V4) state that an interpreter should be made available for service users who have experienced abuse or neglect and have communication difficulties, such as English as a second language or are deaf.

Appropriate support for the person's mental health needs should be arranged, taking into account the impact of making a disclosure or becoming aware a safeguarding concern has been raised by someone else, this may include an assessment of the service user's clinical mental state. This should be carried out by a senior clinician (in the event they are directly involved in the allegation an alternative clinician should be sought).

At times a service user may retract the disclosure and this can be for a number of reasons, such as a fear of not being believed or being placed under pressure by the alleged perpetrator. Retraction does not necessarily mean that the abuse did not occur and support should still be offered.

Following a disclosure it is important that the disclosure is recorded accurately, in the service user's own words including the responses given by the staff member; and discuss with the individual the next steps and choices available to them. If the service user states they do not want the police involved at this time, they may later change their mind and a first disclosure may well become important evidence in any subsequent criminal investigation and trial. Therefore the accurate recording of this disclosure remains vital.

If possible, the member of staff to whom the disclosure is made should establish whether the service user continues to have contact with the alleged perpetrator and if they are aware if the alleged perpetrator has any contact with children or other adults with care and support needs.

5. Procedure for Reporting Adult Safeguarding

Any incidents of adult safeguarding in an inpatient setting should be reported to the Nurse in Charge/Ward Manager, who must inform the Senior Manager immediately if the abuse has occurred in an inpatient setting. If the disclosure of adult safeguarding takes place in the community it should be reported to the Team Manager as soon as reasonably possible.

The incident must be reported on the electronic incident reporting system and must be submitted as soon as practicable; when assessing the level of severity consideration must be given to the psychological impact of the incident on the victim alongside any physical injuries.

As part of the electronic incident reporting an adult safeguarding referral should also

be completed by selecting the adult safeguarding radio button within the reporting form (see Appendix 2: Referral Process for Adult Safeguarding).

When the service user requests the involvement of the police, they should be contacted immediately; providing the service user's mental state does not preclude this as a relevant action.

A factual, comprehensive record of the concern or disclosure and immediate steps taken to protect them should be recorded in the service user's electronic care records. It is important to bear in mind this record may be used as evidence in a subsequent criminal trial.

Adult safeguarding procedures should not be invoked as a means to escalate or resolve professional disagreements or interpersonal issues unless a risk to the adult is clearly indicated.

6. Section 42 Enquiries

Section 42 enquiries are the statutory adult safeguarding processes outlined in Section 42 of the Care Act (2014). These are carried out when there have been concerns raised and it has been identified that the threshold described in Section 3 of this policy has been met.

The Care Act (2014) and its supporting Guidance are not prescriptive as to who should undertake an enquiry or how it should be conducted (although it is clear that the duty to ensure that an enquiry takes place lies with the Local Authority). This decision will be determined by the context of the concerns and the relative complexity of the situation. The guidance makes clear that in its most basic form an enquiry may be a conversation but also that at other times it will require a wide range of professional skills and the ability to co-ordinate a multi-agency response.

The Local Authority can cause others to make enquiries. This means that a provider or partner agency can be asked to conduct its own enquiries, and report these back to the Local Authority. In line with making safeguarding personal, Section 42 enquiries should be led by the professional who knows the adult at risk best and NHS Trusts have a legal duty under The Care Act (2014) to cooperate in formal adult safeguarding enquiries.

Where a crime has or may have been committed the Police are responsible for conducting a criminal investigation.

The objectives of a Section 42 enquiry are to:

- Establish facts.
- Ascertain the adult's views and wishes.
- Assess the needs of the adult for protection, support and redress and how they might be met.
- Protect from the abuse and neglect, in accordance with the wishes of the adult.
- Make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect; and enable the adult to achieve resolution and recovery.

- An enquiry should reflect the adult's wishes wherever possible, as stated by them or by their representative or advocate.

Please refer to the SSASPB guidance on undertaking a Section 42 enquiry for additional detailed guidance. <https://www.ssaspb.org.uk/Guidance/Chapter-Four-Safeguarding-Enquiries-Section-42-Care-Act-2014.pdf>

7. Information Sharing and Confidentiality

- 7.1 Sharing the right information, at the right time, with the right people, is fundamental to good practice in adult safeguarding but has been highlighted as a difficult area of practice. The Care Act 2014, section 45 'supply of information' covers the responsibilities of others to comply with any requests for information from the Safeguarding Adults Board for the purposes of progressing an enquiry. Sharing information between organisations as part of day-to-day safeguarding practice is already covered in the common law duty of confidentiality, the Data Protection Act 2018, the General Data Protection Regulation (GDPR) the Human Rights Act and the Crime and Disorder Act.
- 7.2 The Mental Capacity Act is also relevant as all those coming into contact with adults with care and support needs should be able to assess whether someone has the mental capacity to make a decision concerning risk, safety and sharing information.

Organisations need to share safeguarding information with the right people at the right time to:

- prevent death or serious harm;
- coordinate effective and efficient responses;
- enable early interventions to prevent the escalation of risk;
- prevent abuse and harm that may increase the need for care and support;
- maintain and improve good practice in adult safeguarding;
- reveal patterns of abuse that were previously undetected and that could identify others at risk of abuse;
- identify low-level concerns that may reveal people at risk of abuse;
- help people to access the right kind of support to reduce risk and promote wellbeing;
- help identify people who may pose a risk to others and, where possible, work to reduce offending behaviour;
- reduce organisational risk and protect reputation.

Adults have a general right to independence, choice and self-determination including control over information about themselves. In the context of adult safeguarding these rights can be overridden in certain circumstances which may warrant the sharing of relevant information without consent, such as emergency or life-threatening situations.

The law does not prevent the sharing of sensitive, personal information within organisations. If the information is confidential, but there is a safeguarding concern, sharing it may be justified. In addition, the law does not prevent the

sharing of sensitive, personal information between organisations where the public interest served outweighs the public interest served by protecting confidentiality – for example, where a serious crime may be prevented. The Data Protection Act 2018 and the General Data Protection Regulation (GDPR) enables the lawful sharing of information

8. Safeguarding Children and Young People

If during the course of an adult service user's disclosure it becomes apparent that children or young people under the age of 18 years may be at risk a referral for child safeguarding must be made.

If the service user making the disclosure is a child or young person under the age of 18 years a child safeguarding referral must be made.

In both cases a referral is needed so that further enquiries can be made; assessments conducted and appropriate safeguarding action taken. A child protection referral needs to be made in accordance with the Safeguarding Children and Young People Policy (Trust Policy 4.01) and this should be recorded in the patient's electronic records. An alert should also be placed on the electronic record to ensure other practitioners within the organisation are aware of the referral.

Child safeguarding referrals are dealt with by Children's and Families Social Care and as such can create anxiety and stress for victims. It is important to reassure the individual that Children's and Families Social Care will work with them so that they and any other children at risk can be protected and safe.

9. Safeguarding Adult Reviews

The Care Act (2014) states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies or is seriously harmed as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. This is a statutory responsibility.

The overall purpose of a Safeguarding Adult Review is to promote learning and improve practice, not to re-investigate or to apportion blame. The objectives include establishing;

- Lessons that can be learnt from how professionals and their agencies work together.
- How effective the local safeguarding procedures are.
- Both learning and good practice.
- How to improve local inter-agency working.
- Service improvements or development needs for one or more service or agency.

SARs look in detail at the care provided to the adult across all agencies, a chronology and independent management review or summary report will usually be submitted and clinical staff who have worked with the person (or identified significant others in

the case) may be invited to attend review panels. If staff are involved in a SAR, support and supervision should be sought from your line manager or the safeguarding team.

10. Supporting Staff with Adult Safeguarding Concerns

The Trust aims to respond sympathetically, effectively and confidentially to any member of staff who discloses adult safeguarding concerns outside of their professional role and is committed to supporting our staff. The Trust will work with the member of staff, and where agreed other agencies, to identify what actions can be taken to support them throughout the safeguarding process.

Members of staff who are experiencing adult safeguarding concerns in their personal lives may choose to disclose, report to or seek support from a staff side representative, a manager, or colleague. Members of staff who receive information from staff regarding adult safeguarding will not counsel victims, but can offer a listening ear, information, workplace support, and signpost to other organisations that may provide help and support.

Both the Named Doctor and Named Nurse for Safeguarding are also available to provide support for members of staff. They can also provide guidance for managers and staff side representatives.

Employee's right to confidentiality and discretion around personal details of employees will be respected. However, in cases where there are believed to be safeguarding concerns either relating to children or adults with care and support needs there is a statutory obligation upon the Trust to share this information with certain other statutory agencies such as the police and adult or children's social care and confidentiality cannot be guaranteed.

11. Advice and Supervision

The Trust Safeguarding Team is available to provide support and advice to staff and volunteers on safeguarding adults (including advice on specific cases). Details on how to contact the Safeguarding Team are available on CAT.

Adult safeguarding can be a rare occurrence for some staff and some staff will work with complex caseloads where there may be a number of safeguarding cases. Working with people at risk can be emotionally demanding and it is important that staff access the relevant support.

Safeguarding supervision is available to all staff and can be:

- Telephone advice re individual cases.
- 1:1 supervision.
- Team supervision.

Adult safeguarding issues should also be routinely discussed as part of the supervision arrangements for all practitioners as set out in the Trust Supervision Policy (1.14a). The outcomes from supervision should, in individual cases, be recorded in the relevant electronic care record.

All safeguarding concerns including those discussed in supervision must be recorded within electronic patient records, except for specific cases where recording information would increase risks to the adult.

12. Escalation

- 12.1 The SSASPB encourages the safeguarding workforce to use the Escalation Policy to help with the resolution of professional differences. Good practice includes the expectation that constructive challenge amongst colleagues within and between agencies provides a healthy approach to the work. Where members of staff from any agency feel that concerns regarding an adult at risk are not being addressed it is expected that the Policy should be used until a satisfactory resolution is reached. [Escalation policy \(ssaspb.org.uk\)](https://ssaspb.org.uk).

13. Duties and Responsibilities

13.1 Chief Executive and Other Executive Directors

It is the responsibility of the Executive Directors to ensure that this policy is enforced.

13.2 Line Managers, Senior Medical Staff, Senior Nursing Staff, Senior Managers

It is the responsibility of senior members of staff to ensure that the policy is implemented.

13.3 Safeguarding Team

The Safeguarding Team will provide advice, training, information and support to clinical staff regarding adult safeguarding concerns.

The Senior Safeguarding Nurse will process adult safeguarding referrals on behalf of the Local Authority as part of any Section 75 arrangements.

13.4 Professional Registered Clinical Staff

All professionally registered clinical staff have a responsibility to appropriately support service users and report incidents in line with Trust policy.

13.5 All Members of Staff

All members of staff have a duty to respond appropriately to disclosures of adult safeguarding concerns and should access available training as appropriate to their role.

14. Appendices

14.1 Appendix 1:

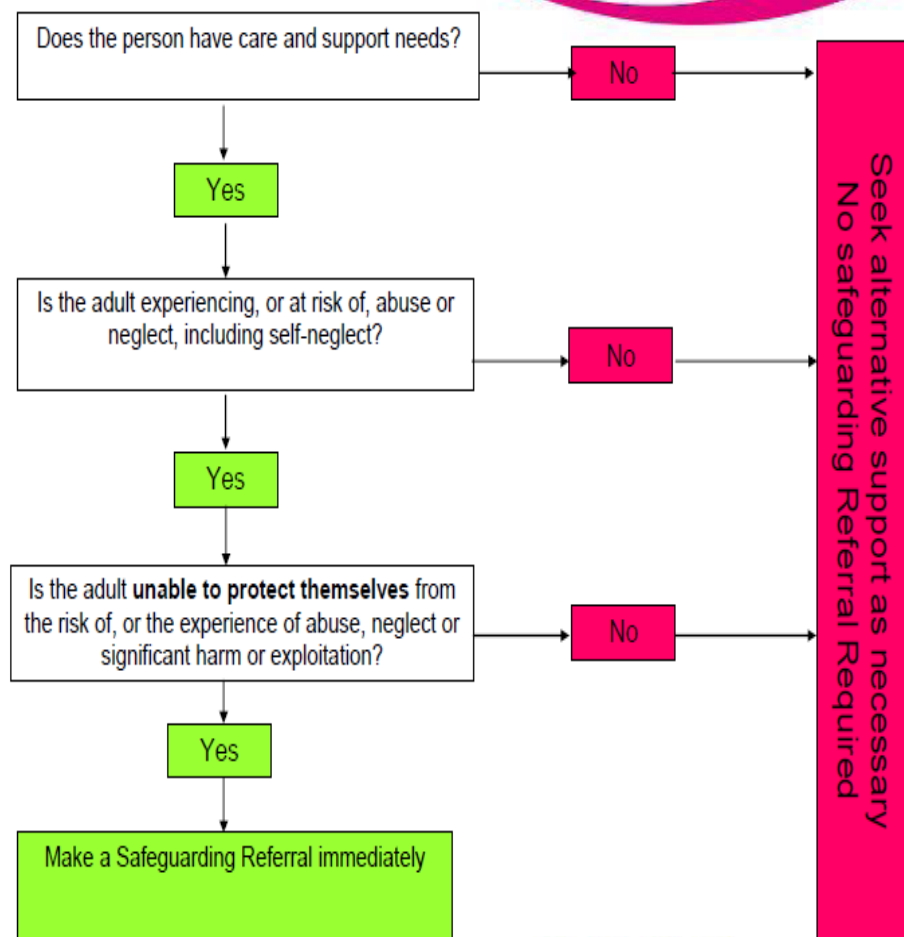
Adult Safeguarding Decision Making Flowchart

An adult at risk of abuse or neglect:

- *Has needs for care and support (whether or not the Local authority is meeting any of these needs) and;*
- *Is experiencing, or at risk of abuse or neglect; and;*
- *As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect or significant harm or exploitation.*

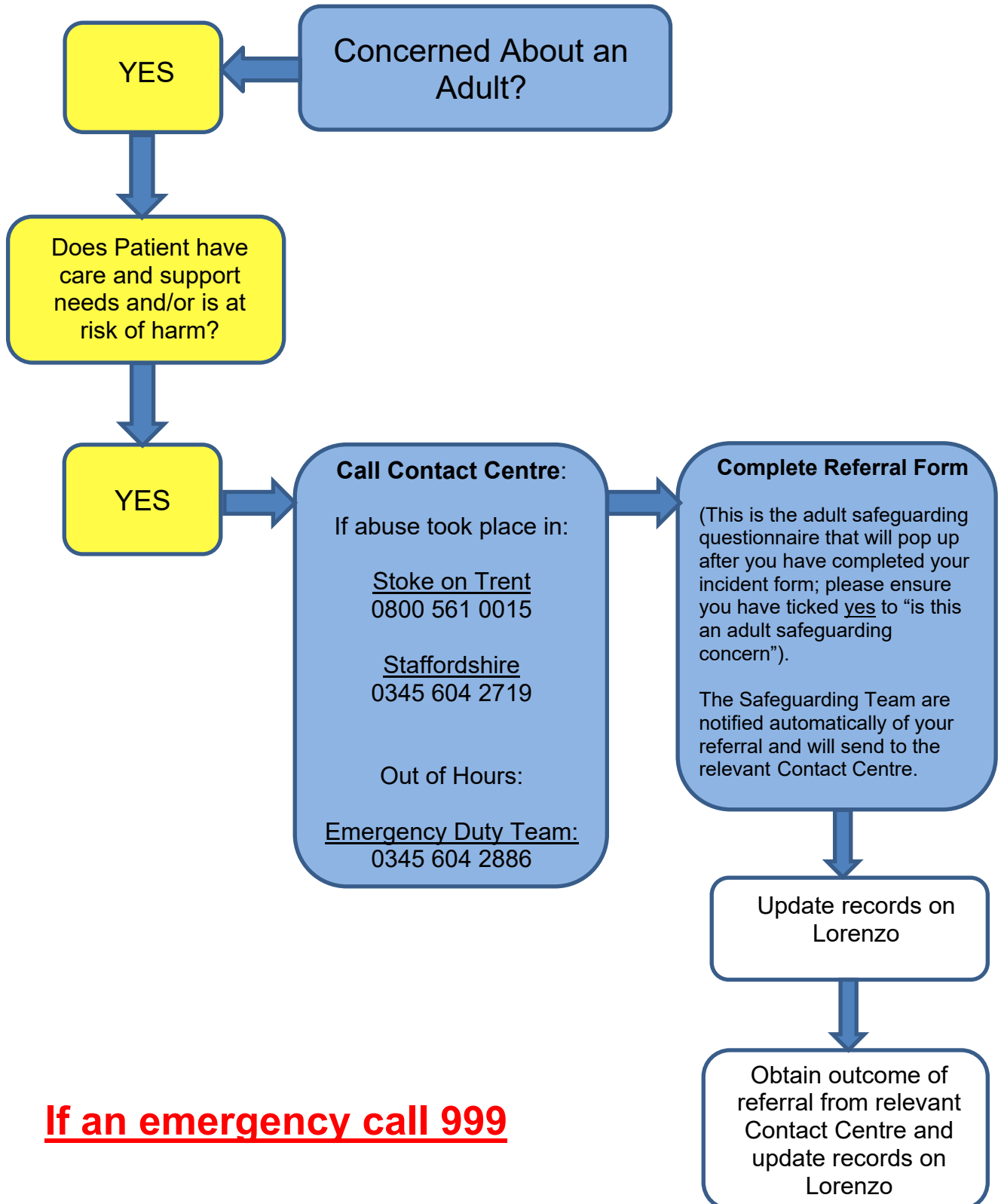
Types of abuse:

Physical Sexual
Financial Discriminatory
Neglect Self-neglect
Psychological
Organisational abuse
Domestic abuse
Modern slavery



14.2. Appendix 2:

Adult Safeguarding Referral Process



14.3. Appendix 3:

Training Needs Analysis

Training Needs Analysis for the policy for the development and management of Trust wide procedural/approved documents

There <u>is no</u> specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	
There <u>is</u> specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	✓

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trust wide learning programme for this staff group (✓ if yes)
Career Grade Doctor	✓	3 yearly	eLearning/Face to face	✓
Training Grade Doctor	✓	3 yearly	eLearning/Face to face	✓
Locum medical staff	✓	3 yearly	eLearning/Face to face	✓
Inpatient Registered Nurse	✓	3 yearly	eLearning/Face to face	✓
Inpatient Non-registered Nurse	✓	3 yearly	eLearning/Face to face	✓
Community Registered Nurse	✓	3 yearly	eLearning/Face to face	✓
Community Non Registered Nurse / Care Assistant	✓	3 yearly	eLearning/Face to face	✓
Psychologist / Pharmacist	✓	3 yearly	eLearning/Face to face	✓
Therapist	✓	3 yearly	eLearning/Face to face	✓
Clinical bank staff regular worker	✓	3 yearly	eLearning/Face to face	✓
Clinical bank staff infrequent worker	✓	3 yearly	eLearning/Face to face	✓
Non-clinical patient contact	✓	3 yearly	eLearning	✓
Non-clinical				

non patient contact				
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Please give any additional information impacting on identified staff group training needs (if applicable)

All front line clinical staff will be required to complete adult safeguarding level1 and 2 eLearning. All identified professionally qualified staff are required to complete Level 3 eLearning training in addition to level 1&2. This should be repeated 3 yearly.
The Training Department will maintain records of training and report on levels of compliance.

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information

Completed by	Head of Safeguarding	Date	03/10/2022
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Document level:

Code: 3.01

Issue number: 3

Disciplinary Policy and Procedure


Lead executive	Chief People Officer
Author's details	Senior HR Advisor / Sarah Vincent Workforce Business Partner

Type of document	Policy
Target audience	All Trust staff
Document purpose	This document describes the procedure for managing disciplinary matters in the Trust.

Approving meeting	PCDC	Meeting date	3 rd April 2024
Implementation date	15 th February 2021	Review date	30 th April 2025

Trust documents to be read in conjunction with	
	Safeguarding Vulnerable Adults in Stoke on Trent and Staffordshire – Interagency policy and procedure
3.09	Freedom to Speak Up Policy
3.02	Resolution and Grievance Policy
3.06	Pay Protection Policy
3.23	Supporting Staff to Improve Performance Policy
3.11	Supporting Attendance at Work Policy

Document change history		Version	Date
What is different?	Policy has been updated as part of an interim phase 1 review in the following areas to reflect current practice at NSCHT. This is in response to NHSE/I letter sent to NHS Trust CEO and HR / People Directors dated 01 December 2020 sharing good practice to improve our people practices:		

	 <p>Examples of some of the changes are as follows:</p> <ul style="list-style-type: none"> - Policy underpinned by provisions of current ACAS best practice. - Ensuring objectivity and independence is maintained. - Application of “just culture” principles. - Relevant training provided. - Concern for the health and welfare of people involved in investigation and disciplinary procedures are paramount, inclusion of point of contact for pastoral support and communication plan. - Inclusion of investigation terms of reference 		
Appendices / electronic forms	<ul style="list-style-type: none"> - N/A 		
What is the impact of change?	<p>Impact of change demonstrates the Trust's commitment at a policy level to align with:</p> <ul style="list-style-type: none"> - People practice recommendations In May 2019 from NHSE/I in response to a tragic event at Imperial College Healthcare NHS Trust (ICHT) 4 years ago. <ul style="list-style-type: none"> o Sadly, Amin Abdullah, a nurse who at the time was the subject of an investigation and disciplinary procedure, tragically took his own life. - Best practice, including a review of ICHT's policy <p>This is a phase 1 Interim policy review to demonstrate at a policy level a fair and compassionate culture in line with the recently published People Plan and People Promise</p>		

Training requirements	No specific requirement, general awareness via usual communication channels
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Document consultation	
Directorates	JNCC Policy Working Group meetings
Corporate services	JNCC Policy Working Group meetings
External agencies	JNCC and JLNC Policy Working Group Meeting

Financial resource implications	None
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External references
1.N/A

Monitoring compliance with the processes outlined within this document	N/A
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Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Less favourable / More favourable / Mixed impact
Does this document affect one or more group(s) less or more favorably than another (see list)?		
– Age (e.g. consider impact on younger people/ older people)	No	
– Disability (remember to consider physical, mental and sensory impairments)	No	
– Sex/Gender (any particular M/F gender impact; also consider impact on those responsible for childcare)	No	
– Gender identity and gender reassignment (i.e. impact on people who identify as trans, non-binary or gender fluid)	No	
– Race / ethnicity / ethnic communities / cultural groups (include those with foreign language needs, including European countries, Roma/travelling communities)	No	
– Pregnancy and maternity, including adoption (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples)	No	
– Sexual Orientation (impact on people who identify as lesbian, gay or bi – whether stated as ‘out’ or not)	No	
– Marriage and/or Civil Partnership (including heterosexual and same sex marriage)	No	
– Religion and/or Belief (includes those with religion and /or belief and those with none)	No	
– Other equality groups? (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending)	No	

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population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups)		
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
If you have identified potential negative impact: - Can this impact be avoided? Staff are required to complete mandatory education to ensure a safe service provision - What alternatives are there to achieving the document without the impact? Can the impact be reduced by taking different action?		
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?		
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason		
Enter details here if applicable		
Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact. Discussed the above with the Inclusion & Diversity Lead – adjustments offered and made ensured equality and inclusion. For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@combined.nhs.uk		
Was a full impact assessment required?		
What is the level of impact?		

Training Needs Analysis for the policy for the development and management of Trust wide procedural / approved documents

Please tick as appropriate

There is no specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	✓
There is specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trust wide learning programme for this staff group (✓ if yes)
Career Grade Doctor				
Training Grade Doctor				
Locum medical staff				
Inpatient Registered Nurse				
Inpatient Non-registered Nurse				
Community Registered Nurse				
Community Non Registered Nurse / Care Assistant				
Psychologist / Pharmacist				
Therapist				
Clinical bank staff regular worker				
Clinical bank staff infrequent worker				
Non-clinical patient contact				
Non-clinical non patient contact				

Please give any additional information impacting on identified staff group training needs (if applicable)

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information

Completed by

Date

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1 Policy Statement and Purpose

- 1.1 This document describes the procedure for managing disciplinary matters in the Trust.
- 1.2 This policy supports application of our Trust Values which guide our actions and behaviour as an employer and provider of services. These are:-

Proud to CARE:

- Compassionate
- Approachable
- Responsible
- Excellent

- 1.3 Our vision at North Staffordshire Combined Healthcare NHS Trust is “To be Outstanding” – in all that we do and how we do it. This vision is a “golden thread” instilled within our policies and processes and is achieved and continually improved through the high standards of conduct and behaviour exhibited by our staff and through our Trust Values: Compassionate, Approachable, Responsible and Excellent.
- 1.4 Our commitment is to foster and promote a culture that will aim to learn from any mistakes that may arise and to help our employees to improve and develop where their actions are in breach of Trust policies, or where their conduct fails to meet the expected behaviour standards.
- 1.5 This policy has been developed to drive an efficient process and framework to support fairness, transparency and learning with an intended outcome and focus on staff feeling confident and empowered to speak up when something has gone wrong, rather than fearing the placement of blame. When such circumstances arise, an objective examination should take place without undue delay to establish whether or not there is evidence to support the initiation for a formal investigation process; or whether an informal approach is more appropriate with any following learning outcome and improvements being acknowledged and implemented to the benefit of all employees and the Trust as a whole.
- 1.6 This policy should be applied equitably to all employees ensuring that there is no discrimination on the grounds of age, disability, race, ethnicity, gender, gender reassignment, sexual orientation, religion, belief, offending background, trade union activities, family circumstances or domestic/care arrangements.
- 1.7 The Trust’s Disciplinary Policy and supporting processes are fully compliant with the [ACAS Code](#) and best practice on disciplinary procedures and other non-statutory ACAS guidance; the [GMC’s ‘principles of a good investigation’](#), and other relevant professional bodies if/when they become available. Regular

reviews are carried out in a timely manner as part of the Trust's Policy review process. However, if the ACAS code is changed or legislation changes prior to the review date, a review will be instigated. This policy is negotiated as part of the Trust's Joint Negotiating and Consultation Committee (JNCC).

- 1.8** If it becomes apparent that an employee's capability to perform effectively in their job, for example due to a training need, is deemed to be the overriding reason for a mistake, this will be reviewed and managed in line with the Trust policy 3.23 Supporting Staff to Improve Performance Policy

2 Scope

- 2.1** This procedure applies to all staff employed by the Trust. The procedure will be applied equally to all employees, ensuring that there is no unlawful discrimination.
- 2.2** In the case of Medical and Dental staff, this procedure will apply to any matters concerning misconduct. However, where the alleged misconduct relates to matters of a professional nature or issues of professional conduct, the investigating officer must obtain appropriate independent professional advice. Similarly, where a case involving issues of professional conduct proceeds to a hearing under this policy, the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation.
- 2.3** In exceptional circumstances, where an employee has less than 2 years continuous service with the Trust, the Trust may decide not to follow this procedure or to follow an abridged version of this procedure.

3 General principles

- 3.1** The procedure is designed to help and encourage employees to achieve and maintain standards of conduct acceptable to the Trust.
- 3.2** Where deemed appropriate the Trust will use formal counselling, to address misconduct issues before implementing the full disciplinary procedure.
- 3.3** The Trust recognises that it is a manager's responsibility to ensure that employees are aware of the standards and conduct expected of them and to give them assistance and support to meet them. This will include the provision of induction training, regular discussions as part of the personal review process and appropriate training and development.
- 3.4** At all stages of the procedure employees will have the right to be represented by a Trade Union representative or accompanied by a work colleague.
- 3.5** At the earliest appropriate stage the employee will be advised in writing of the

general nature of the complaint against them and will be given the opportunity to state their case before any decision is made. Different arrangements apply in safeguarding cases, please see section 8.

- 3.6** This procedure may be implemented at any stage.
- 3.7** An employee will have the right to appeal against any disciplinary sanction.
- 3.8** An employee who is called to give evidence as part of a disciplinary investigation or interview shall have the right to be represented by a trade Union representative or accompanied by a work colleague.
- 3.9** Confidentiality will be maintained at all stages of the procedure.
- 3.10** In the case of Medical and Dental staff, matters of misconduct will be managed in line with this policy, however the provisions relating to investigation and exclusion as laid out within 'Maintaining High Professional Standards in the NHS' will be applied.
- 3.11** Individuals should not be appointed as commissioning managers, investigating officers or panel members unless they have received related up to date training and through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciative of diversity and inclusion principles required to undertake these roles. This includes, but is not limited to, race and cultural considerations, taking steps and undergoing training to enable inclusion to mitigate against unconscious bias) . This training includes, but is not limited to, coaching from members of HR.
- 3.12** Before commencing investigation and disciplinary procedures, appointed commissioning managers, investigating officers and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of the disciplinary panels) are truly independent should also be considered.
- 3.13** Concern for the health, wellbeing and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.
- 3.14** The development and application of our local investigation and disciplinary procedures are informed and underpinned by the provisions of current best practice, principally that which is detailed in the [ACAS 'code of practice on disciplinary and grievance procedures'](#) and other non-statutory ACAS guidance; the [GMC's 'principles of a good investigation'](#), and other professional bodies

if/when they become available. All commissioning managers, investigating officers and disciplinary panel members must review this best practice when involved in any investigation and disciplinary matters.

- 3.15** All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require sourcing of independent external advice and expertise).
- 3.16** Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps ([Appendix 4](#)).
- 3.17** In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.
- 3.18** A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.
- 3.19** Mechanisms are established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at the People, Cultural and Development Committee, which reports directly to Trust Board.

4 Supporting Employees

- 4.1** Being notified of a disciplinary matter and subject to allegations of misconduct can be an upsetting and stressful time for the employee and other colleagues involved.
- 4.2** It is important throughout the process that the employee is supported from a health and wellbeing perspective and therefore an appropriate point of contact will be allocated who is independent from the investigation. The point of contact will establish a communication plan and be able to provide pastoral support. Frequency of contact and support can be discussed to best suit the needs of the employee, however, once weekly contact is recommended in the first instance. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

- 4.3** The provision of the independent point of contact is a supportive measure for confidential communication with the intention to help to support and alleviate stress or other mental health issues that may arise. Communication and feeling informed and supported is key throughout the process. The Trust acknowledges that support is also important once a disciplinary process has concluded and the support from the point of contact will be available. A communication plan can be drawn up between the employee and the point of contact to ensure regularity of contact, tailored support and open communication.
- 4.4** Where there are concerns about an employee's health or wellbeing, Occupational Health advice will be obtained.
- 4.5** All employees, including those who are involved as witnesses, will be supported and will have access to Occupational Health and the Trust's Staff Counselling Service.
- 4.6** Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt actions should be taken in response to the identified harm and its causes and whether the matter is RIDDOR reportable In line with [HSE guidance](#). Information with regards to 'never events' is outlined in [Appendix 3](#).

5 Conduct Counselling

- 5.1** In cases deemed to be minor misconduct, a manager may decide to undertake conduct counselling with the employee as an alternative to instigating all or part of the formal disciplinary procedure. This part of the process is informal and holds no right of appeal. The following apply:
- Conduct counselling will normally take place on a one to one basis
 - The purpose of the counselling will be to make the employee aware of the areas of misconduct and of the standards required.
 - Evidence will be discussed and the reasons for the misconduct will be explored and support/training offered where required. These will be documented.
 - A set of expectations will be set out to assist the employee to achieve the required improvement in their conduct and a timescale within which an improvement is required will be set out.
 - Formal disciplinary action may result if the necessary improvement in conduct is not forthcoming within a defined timescale
 - If it becomes apparent that the matter is more serious, then the discussion should be adjourned and the employee advised that it may be taken forward under the formal disciplinary procedure.

- 5.2** The content of each counselling meeting should be confirmed in writing with the employee and a copy kept on the personal file (see [appendix 5](#)).

6 Resolution Meeting

- 6.1** A resolution meeting is an alternative procedure in which a disciplinary matter can be considered and if appropriate a disciplinary warning (up to, and including, a final written warning) can be given to an employee. A disciplinary meeting is not suitable in cases of gross misconduct, when a referral may be made to a professional body, or where an employee is already subject to a final written warning or if some, or all, of the allegations are denied. The resolution meeting would take the form of a disciplinary meeting, rather than a disciplinary hearing, and would only be appropriate where the employee has taken full responsibility for their actions and accepted the allegations against them. It enables a faster resolution and closure to a disciplinary matter for the employee. It is a less formal meeting than a disciplinary hearing, consisting of the Commissioning Manager (which can be either the Commissioning Manager or a nominated deputy), HR representative, the employee and their representative (where applicable). By their nature, these discussions are “without prejudice” and should not form part of the Investigation Pack, any other documentation, or be verbally referred to at a later date should the allegation result in a hearing.
- 6.2** At the meeting, the Commissioning Manager (or nominated deputy) will feedback the outcome of the case review and the employee will have the opportunity to give a response to the allegations and raise any mitigation. If no further issues come to light, and before making any decision, the Commissioning Manager (or nominated deputy) should adjourn and take account of the employee’s disciplinary and general record, length of service, actions taken in any previous similar cases, the explanations given by the employee and whether the intended disciplinary action is reasonable under the circumstances. The Disciplining Manager may issue a disciplinary warning up to and including a final written warning. This will be confirmed in writing, with a copy placed on the employee’s personal file. The employee will have the right to appeal to the next most senior manager above the Disciplining Manager (or an appropriate equivalent) and will have 14 calendar days from receipt of the letter to do so.
- 6.3** A resolution meeting can be considered at any time during a Disciplinary Process, up to the point when a Disciplinary Hearing has been deemed appropriate by the Commissioning Manager, who will be supported by a member of the HR department. Where the original Commissioning Manager is unavailable, for example due to annual leave, it may be appropriate for this decision to be made by another Senior Manager, such as the Clinical Director or Director of Operations.

7 Disciplinary Procedure

7.1 Suspension

Suspension (termed 'exclusion' under 'Maintaining High Professional Standards'; (See 3.10). In some serious cases it may be necessary for the manager to consider whether it is appropriate to implement a period of suspension whilst the investigation is carried out. Suspension is not a disciplinary sanction and there is no assumption of guilt. This may be required if genuine risks are identified and all alternative options have been ruled out, for example where:

- an employee's presence constitutes a risk to him/herself,
- an employee's presence constitutes a risk to the Trust
- an employee's presence constitutes a risk to patients or staff
- an employee's presence constitutes a risk to the investigation

7.2 Prior to taking a decision to suspend full consideration will be given to alternatives to suspension and could include the employee temporarily:

- being moved to a different area of the workplace / Trust
- changing their working hours
- being placed on restricted duties including having reduced access to Trust systems where appropriate
- working under supervision
- being transferred to a different role within the organisation (the role should be of a similar status to their normal role, and with the same terms and conditions of employment).
- Other meaningful activities that the individual could do should be actively explored. This could include working remotely from home, carrying out activities such as audits, research or teaching.

7.3 Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, time bound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

7.4 Any decision to suspend/exclude an individual is taken by a minimum of two Executives (The Director of People, OD and Inclusion, and either the Medical Director/Director of Nursing & Quality/Director of Operations (dependent on the allegation and registered professional status). The Executive Directors are briefed by the respective Associate Director and Workforce BP. Out of hours the Trust has an on-call system which ensures that an appropriate senior on call manager would be contacted who in turn would contact the Executive

Director on call before a decision to suspend/exclude. The matter is then picked up at the earliest convenience and further consideration given to ensure the suspension/exclusion is required e.g. review fact find information. With regards to Exclusions for medical staff, the above principles apply along with oversight provided to the Medical Director and Appointed Non-Executive Director, in accordance with Maintaining High Professional Standards requirements.

- 7.5** Suspension in these circumstances will always be on full pay including any allowances or enhancements that the employee would have normally received. These enhancements will be calculated based on an average of the preceding twelve weeks to the date that the suspension commenced.
- 7.6** The decision to suspend is not taken lightly and the Trust seeks to ensure that staff remain as supported as possible if this step is deemed necessary. In order to facilitate this, a Point of Contact will be allocated to a suspended member of staff who is responsible for establishing a communication plan, ensuring the staff member continues to receive routine organisational communications and remains in contact with the organisation while they are suspended or restricted. The Trusts Staff Support and Counselling Service will also be offered to support staff when suspended.
- 7.7** Once a decision has been made regarding suspension, the relevant Associate Director must be assured that the manager who gives this message is supported and competent to do so, whereby they demonstrate effective leadership in a human, compassionate and sensitive manner that takes into account the needs of the person, alongside following the process requirements. Managers delivering this message should arrange for a Trade Union representative to be available (where the individual is represented and where this is practicable subject to availability given the urgent timescales). Managers should also consider the most appropriate venue to deliver the message, identify what support is in place for the individual after receiving this message; such as the time needed to digest the message and if the individual wants to discuss with their trade union representative (where applicable) and or / their assigned point of contact, how they will get home safely, and their support at home.
- 7.8** When notifying an employee of the decision to suspend, every effort will be made for the manager to meet with them in person and the meeting will be followed up in writing. The employee will be notified:
 - of the reason for the suspension and that it carries no assumption of guilt (subject to safeguarding procedures – see [Appendix 2](#))
 - of the initial duration of the suspension and arrangements for any extension
 - of their point of contact who is a person allocated to the suspended member of staff responsible for ensuring that the staff member continues to receive routine organisational communications and remains in contact with the

organisation while they are suspended and for pastoral support

- that suspension is on full pay
- Of any conditions attached to the suspension, in particular the need to maintain confidentiality and to obtain permission from the manager before attending the workplace or other Trust site or contacting staff, and the need to remain available during normal working hours.
- If it is necessary to explain the employee's non-attendance at work, the manager and the employee will discuss and agree a statement for how they would like it to be communicated to colleagues and/or patients. The matter must be kept confidential, however, sometimes if no explanation is given people will make assumptions. Acknowledging the non-attendance but ensuring a confidential and neutral explanation is advisable for the wellbeing of the employee during suspension.

7.9 The terms of the suspension and the employee's obligations will also be provided which includes:

- not doing anything that could interfere with the investigation
- treating the matter confidentially
- seeking permission from the manager to contact colleagues
- if they wish to contact witnesses to support their case, they should do this via their manager or, if different, the manager dealing with the matter or their Trade Union representative or companion
- except for medical appointments, they must not visit Trust premises unless given permission by the line manager or a named deputy to attend for a specific purpose, e.g. a meeting a representative, an investigation meeting, a counselling appointment, a medical consultation
- the requirement to remain available between 9.00 am to 5.00pm, Monday to Friday, excluding public holidays, to attend meetings. Permission for any periods of absence, e.g. annual leave, must be requested

7.10 The **suspension will be for the minimum time necessary and will be reviewed on a regular basis** (see MHPS for formal reviews in the case of doctors and dentists). **Suspension will be lifted if the reason for suspension no longer exists and employee will be supported back in to the workplace.**

8 Safeguarding

8.1 In cases of allegation of abuse involving vulnerable adults or children, the issue should be reported immediately to the senior manager on duty, who will then report to the Executive Lead for Safeguarding and then through the process as laid out in the Safeguarding Policy; Managing Allegation of Abuse (see [Appendix 2](#) for additional information).

9 Counter Fraud cases

- 9.1** In cases which relate to allegations of fraud, the process may result in a criminal investigation by the NHS counter fraud agency which is different to the normal disciplinary process route.

10 Investigation

- 10.1** The overriding consideration should be that the investigation is undertaken promptly and in sufficient detail to establish the relevant facts. An indicative timescale may be given for completion of the investigation and where it is felt that this timescale cannot be achieved the employee and their representative should be advised of the likely further time needed by the Investigating Officer.

- 10.2** All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated.

- 10.3** Prior to commissioning a formal investigation the Commissioning Manager will ensure careful consideration of context and prevailing factors should be reviewed when determining next steps. This is consistent with the application of 'just culture' principles, which recognises that it is not always appropriate or necessary to invoke formal management action, such as suspension or disciplinary investigation, in response to a concern or incident. This triaging process is to ensure the health, safety and wellbeing of our employees within a restorative and just culture context. The decision making methodology for triaging employee relations cases is [Appendix 4](#) of this policy document.

- 10.4** The Commissioning Manager will be the person to whom the investigating officer is accountable.

- 10.5** Where it is deemed that an investigation is required, the Commissioning Manager will appoint an Investigating Officer to establish all the relevant facts. This will be achieved through a process of interviews and consideration of any other appropriate information/ documentation and to produce a report in which the Investigating Officer will make a recommendation as to whether or not, on the balance of probabilities, there is a case answer. After the commissioning manager completes a detailed review of the report provided by the Investigating Officer, the Commissioning Manager will decide if the matter should be considered further in a disciplinary hearing.

- 10.6** The Commissioning Manager will formulate the terms of reference for the investigation and will provide this to the Investigating Officer. The terms of

reference will clearly explain what the investigating officer's role and responsibilities are and also the scope of the investigation.

10.7 All Investigating Officers should have received training: a central record will be held by the HR Department.

10.8 The Commissioning Manager should notify the employee at the earliest opportunity of:

- The general allegation
- That an investigation will be undertaken
- That they will be interviewed as part of that investigation
- How long the investigation is likely to take if they are able to make such an assessment.

10.10 Prior to interviewing the employee against whom allegations have been made, the investigating officer should notify the employee in writing of the general allegations. During the course of an investigation, it may be that allegations are amended, added to or disproven, in which case the employee will be informed accordingly. The investigating officer must avoid reaching early conclusions and must not focus only on those areas that may support one particular viewpoint. During the investigatory interview the employee should be given every opportunity to refute the allegations, to give their own account of events and to explain any mitigating circumstances.

10.11 Any employee interviewed as part of an investigation shall have the right to be represented at the interview by a Trade Union representative or accompanied by a work colleague. A note of the meeting will be produced by the Trust either from notes taken at the interview or a recording made of the interview. The employee will be provided with a copy of the notes.

10.12 All employees must be advised at the beginning of the interview that any information given may be used at a disciplinary hearing, if it is decided that such a hearing should take place.

10.13 Having gathered all the relevant facts, the investigating officer must produce a report which will be submitted to the Commissioning Manager.

10.14 The report should contain details of those employees interviewed as part of the investigation together with any other findings and relevant documentation. Copies of employee statements/meeting notes should be provided as an appendix to the report.

10.15 Having considered the investigation report the Commissioning Manager, supported by HR, will decide what action to take and advise the employee accordingly.

11 Disciplinary Hearing

11.1 In circumstances where a disciplinary hearing is deemed appropriate, then the commissioning manager should set a date for the hearing. Due regard should be given for the need for timeliness, but allowing sufficient time for the employee to arrange a companion and to prepare for the hearing.

11.2 A minimum of 7 calendar days' notice of a disciplinary hearing will be given.

11.3 Arrangements should be confirmed in writing to the employee giving details of:

- The date, time and venue of the hearing;
- The allegations against the employee;
- The right to be represented by a Trade Union representative or accompanied by a work colleague
- who will be present at the hearing on behalf of management;
- the names of any witnesses that will be called; copies of any relevant documents including the full investigation report;
- the requirement for the employee/management to notify the manager of any witnesses they intend to call; and
- Whether the employee could be dismissed as a result of the hearing, and the fact that if the allegations could amount to gross misconduct, summary dismissal is a potential outcome.

11.4 Disciplinary panels will normally comprise two managers (usually the commissioning manager) and one other, and a member of the HR Department. If professional, technical or otherwise sufficiently complex issues are involved, then a senior manager of the appropriate profession may also sit on the panel. Neither the second manager or the professional/technical manager should have been involved at an earlier stage.

11.5 If the employee has any additional evidence or information that they would like to be considered at the hearing, this information is to be submitted no less than 3 calendar days prior to the hearing.

11.6 Witness statements will be accepted by the panel as read; however the employee or investigating officer can call witnesses to the hearing.

11.7 If the employee wishes to call any witnesses, the names of the witnesses must be submitted to the panel no less than 3 calendar days prior to the hearing.

11.8 Disciplinary hearings may be recorded by the Trust with the mutual

consent of the employee, and/or a note-taker will be present.

11.9 The hearing process will normally be as follows:

- At the beginning of the hearing the allegations will be set out
- The procedure to be followed will be explained
- Management side will present their case, calling any witnesses that may assist in the presentation of the facts
- The employee will present their case, calling any witnesses
- The panel will adjourn and reach a decision

12 Disciplinary Sanctions

If it is decided that disciplinary action is required, then a number of measures are available. Although these are described as a series of sequential warnings, the procedure can be implemented at any stage depending on the nature and seriousness of the offence. The seriousness of the misconduct will determine the level of disciplinary action to be taken.

12.1 First written warning

In the case of offences that need action over and above counselling or where there is an accumulation of minor offences, the employee may be given a written warning, setting out the nature of the offence and if appropriate what improvement is required within what timescale. The likely consequences of any further offence or failure to improve performance should also be made clear. The First Written warning be confirmed in writing and will remain current for a maximum period of 12 months.

12.2 Final written warning

Continued misconduct or serious misconduct

In the case of further offences of misconduct or a first instance of serious/gross misconduct, the employee may be given a final written warning, setting out the nature of the offence and containing the statement that any recurrence or further misconduct may lead to dismissal. The warning will remain current for up to 2 years depending on the nature of the offence.

Final written warning and other measures as an alternative to dismissal

Where the decision of the Disciplinary panel is to dismiss the employee, they may go on to determine that, as an alternative to dismissal it is preferable to impose a final written warning in addition to other measures. These measures include down-grading, where appropriate, without protection and/or transfer without protection, as well as retraining. Where down- grading is applied the

employee will be advised of the period before they may be able to apply for vacant posts within the Trust on their former grade.

12.3 Dismissal

The final measure in the procedure is dismissal with the appropriate period of notice or payment in lieu of notice. The manager has discretion to decide whether the employee will be required to work their notice.

12.4 Summary dismissal

In cases of gross misconduct, summary dismissal without notice pay will apply.

13 Examples of Misconduct

The following list gives examples of the circumstances that could lead to disciplinary action (this list is not exhaustive).

- Employees are expected to combine prompt and efficient service with respect for the feelings of others, including patients, visitors and colleagues in line with the Trust values. Bullying and Harassment
- Employees refusing to work
- Employees must be open, honest and truthful in all their dealings with patients, colleagues and the public.
- Employees are expected to attend for duty for the hours detailed in their contracts of employment and as agreed with their managers.
- Being absent without permission. In cases of sickness or sudden domestic emergency, employees must inform their manager in accordance with Trust policy.
- During periods of sickness absence, employees are expected to keep their manager informed of their progress and submit GP fit note certificates promptly.
- Misuse of social media affecting the reputation of the Trust or causing colleagues distress/offence
- Employees must carry out reasonable instructions.
- Anyone undertaking other employment outside their contractual hours must ensure that it does not hinder or conflict with the interests of their employment with the Trust or their duty to abide by relevant professional codes of conduct or have any adverse effect upon their work performance. Employees should inform their managers of employment outside working hours.
- Breach of confidentiality

- Misuse of authorised access to information and systems, unauthorised access to information and systems, and any activity that could breach the security of the Trust ICT Infrastructure and any other breach of the Trust Information Security Policy
- Sleeping on duty (this does not include sleeping during agreed breaks or out of hours arrangements)
- Employees are expected to comply with health and safety requirements.
- Employees are expected to treat Trust facilities and property with respect.
- Employees must inform their managers of any charge, caution or conviction, relating to acts committed on or off duty, at the earliest possible opportunity.
- Failure to maintain professional registration where it is a requirement of the job (see requirements as per Trust Professional Registration policy)
- Employees should at all times undertake their work in accordance with Trust and departmental policies and procedures and, where appropriate, their professional codes of conduct.
- People are expected to display positive attitudes and supportive behaviours in line with Trust values in their interactions with other people
- Breaches of professional codes of conduct and Trust policies
- Behaviour outside of work that could affect the professional reputation of the individual or the reputation or operations of the Trust.

14 Examples of Gross Misconduct

Examples of gross misconduct could include (this list is not exhaustive):

- Serious lack of care to duties or other people which could result in serious loss, damage or injury ('gross negligence')
- Theft
- Fraud
- Deliberate falsification of records or documents
- Working without valid "Right to Work" documentation
- Working without statutorily required qualifications
- Working elsewhere whilst on sick leave
- False declarations made during the recruitment process
- Receipt of money, goods, favours or excessive hospitality in respect of services rendered while a Trust employee
- Physical violence
- Verbal abuse
- Harassment or bullying
- Unlawful discrimination
- Being unfit for duty through the effects of alcohol or drugs
- Abuse, misuse or deliberate damage of Trust property or equipment
- Serious breach of data security requirements, any activity that could breach security of the Trust ICT Infrastructure and any other serious breach of the

Trust Information Security Policy including serious misuse of authorised access / unauthorized access to information and systems.

- Serious breach of Health and Safety and other statutory rules
- Serious breach of a professional code of conduct as determined by the professional body
- Failure to act impartially or to declare interest in a contract or business in which the Trust is engaged or considering
- Scientific Misconduct - Fabrication, falsification, plagiarism or deception in proposing, carrying out or reporting results of research
- Serious breach of trust and confidence - Any act which causes irreparable damage to the relationship of trust and confidence between the employee and the Trust.

15 Notification of Outcome

15.1 When the decision has been taken on what action to take the hearing should be reconvened with all parties present. The manager should then explain the decision that has been reached and any conditions attached to it. The right of appeal and how to exercise it should also be explained.

15.2 Where there is insufficient time on the day to make a decision due to the amount of information presented, the hearing manager should advise the employee within what timescale they will notify them of the outcome and the method of notification.

15.3 The manager will confirm the outcome of the hearing in writing to the employee with a copy to the representative as soon as reasonably practicable and within no later than 7 calendar days of the hearing, any extension to this timeframe will be outlined from the outset A copy should remain on the personal record of the employee. The letter should:

- State the precise nature of the misconduct
- State if appropriate the improvement in conduct which is required and the timescale for such improvement;
- Specify the disciplinary action being taken and how long that action will remain on the employee's personal record;
- Specify any other action being taken;
- Indicate the consequences of any further offence or failure to improve performance; and
- Inform the employee of their right of appeal and how to exercise that right.
- Give the reasons for the decision where dismissal is involved

16 Action in particular cases

16.1 Trade Union representation

Where disciplinary action is being considered against an employee who is a trade union representative the normal disciplinary procedure should be followed. Depending on the circumstances, for example if the allegations relate to Trade Union duties, a discussion relating to the matter will take place between the Associate Director of Human Resources and the appropriate official employed by the union, after notifying the employee's agreement.

16.2 Criminal offences

If an employee is arrested on a criminal charge or served with a summons on criminal charges, whether or not arising out of their employment, their manager will need to consider whether or not the alleged offence has any implications for the duties of the individual in the Trust's employment.

The Trust reserves the right to suspend the employee from duty pending the outcome of any police investigation or criminal proceedings. Such suspension will be on full pay. In most cases it will be appropriate to proceed with internal investigations without waiting for the result of any criminal proceedings.

Where an employee is detained and unavailable for work due to criminal proceedings, they will be suspended on no pay. At the point they are released and become available for work a judgement should be made on whether they should be suspended on full pay pending an investigation.

Every effort should be made to enable the employee to respond to the allegations ahead of a hearing and where possible the hearing should be convened once the individual has been released. However the Trust retains the right to hold a hearing in the absence of the employee where a significant detention is likely.

17 Delays

17.1 Unavailable employee

The Trust will only consider requests for postponement of investigation and disciplinary meetings/hearings where there is a good reason for inability to attend. If the employee is unable to attend the rearranged meeting/hearing, the Trust reserves the right to hold the meeting/hearing in their absence.

17.2 Unavailable companion

Where delays are due to unavailability of union representatives, then only one request for postponement will be accepted. A new date will be given and the employee will be expected to arrange representation.

17.3 Failure to attend re-arranged hearing

Where an employee is unable or unwilling to attend a re-arranged disciplinary hearing without good cause the Trust will make a decision in their absence based on the evidence available at that time.

17.4 Ill health absence

Where a postponement is requested due to ill health, the hearing may be deferred on review of all the available evidence and, if it is, it will be reconvened at the earliest opportunity.

17.5 Where deemed necessary in these cases, and if further requests for postponement are submitted, advice will be sought from Occupational Health to ensure that the employee is well enough to participate and that all relevant support is being offered and reasonable adjustments made.

17.6 Where the employee is unable to attend a hearing within a reasonable time frame the Trust reserves the right to proceed with the hearing in their absence. The individual may be represented in their absence at the hearing by their trade union or a colleague and may make written submissions.

18 Levels of Authority

18.1 Wherever possible, disciplinary action, other than dismissal, should be dealt with by the employee's immediate line manager supported by a suitable person from HR. When the sanction may be dismissal, then, this will be dealt with by a manager at least 2 levels above the employee. This will normally be a member of a Directorate Senior Management Team or a manager at an equivalent level.

18.2 Where professional issues are involved and the manager hearing the case does not come from that discipline, a senior manager of the appropriate discipline will sit on the panel.

19 Appeals procedure

19.1 Where an employee wishes to appeal against the imposition of any formal disciplinary action they may do so following this procedure:

- Appeals against disciplinary action should be lodged with the next level of manager within 14 calendar days of receipt of written confirmation of the action.
- The appeal letter must state each ground on which the appeal is being made
- Appeals should be heard by the next level of management above the manager who made the original decision, supported by a representative from Human Resources. If 'professional' issues are involved, then a

senior manager of the appropriate profession may provide specialist advice to the Appeal manager or panel. This manager should not have been involved at an earlier stage.

- Not less than 5 calendar days prior to the hearing the disciplining manager and the employee will be required to submit to the panel and exchange with each other written statement of case which should fully address the grounds of the appeal.
- Employees will have the right to be represented by a Trade Union representative or accompanied by a work colleague.
- Appeal hearings will be recorded and/or a note-taker will be present

19.2 The appeal hearing will adopt the following procedure:

- The employee and/or representative will present the grounds for the appeal calling any witnesses.
- The management representative may ask any questions of the employee or witnesses as may the appeal manager or panel.
- The management representative will then be asked to outline the management case calling any witnesses that may be required.
- The employee and/or representative have the right to ask questions of the management representative and any witnesses, as does the appeal manager or panel.
- Both parties will have the opportunity to sum up their case with the employee speaking last.
- The hearing will then be adjourned to allow the appeal manager or panel to reach a decision in private. The appeal panel cannot increase the disciplinary sanction originally awarded.
- The Appeal Panel chair will confirm the method of communication for the decision.
- The decision of the appeal manager or panel will be notified to the employee in writing.

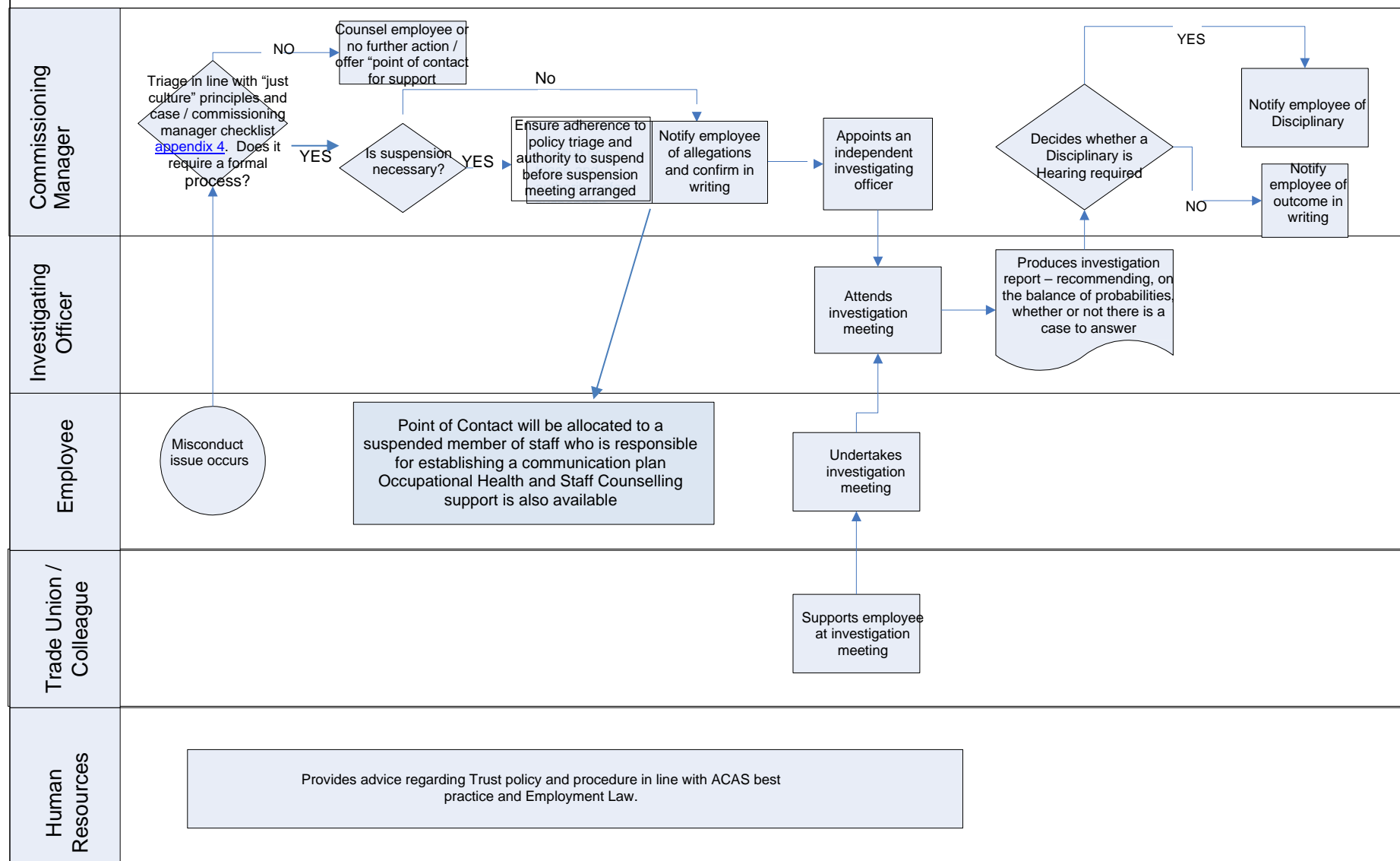
20 Referrals

In some circumstances it may be necessary to make a referral to the relevant external bodies. Managers should take advice from the appropriate professional lead for the trust before making such a referral.

21 Implementation and Monitoring

This policy will be reviewed 3 yearly or earlier in light of changes in legislation or new national guidance.

Disciplinary Procedure (Appendix 1 - Page 1)



Investigating Officer	<p>Presents investigation findings and calls witnesses as appropriate</p>				
Commissioning Manager	<p>Chair Disciplinary Hearing</p> <p>Decides on appropriate penalty</p> <p>Notify employee of outcome in writing – include right of appeal</p> <p>Implement monitoring / action plans as appropriate</p>				
Employee	<p>Attend Disciplinary Hearing</p> <p>Receives notification of outcome</p> <p>Decision whether to appeal</p> <p>YES</p> <p>Send appeal letter within 14 calendar days</p> <p>Attends appeal hearing</p> <p>NO</p> <p>End of Process</p>				
Trade Union / Colleague	<p>Supports employee at Disciplinary Hearing</p> <p>Supports employee at appeal hearing</p> <p>Receives outcome – END OF PROCESS</p>				
Human Resources	<p>Support Manager at Disciplinary Hearing</p> <p>Supports Appeal Manager</p>				
Appeal Manager	<p>Arranges Appeal Hearing</p> <p>Chair Appeal Hearing</p> <p>Notify employee of outcome in</p>				

APPENDIX 2 - SAFEGUARDING

In cases of allegation of abuse involving vulnerable adults or children, the issue should be reported immediately to a senior manager.

These cases must be managed in line with the interagency policy and procedures for Safeguarding Vulnerable Adults and Children in Stoke on Trent and Staffordshire. The senior manager will make an appropriate referral to the relevant agencies/Local Authority Designated Officer (LADO) in line with these procedures.

The senior manager should consider whether it is appropriate for the worker to continue to work. Suspension should not be seen as an automatic response to an allegation and all cases should be individually considered. It may not be apparent whether suspension is necessary until wider information sharing and discussion between agencies has taken place. It may also be appropriate to seek an opinion of the LADO on the appropriateness of a suspension.

Suspension should be considered in any case if:

- 21.1.1 there is cause to suspect a child or vulnerable adult is at risk of significant harm
- 21.1.2 there is any possibility of further incidents or abuse;
- 21.1.3 the allegations warrant investigation by the police
- 21.1.4 the allegation is so serious it may constitute gross misconduct
- 21.1.5 continuing to work might compromise evidence; would adversely affect the worker, colleagues or service users, or if it might increase the suspicions or concerns.

Where suspension is deemed appropriate the individual should be notified that they are being suspended “pending an investigation into a safeguarding matter”. Further details of the alleged offence should be given only after the strategy meeting (which should take place 2-4 working days after the incident) has been concluded and it is clear that to provide further details will not compromise any other investigation. Details of the allegation will usually be released at the initial investigation meeting, unless otherwise agreed with Strategy meeting leads.

No disciplinary investigation should be commenced prior to a referral to agencies and Designated Officers as stated in the Safeguarding Procedures and a resulting Strategy discussion /meeting has been held (where deemed necessary). Proceeding with a premature investigation may compromise evidence and adversely affect other formal investigations

APPENDIX THREE – NEVER EVENTS

The NHS Improvement defines ‘never events’ as ‘serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers’.

More information can be obtained from NHS Improvement website

<https://www.england.nhs.uk/publication/never-events/>

<https://improvement.nhs.uk/resources/never-events-policy-and-framework/#h2-revised-never-events-policy-and-framework-and-never-events-list-2018>

APPENDIX FOUR

Case / Commissioning manager checklist Decision making methodology for triaging employee relations cases

The purpose of this checklist is to ensure that a comprehensive and consistent decision-making methodology is applied in response to a concern or incident that provides for full and careful consideration of context and prevailing factors when determining next steps.

This is consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action, such as suspension or disciplinary investigation, in response to a concern or incident.

This checklist responds to one of the requirements from the NHSEI review into improving people practices, in light of the tragic circumstances of Amin Abdullah, to ensure the health, safety and wellbeing of our people within a restorative and just culture context. Even though the just culture decision tree relates to patient safety incidents, the Trust believes that the decision making methodology is transferable and applies to all concerns and incidents; particularly as all of our people contribute to patient care whether that be directly or indirectly.

Case / Commissioning Manager Checklist	Y / N	Rationale / findings summary
<p>1. Are you clear on what the issue is and what policy you are using?</p> <ul style="list-style-type: none"> Starting with asking what has happened rather than who is responsible Is the issue is related to a wider engagement, <i>*cultural</i> or environmental issue across the team rather than a small number of individuals? Conduct (won't do) or capability (can't do)? Or grievance or raising concerns or Bullying & Harassment at Work? If it is a conduct issue, decide whether an investigation is necessary? Would a quiet word / informal action resolve the matter and be appropriate, subject to severity? Is it a safeguarding and / or police matter? Has MHPS been considered if medical staff member? <p><i>*cultural issue – e.g. team dynamics work related culture or relating to a protected or non-protected personal characteristic, including (but not limited to) religious, ethnic, national or cultural group, ability/disability, sexuality, gender or gender identity)</i></p>		
<p>2. Have you reviewed the NHSI Just Culture guide and website to inform your decision making?</p> <ol style="list-style-type: none"> Deliberate harm test Health test Foresight test Substitution Test Mitigating circumstances 		
<p>3. Would you benefit from a preliminary investigation?</p> <ul style="list-style-type: none"> Where it is uncertain whether a full investigation is unnecessary or appropriate, a manager may benefit from trying to find this out first. Usually this would be limited to gathering appropriate initial evidence on the matter, e.g. witness statements. 		
<p>4. Have you fully considered all of the above to inform your decision?</p>		<p>Delete as appropriate or specify if other – Informal action / Commission a formal investigation under the Disciplinary Policy / Temporary transfer / Suspension Facilitated meeting / Mediation / OD intervention</p>

APPENDIX FIVE – Conduct Counselling Record

Date & location of Conduct counselling Meeting			
Staff Member		Position	
Manager/ Supervisor		Position	

Please use the table below to record each aspect of the discussion, if it becomes apparent that the matter is more serious the meeting should be adjourned and the staff member advised that the issue may be taken forward under the formal disciplinary procedure. A copy of this signed form should be given to the staff member and a copy retained on their personal file.

Misconduct issue	Evidence	Mitigation/reason	Expectation/Standard required	Training / Support required (what/by whom/when)	Timescale or deadline for improvement

If the necessary improvement in conduct is not forthcoming within the defined timescale or is the misconduct is repeated formal disciplinary action may be taken. If a reason preventing the improvement becomes apparent this must be raised by the staff member at the earliest opportunity and must be documented.

Staff member signature	Date	Manager/Supervisor signature	Date
------------------------	------	------------------------------	------

3.13 Bullying & Harassment At Work Policy

DOCUMENT INFORMATION

CATEGORY:	Policy
THEME:	Human Resources
DOCUMENT REFERENCE:	3.13
DIRECTOR LEAD:	Director of Leadership and Workforce
APPROVAL DATE:	6 th June 2024
APPROVAL BODY:	PCDC
BOARD RATIFICATION DATE:	7 th September 2017
FINAL REVIEW DATE:	30 th June 2025

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1 Policy Statement

- 1.1 As an equal opportunities employer, North Staffordshire Combined Healthcare NHS Trust (the Trust) supports a working environment for individuals in which dignity at work is paramount. The purpose of this policy is to support a working environment and culture in which bullying and harassment is unacceptable.
- 1.2 This policy supports application of our Trust Values which guide our actions and behaviours. We are Proud to CARE:

Caring
Approachable
Responsible
Excellent

2 Scope

- 2.1 This policy applies to all workers within the Trust, employees, visitors, patients, contractors, volunteers, students and staff from other organisations working on Trust premises. It also applies to all Trust employees working in other premises.

3 Duties

- 3.1 **The Executive Lead** for this policy is the Director of Leadership & Workforce, who is responsible for ensuring that there is an appropriate policy lead, that the policy is reviewed and updated appropriately and that compliance with this policy is monitored.
- 3.2 **The Policy Lead** has a responsibility to:
- Ensure the policy is reviewed in line with updates in legislation
 - Carry out a full review of the policy every three years or sooner if changes are required
 - Ensure the policy is produced in the agreed Trust format using the Trust template
 - Contact all contributors at times of review
 - Provide the approving committee with a final draft at the appropriate times
 - Ensure that compliance is being met against this policy
- 3.3 **Managers** have a duty to encourage a culture free from bullying and harassment by:

- Setting a positive example by treating others with respect and demonstrating acceptable behaviours.
- Promoting a working environment where bullying and harassment is unacceptable.
- Taking prompt action to stop any form of bullying or harassment as soon as it occurs.
- Ensuring that potentially offensive material is not displayed or circulated in the workplace.
- Ensuring that staff who report incidents of bullying or harassment are protected from victimisation, and are aware of support available such as Occupational Health and the Staff Support and Counselling Service.
- Ensuring that staff attend Bullying & Harassment training sessions where a need has been identified.
- Seeking advice from Staff Side Representatives and Human Resources.

3.4 Any person described in section 2.1 has a duty to ensure they do not bully, harass, or contribute to or condone bullying or harassment of colleagues by others. Staff will also be required to attend Bullying & Harassment training sessions when requested by a manager.

All working on behalf of the Trust have a responsibility to support a culture free from bullying and harassment and to promote inclusive team working and care environments. The Trust will not tolerate any form of racist, cultural, religious, sexist, misogynistic, ableist, biphobic, homophobic and/or transphobic discrimination, bullying and harassment in any of our services, whether from service users and patients, members of the public, or those working on behalf of the Trust. Action will always be taken where this occurs.

3.5 The HR department have a responsibility to ensure that the policy is followed fairly and consistently. Their duties will involve:

- Advising managers on the application of the policy
- Ensuring that all staff and managers involved are aware of support available to them
- Ensuring the effective implementation of the policy
- Monitoring incidents of bullying and harassment and initiating appropriate action
- Reviewing and amending the policy as necessary
- Ensuring that Bullying & Harassment training sessions are held and are open to all managers to attend.

3.6 Trade Union Representatives may support their members as required and guide them through the process if needed.

4. Framework

4.1 All employees have a right to be treated with dignity and respect and to work in an environment free from bullying or harassment.

- 4.2** The Trust recognises that bullying or harassment in the workplace is improper and inappropriate behaviour, which may cause stress and undermines the health and safety of people at work. Such behaviour will not be tolerated.
- 4.3** Managers and Trade Unions have a joint commitment to working together to monitor incidents of bullying and harassment, and to resolving issues in an effective and consistent manner, using appropriate mechanisms.
- 4.4** Each member of staff carries personal responsibility for their own behaviour and are responsible for ensuring that their conduct is in line with the standards set out in the behaviours framework (Appendix 2) and this policy. Staff should report to the appropriate manager, or trade union representative, or HR department, any incidents of bullying and or harassment which come to their attention.
- 4.5** Allegations raised regarding bullying and harassment will be taken seriously and treated confidentially. The Trust gives an assurance that there will be no victimisation against an employee making a complaint under this policy or against employees who assist or support a colleague in making a complaint.
- 4.6** Bullying and harassment may be treated as a disciplinary offence and will be managed in accordance with the Trust Disciplinary Policy. Disciplinary action may also be taken if a complaint is found to have been submitted maliciously or in bad faith.
- 4.7** The Trust aims to ensure that all managers are trained to recognise and deal with bullying and harassment, and that appropriate support is available to managers dealing with incidents, where required.
- 4.8** The Trust recognises that bullying or harassment causes stress and can affect job performance. Anyone who feels they are experiencing Bullying and harassment, or is involved in any way is encouraged to seek confidential support and advice from the Trust's Staff Support and Counselling Service, or the Occupational Health Service, at any stage.

5 Definitions

- 5.1** The Trust uses the following definitions to determine whether any reported behaviour constitutes bullying or harassment:

5.2 Harassment as defined in the Equality Act 2010 is:

Unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual. The characteristics that are protected by the Equality Act 2010 are:

- age
- disability

- gender identity and gender reassignment
- marriage or civil partnership pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation.

5.3 An employee may find behaviour offensive and make a complaint even if the conduct is not directed at them and they need not possess the relevant protected characteristic themselves.

5.4 It doesn't matter whether any of these characteristics apply to you, or the people in your life. If you are treated worse because someone thinks you belong to a group of people with protected characteristics, this is discrimination.

5.5 The Act now also protects you if people in your life, such as family members, friends or co-workers have a protected characteristic and you are treated less favourably because of that. For example, you are discriminated against because your son is gay.

5.6 Bullying

5.7 Bullying may be characterised by offensive, intimidating, malicious or insulting behaviour, or an abuse or misuse of power which results in the recipient feeling threatened, undermined, humiliated or vulnerable.

5.8 Bullying or harassment may be by an individual against an individual (perhaps by someone in a position of authority such as a manager or supervisor) or involve groups of people. It may be obvious or it may be insidious. Whatever form it takes, it is unwarranted and unwelcome to the individual. Appendix 1 gives examples of unacceptable behaviours that can be considered to constitute bullying and harassment.

6 Procedure

6.1 A process map of the procedure can be found at Appendix 3.

6.2 Incidents of bullying or harassment may be reported to any manager, Union representative or the HR department. The person reporting the incident will be asked to complete a Bullying & Harassment Reporting Form in order to capture the details of the incident(s). This form can be found at Appendix 4, and the completed form should be forwarded to the Union office and or the HR department.

6.3 It is in the interests of all parties that allegations of bullying and/or harassment are resolved informally where possible in order to preserve working relationships. However, where a formal investigation into allegations of Bullying

or Harassment is required, this will be undertaken using the Disciplinary investigation process.

6.4 If allegations of bullying or harassment are substantiated, the alleged offender will be subject to the disciplinary process.

6.5 If the complainant is not satisfied with the outcome of the investigation at paragraph 6.3, they will have the right to appeal the outcome at Stage 3 of the Resolution of Grievance and Dispute Procedure.

7 Implementation and Monitoring

7.1 Compliance with this policy will be monitored through the mechanisms detailed in the table below. Where compliance is deemed to be insufficient and the assurance provided is limited an action plan will be developed to address the gaps; progress against the action plan will be monitored at the specified group / committee.

Minimum requirement to be monitored	Process / Method	Responsible individual / group / committee	Frequency of monitoring	Responsible individual / group / committee for review of results	Responsible group / committee for monitoring action plan
Duties	PDR	Line Manager	Annually	Line Manager	Line Manager
Statement by the organisation that harassment and / or bullying is not acceptable	Policy review	HR Team	3-yearly	N/A	N/A
Process for raising concerns about harassment and / or bullying	Report	HR Team	Monthly	- Head of Directorate - Executive Team - Trust Board	Head of Directorate
	Review of Staff Survey	Training & Development Team	Annually	Quality Committee JNCC	Quality Committee JNCC
	Analysis of completed Bullying and Harassment forms plus disciplinary / grievance cases	HR Team	At least annually		
Process to be followed once a concern has been raised	Report	HR Team	Monthly	- Head of Directorate - Executive Team - Trust Board	Head of Directorate

	Review of Staff Survey	Training & Development Team	Annually	Quality Committee	Quality Committee
	Analysis of completed Bullying and Harassment forms plus disciplinary / grievance cases	HR Team	At least annually	JNCC	JNCC
Organisation's expectations in relation to staff training, as identified in the TNA	PDR	Line Manager	Annually	Line Manager	Line Manager

8 Associated Policy and Procedural Documentation

- 8.1** The Trust has a legal duty to provide its workers with a workplace that is free from harassment, intimidation and bullying. The Trust recognises and will adhere to its obligations arising from employment legislation, in particular:

Equality Act 2010

Employment Act 2002

Health and Safety at Work Act 1974

- 8.2** This policy should be read in conjunction with other relevant Trust policies such as the *Disciplinary Policy*, the *Performance Improvement Procedure*, and the *Work-related Stress Policy*.

9 Training

- 9.1** Bullying & Harassment training is available as part of the People Management Programme, and is open to anyone to attend. Consideration may also be given to arranging a departmental training session if sufficient numbers of staff require it. Managers should contact the HR Department to arrange this.

- 9.2** Requirement for Bullying & Harassment Awareness training should be identified as part of the Trust process of Training Needs Analysis.

9.3 Attendance at training sessions is recorded on the Trust training database.

Appendix 1

Examples of unacceptable behaviour that can be considered to constitute bullying and harassment:

- Shouting at an individual to get things done
- Picking on one person when there is a common problem
- Ridiculing or humiliating an individual especially in front of their colleagues
- Physically abusing or threatening someone
- Victimising or treating someone less favourably than another, for example because a person has brought proceedings, given evidence or complained about the behaviour of someone who has been harassing or discriminating against them or others
- Consistently undermining someone and their ability to do their job
- Changing working practices or job content/responsibilities at short notice without consultation or explanation
- Communicating instructions through third parties or in writing when direct verbal communication would be the norm
- Delegation of excessive workload, delegation of work with unreasonably tight deadline or delegation of demeaning tasks
- Excessive supervision/monitoring of work
- Persistent and unjustifiable criticisms of work performance
- Bypassing an employee by persistently seeking advice and information from the employee's manager/colleagues/subordinate staff
- Personal abuse and micro aggressions relating to gender identity, culture, race, religion, ability/disability, sexual orientation or other personal attribute or characteristic
- 'Trolling' and personal abuse on social media

Appendix 2

Behaviours Framework

Proud to CARE **Compassionate Approachable Responsible Excellent**

The following is the behaviour framework, broken down by each value:

Compassionate <ul style="list-style-type: none">✓Listening to others, considering their feelings and needs✓Respecting and being responsive towards diversity and difference✓Pulling together, helping colleagues out when their priorities are greater than your own✓Recognising your own stresses & limitations and developing ways to cope with them✓Promoting and encouraging Healthy living and recovery with service users and colleagues	Approachable <ul style="list-style-type: none">✓Communicating with everyone openly, clearly and appropriately✓Keeping a positive and calm manner when faced with challenging situations✓Providing and welcoming feedback to support good behaviour and challenge inappropriate behaviour✓Taking people's understanding, viewpoints and needs into account when making decisions✓Being friendly and welcoming, making eye contact, giving your name and smiling where appropriate
Responsible <ul style="list-style-type: none">✓Always putting service users' first, maintaining professional integrity, confidentiality, following correct procedures, adhering to standards and adopting best practice✓Holding ourselves & others to account to prioritise our workload in delivering high quality timely care✓Developing our self-awareness by seeking feedback from others, reflecting and acting upon it✓Making the most effective use of available resources to provide best value at all times✓Take full responsibility for patients you come in contact with, ensuring any other needs are properly co-ordinated	Excellent <ul style="list-style-type: none">✓Encouraging team problem-solving to create better outcomes and solutions✓Being flexible and responsive, changing our own practice and behaviours to ensure we continually improve✓Inspiring and recognising others, so they feel they want to strive to improve or do something different✓Welcoming and being prepared to take acceptable risk to innovate or provide safe patient-centred care✓Looking outside the trust to compare our performance, search out best practice, develop relationships and share learning to improve ways of working

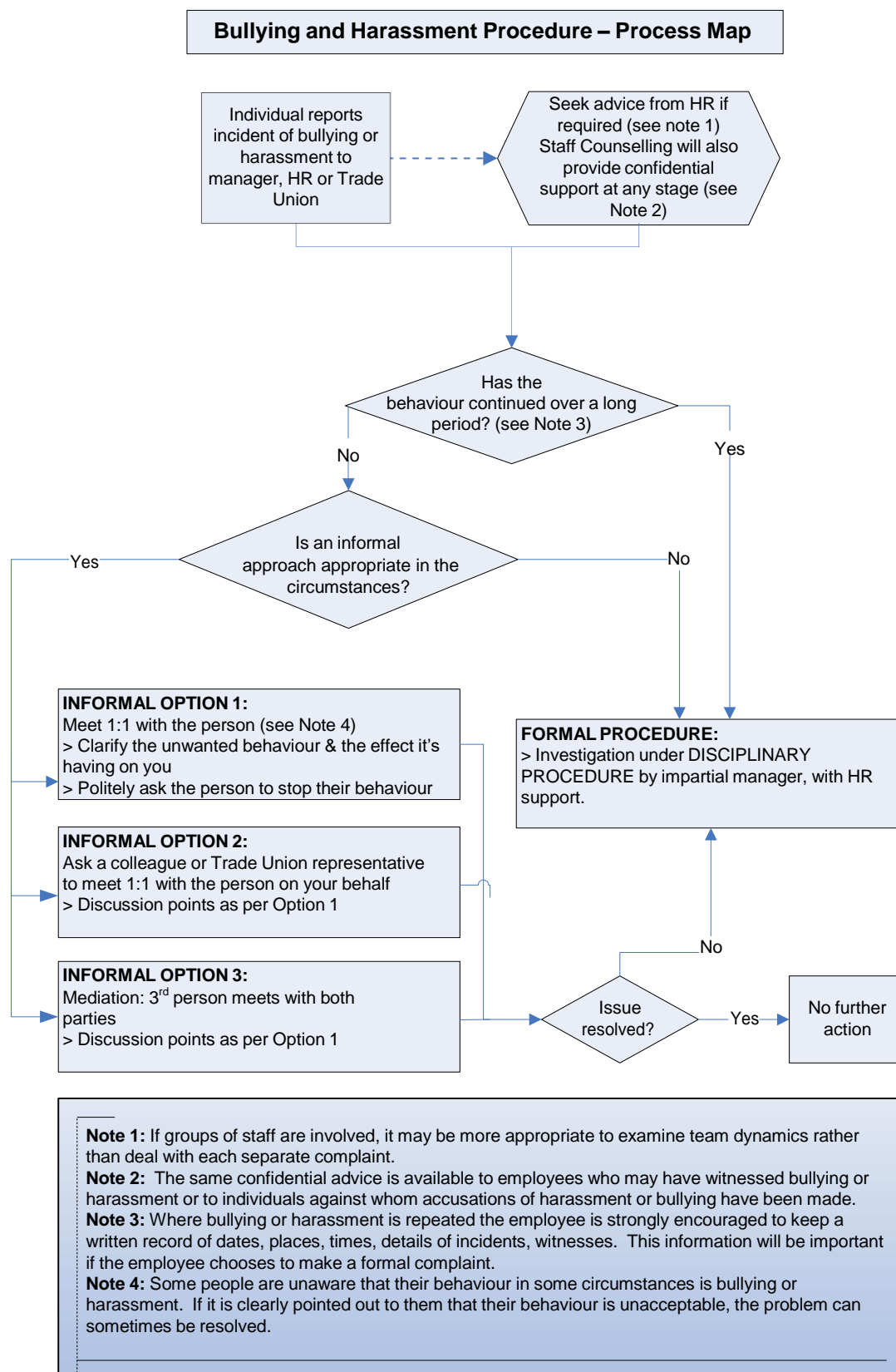
Document Reference: 3.13

Approval Date:

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Appendix 3



OUR ASSURANCE

All information will be treated as strictly confidential and no action will be taken without the complainant's knowledge.

We would still appreciate details of the incident for monitoring purposes, even if you do not wish any further action to be taken.

Do you agree to the Trust holding this information, in accordance with the Data Protection Act?

Incident details only

☐ Yes ☐ No

My details

☐ Yes ☐ No

Signature

Date

DON'T SUFFER IN SILENCE

REPORTING FORM FOR INCIDENTS OF BULLYING AND / OR HARASSMENT



Please complete this form and return it
to your Senior Manager, Union
Representative or a HR Advisor

ABOUT THIS FORM

This form has been designed for you to report any form of bullying or harassment occurring in the Trust that you may have directly experienced, witnessed or are reporting on behalf of someone else.

Sometimes you may feel that the incident is too minor to report. It is, however, still important to tell us what's happened.

ABOUT YOU

The details you provide will be recorded for monitoring purposes. If you wish this incident to be investigated please include how you would prefer to be contacted.

Are you the complainant or a witness?

☐ Complainant ☐ Witness ☐ Third Party

Name

Job Title & Grade

Address where you wish to be contacted:

.....
.....
.....

Tel no (work or home):

E:mail:

If you wish to be contacted only at certain times or locations, please give details:

.....
.....

OTHER WITNESSES

Were there any other witnesses to the incident?

☐ Yes ☐ No

If Yes, please give names, grades and base or work location

.....
.....

ABOUT THE INCIDENT

What do you think motivated this treatment?

☐ Racism ☐ Religion ☐ Disability

☐ Sexuality ☐ Gender ☐ Age

☐ Other

When did the incident take place?

Time Day Date

Where did this happen?

.....
.....

Were there any injuries?

☐ Yes ☐ No If Yes please give details:

Did any loss or damage to property result from the incident?

☐ Yes ☐ No If Yes please give details:

.....
.....

Please tell us about the incident in your own words, giving as much detail as possible – continue on a separate sheet if necessary.

.....
.....
.....
.....
.....
.....
.....
.....
.....
.....

ABOUT THE COMPLAINANT

Age Gender

First Language

Please tick how you would describe yourself:

Religion

☐ Buddhist

☐ Christian

☐ Hindu

☐ Jewish

☐ Muslim

☐ Rastafarian

☐ Sikh

☐ Other

☐ No religion

☐ Prefer not to say

Sexuality

☐ Heterosexual

☐ Bisexual

☐ Gay/Lesbian

☐ Prefer not to say

Ethnicity

☐ White British

☐ White Irish

☐ White other

☐ Black Caribbean

☐ Black African

☐ Black other

☐ Asian

☐ Indian

☐ Pakistani

☐ Bangladeshi

☐ Chinese

☐ Other (please clarify)

.....

☐ Prefer not to say

ABOUT THE ALLEGED OFFENDER(S)

How many alleged offenders were there?

Do you know them?

☐ Yes ☐ No

If Yes, please give names, grades and base or work location

Document level: Trust Wide

Code: 4.01

Issue number: _____

Safeguarding Children and Young People Policy

Lead executive	Chief Nursing Officer
Authors details	Head of Safeguarding

Type of document	Policy
Target audience	All individuals employed by the Trust including contractors, voluntary workers, students, locums, agency and bank staff.
Document purpose	To ensure safe working systems are in place to protect patients, relatives, staff and the public. Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguarding and Promote the Welfare of Children (2023) sets out how professionals should work together in multi-agency team to promote children's welfare and protect them from abuse. This policy is not intended to replace this guidance or that of the local Safeguarding Partnerships, but to be read in conjunction with them.

Approving meeting	Quality Committee	Meeting date	7 th November 2024
Implementation date	Existing Policy	Review date	30 th November 2027

Trust documents to be read in conjunction with	
1.70	Managing Safeguarding Allegations Against Staff
4.22	Children Visiting Mental Health & Learning Disabilities Hospitals
1.75	Domestic Abuse Policy
1.112a	Safeguarding Adults at Risk
1.87	Sexual Safety and Responding to Sexual Violence
4.26	Listening and Responding PALS and Complaints Policy
5.01	Incident Reporting Policy
4.43	Prevent Policy

Document change history		Version	Date
What is different?	Updated document to reflect updates to Working Together Safeguard Children 2023.	V4	
Appendices / electronic forms			
What is the impact of change?			

Training requirements	Safeguarding Children & Adults Level 1 & 2 is mandatory training for all staff. Face to face Level 3 Child Safeguarding training is mandatory for all professionally qualified staff working with
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	children or their families (ongoing involvement).
Document consultation	
Directorates	
Corporate services	
External agencies	
Financial resource implications	

External references	
<ol style="list-style-type: none"> 1. The Children Act. (1989, 2004). http://www.legislation.gov.uk/ukpga/1989/41/contents 2. Working Together to Safeguard Children: A Guide to Inter-agency Working to Safeguarding and Promote the Welfare of Children (2023) Working together to safeguard children 2023: statutory guidance (publishing.service.gov.uk) 3. Human Rights Act 1998 https://www.legislation.gov.uk/ukpga/1998/42/contents 4. The United Nations Convention on the Rights of the Child. (1990). https://www.unicef.org.uk/what-we-do/un-convention-child-rights/ 5. HM: Government Prevent Duty Guidance (2023) https://assets.publishing.service.gov.uk/media/65e5a5bd3f69457ff1035fe2/14.258_HO_Prevent+Duty+Guidance_v5d_Final_Web_1_.pdf 	

Monitoring compliance with the processes outlined within this document	This will be monitored via the Safeguarding Group, Clinical Safety Improvement Group and the Weekly Incident Group.
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Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Less favourable / More favourable / Mixed impact
Does this document affect one or more group(s) less or more favourably than another (see list)?		
<ul style="list-style-type: none"> – Age (e.g. consider impact on younger people/ older people) – Disability (remember to consider physical, mental and sensory impairments) – Sex/Gender (any particular M/F gender impact; also consider impact on those responsible for childcare) – Gender identity and gender reassignment (i.e. impact on people who identify as trans, non-binary or gender fluid) – Race / ethnicity / ethnic communities / cultural groups (include those with foreign language needs, including European countries, Roma/travelling communities) – Pregnancy and maternity, including adoption (i.e. impact during pregnancy and the 12 months after; including for both heterosexual and same sex couples) – Sexual Orientation (impact on people who identify as lesbian, gay or bi – whether stated as ‘out’ or not) – Marriage and/or Civil Partnership (including heterosexual and same sex marriage) – Religion and/or Belief (includes those with religion and /or belief and those with none) – Other equality groups? (may include groups like those living in poverty, sex workers, asylum seekers, people with substance misuse issues, prison and (ex) offending population, Roma/travelling communities, and any other groups who may be disadvantaged in some way, who may or may not be part of the groups above equality groups) 	<p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p> <p>No</p>	
If you answered yes to any of the above, please provide details below, including evidence supporting differential experience or impact.		
<p>Whilst the policy does not discriminate against any particular group additional consideration has been given to the additional complexities faced by individuals from some minority groups and increased complications for an individual when a disclosure of abuse or neglect also means a disclosure of sexual orientation, gender identity or gender reassignment or any other protected characteristic. However the compassionate response, support and signposting to specialist services provided by all employees of the Trust should be of the same standard regardless of the aforementioned issues.</p>		
<p>If you have identified potential negative impact:</p> <ul style="list-style-type: none"> - Can this impact be avoided? - What alternatives are there to achieving the document without the impact? <p>Can the impact be reduced by taking different action?</p>		

As above	
Do any differences identified above amount to discrimination and the potential for adverse impact in this policy?	No
If YES could it still be justifiable e.g. on grounds of promoting equality of opportunity for one group? Or any other reason	N/A
N/A	
<p>Where an adverse, negative or potentially discriminatory impact on one or more equality groups has been identified above, a full EIA should be undertaken. Please refer this to the Diversity and Inclusion Lead, together with any suggestions as to the action required to avoid or reduce this impact.</p> <p>For advice in relation to any aspect of completing the EIA assessment, please contact the Diversity and Inclusion Lead at Diversity@northstaffs.nhs.uk</p>	
Was a full impact assessment required?	No
What is the level of impact?	Low

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1. Introduction/Background

North Staffordshire Combined Healthcare NHS Trust (NSCHT) is committed to safeguarding and promoting the welfare of children. This policy applies to all children who come into contact with our services, whether as patients, the children of patients, the children of relatives or other close contacts of patients. Working Together to Safeguard Children (2023) states *‘Nothing is more important than children’s welfare. Every child deserves to grow up in a safe, stable, and loving home. Children who need help and protection deserve high quality and effective support. This requires individuals, agencies, and organisations to be clear about their own and each other’s roles and responsibilities, and how they work together.’*

Everyone who works with children, including those who work with parents or carers have a responsibility for keeping children safe. No single practitioner can have a full picture of a child’s needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action. All staff should consider the needs of adult patients as parents or carers and work proactively to provide additional support to families to achieve their right to family life (Article 16 United Nations Convention on Human Rights). However, the welfare of children will be paramount (Children Act 1989, 2004) and appropriate referrals to Children’s Social Care must be made when the threshold for intervention is met.

Parents with mental health problems, a learning disability and or problematic substance misuse may have complex needs and require additional support. Not all parents and children will need the support of health and social care services but those that do can find it difficult to get support that is acceptable, accessible and effective for the whole family. Parents with mental health problems need support and recognition of their responsibilities as parents and their children's needs must also be addressed.

This Safeguarding Children and Young People Policy provides an internal framework for the identification and response to concerns regarding children and young people and provides guidance for the implementation of inter-agency procedures for the protection of children. It is supplementary to the Stoke on Trent and Staffordshire Safeguarding Children Board multi-agency procedures and should be used in conjunction with these.

This policy is not a replacement for one-to-one discussion, support or supervision with the practitioners’ line manager, clinical supervisor, Head of Safeguarding, Named Doctor or Senior Safeguarding Nurse where concerns exist about the welfare of a child and additional support and advice should be sought wherever possible.

2. Policy Synopsis

The purpose of this policy is to:

- Inform staff of best practice when responding to concerns or disclosures of child safeguarding.
- Reduce the risk of harm and improve outcomes for children and young people by recognising child safeguarding as a serious issue which has an adverse impact upon the health and wellbeing of individuals, families and communities.
- Increase awareness and understanding of child safeguarding across the Trust.

- Ensure that all staff are clear regarding their legal and professional duty in tackling and responding to issues surrounding child safeguarding.
- Promoting inter-agency working.
- Provide support for our staff that may be experiencing child safeguarding concerns in the personal life.
- To ensure that processes are in place to support patients following a concern being raised or a disclosure being made.
- Ensure that standards are met in line with monitoring requirements.

2.1 Monitoring Requirements

The Trust's arrangements for safeguarding children are monitored via numerous external organisations, including the Care Quality Commission (CQC), Integrated Care Board (ICB) and the Stoke on Trent Safeguarding Children Board (SOTSCB) and Staffordshire Safeguarding Children Board (SSCB). **This does not absolve individual practitioners of their professional accountability and duties.**

These may include but are not limited to:

- CQC inspections, Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014) sets out in legislation responsibilities to safeguard those who use services from suffering any form of abuse or improper treatment whilst receiving care and treatment. This means that all providers must have robust procedures and processes implemented to make sure that children are protected. Staff must also receive safeguarding training that is relevant and at a suitable level for their role. Training should be updated at appropriate intervals and should keep staff up to date and enable them to recognise different types of abuse and the ways they can report concerns. Safeguarding must have the right level of scrutiny and oversight, with overall responsibility held at board level.
- Section 11 of the Children Act (1989, 2004) places a duty on key persons and bodies, including NHS Trusts, to make arrangements to ensure that, firstly, their functions are discharged having regard to the need to safeguard and promote the welfare of children, and secondly, that the services they contract out to others that are provided have regard to that need. Arrangements made under Section 11 should also take account of the Care Quality Commission (CQC) inspection framework which requires services to be safe; "by safe, we mean that people are protected from abuse and avoidable harm".
- Children Looked After and Safeguarding Inspections (CLAS), under Section 48 of the Health and Social Care Act, the CQC may also carry out special reviews of child safeguarding. This consists of an in-depth review of child safeguarding and looked after children services provided by primary medical health services, acute hospitals, mental health trusts (including child and adolescent mental health services), and community services (to include health visiting, school nursing, child and adolescent sexual health and substance misuse services). This includes risk of harm from radicalisation, female genital mutilation and child sexual exploitation. Recommendations for improvement are made and an action plan developed by all health services is inspected. Information from these reports is then added into intelligence processes and shared with external bodies such as Public Health England, Healthwatch and NHS England as well as partner inspectorates.

- Joint Targeted Area Inspections (JTAI) are inspections carried out by the Care Quality Commission (CQC), Ofsted, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), and Her Majesty's Inspectorate of Probation (HMIP). These thematic inspections look at how well local agencies work together to protect children. Inspections will focus on different 'deep dive' themes, providing an in-depth look at a particular issue. Further information is available on the link below:
<https://www.gov.uk/government/publications/joint-targeted-area-inspection-of-the-multi-agency-response-to-children-and-families-who-need-help>

3. Definitions of Child Safeguarding

A child is defined as anyone who has not yet reached their eighteenth birthday. The fact that a child who has reached 16 years of age and is living independently (or in further education, is a member of the armed forces, is in hospital or in custody in the secure estate for children and young people) does not change his or her status or entitlement to services or protection, (Working Together to Safeguard Children 2023). The word "child" therefore includes "children and young people" under the age of 18 years.

Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- providing help and support to meet the needs of children as soon as problems.
- protecting children from maltreatment, whether that is within or outside the home, including online.
- preventing impairment of children's mental and physical health or development.
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care.
- promoting the upbringing of children with their birth parents, or otherwise their family network through a kinship care arrangement, whenever possible and where this is in the best interests of the children.
- taking action to enable all children to have the best outcomes in line with the outcomes set out in the Children's Social Care National Framework.

(Working Together to Safeguard Children 2023).

4. Categories of Abuse

Child abuse is the maltreatment of a child by another person – either adults or other children. A child may be abused or neglected by inflicting harm, or by individuals failing to act to prevent harm. Children may be abused in a family or in an institutional, educational or community setting by those known to them or by persons unknown to them e.g. via the internet. Abuse can take place wholly online, or technology may be used to facilitate offline abuse.

Child abuse and neglect can and does happen to children from any background, culture, class, ethnicity or faith and can be physical, sexual or emotional.

4.1 Physical Abuse

This is a form of abuse which involves causing physical harm to a child; it may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning or suffocating. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

4.2 Sexual Abuse

Involves forcing or enticing a child or young person to take part in sexual activities whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities such as involving children in looking at (or in the production of) sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Child sexual exploitation (CSE) is also a form of child sexual abuse. CSE occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity in exchange for something the victim needs or wants, and/or for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

Grange Park Sexual Assault Referral Centre (SARC)

Grange Park Sexual Assault Referral Centre (SARC) provides services to men, women and children living in the Staffordshire area, who have been sexually assaulted or abused. At Grange Park there are a range of services that are free and confidential and include specially trained support workers, forensic medical examinations, emergency contraception, sexual health screening and referrals to partner agencies for additional support or counselling.

For anyone aged under 18 there is a dedicated service - West Midlands Regional Children and Young People's Sexual Assault Referral Service <https://www.westmidscyyps.co.uk/>

4.3 Emotional Abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and

learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may also occur alone.

4.4 Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers);
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

4.5 Prevent

The aim of Prevent is to stop people from becoming terrorists or supporting terrorism. Prevent also extends to supporting the rehabilitation and disengagement of those already involved in terrorism.

Please see NSCHT Prevent Policy for further information.

4.6 Contextual Safeguarding

Child Exploitation is a term used to describe the risk of harm young people experience beyond their families and recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse.

Exploitation can include robbery on public transport, sexual violence in parks and gang-related violence on streets, child sexual exploitation, missing children, county lines activity, through to online bullying and harassment from school-based peers and abuse within their intimate relationships.

Young people who are going missing from home or have siblings who have already been exposed to child exploitation are at heightened risk. Children exposed to these types of risks are at serious risk of criminalisation, sexual exploitation and exposure to violence. Criminal and sexual exploitation, like other forms of abuse and exploitation, is a safeguarding concern and constitutes abuse even if the young person appears to have readily become involved.

5. Levels of Need

5.1 Early Help

Early help means providing support as soon as a problem emerges, at any point in a child's life from the foundation years through to the teenage years. Providing early help is proven to be more effective in promoting the welfare of children than reacting later on when issues can often be more entrenched.

Early help can also prevent further problems arising; for example, if it is provided as part of a support plan where a child has returned home to their family from care, or in families where there are emerging parental mental health issues or drug and alcohol misuse. It is recognised there is a continuum of Early Help from preventing issues from occurring, to proactively identifying and responding to low level signs of unmet need through to more complex needs that require a more coordinated response.

5.2 Child in Need

This applies to children who are defined as being in need under Section 17 of the Children Act (1989 and 2004). These children are those whose vulnerability is such that they are unlikely to reach or maintain a satisfactory level of health or development, or their health and development will be significantly impaired without the provision of services, Child in Need also applies to those children who are disabled.

5.3 Significant Harm (Child Protection Procedures)

This is a statutory part of safeguarding children and promoting their welfare. Child protection refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm. This concept was introduced by the Children Act (1989) and is the threshold that justifies compulsory intervention in family life in the best interests of children and gives the local authority a duty to make enquiries (Section 47 of the Children Act) to decide whether they should take action to safeguard and promote the welfare of a child who is suffering or likely to suffer significant harm. It may be a single traumatic event, or a number of significant events, which interrupt, change or damage the child's physical or psychological development.

All agencies and individuals should aim to proactively safeguard and promote the welfare of children, so that the need for action to protect children from harm is reduced. The Framework for Assessing Children in Need and their Families (2000), see link below, is a useful multi-agency assessment tool which provides a common language to understand what is happening to a child, this should be used in conjunction with Threshold of Need models as used by the appropriate local authority to inform decision making regarding the correct level of need. The local threshold of need document is available on Combined Access Tool (CAT). <http://cat.combined.nhs.uk/nursing-quality/safeguarding/>.

6. Children and Parents with Mental Health Needs, Learning Disability or Substance Misuse

All staff, when assessing a patient, **MUST** consider the safety and wellbeing of all children that the patient comes into contact with and any potential harm to the child/children from the

patient. When a patient is being either admitted to a service, having their care reviewed or being discharged from a service consideration must be given to the impact of their health on parenting and their parenting on their health. These areas must be acknowledged appropriately in the care plan and risk assessments.

If a patient has parenting responsibilities these must be acknowledged within any risk assessments and care plans, including contingency planning for if the patient becomes so unwell it is impacting on their parenting capacity. Consideration should be given to the parent, the child and the family as a whole when assessing the needs of and planning care packages for patients with parenting responsibilities.

Details of children living with a patient or children they have regular contact with, must be recorded within the patient's electronic care records. All referral, assessment, monitoring, review, and discharge planning must consider if the patient is likely to have or resume contact with their own child or other children in their network of family and friends, even when the children are not living with the patient.

If the patient has or may resume contact with children, consideration must be given as part of the risk assessment of whether there are any actual or potential risks of harm to the children.

A family focus alone may not be enough to address the problems faced by some parents nor will it necessarily prevent a child from suffering harm. The adults' problems need to be addressed through specific clinical expertise and services, just as children's problems need to be, or those requiring a whole family approach. Factors to consider include:

- Does/did this adult have delusional beliefs that involve children?
- Does/did this adult have suicidal plans that involve children?
- What are the protective factors in relation to this child/children?
- What are the views/opinions/involvement of other agencies in relation to the children in this family?
- Is this adult compliant with medication and actively engaged with services?

Very serious risks to a child's safety and wellbeing may arise if an adult's mental illness incorporates delusional beliefs about them or children in general, or there is the potential for an adult to harm a child as a result of a suicide plan. Emotional harm results from the involvement of a child in an adult's suicide plan even if the child's life is not threatened directly. An urgent referral must be made to Children's Social Care:

- If patients express delusional beliefs involving a child and /or
- If patients might harm a child as part of a suicide plan.

7. Procedure for Reporting Child Safeguarding Concerns

Any child safeguarding incident which occurs on Trust premises should be reported to the Nurse in Charge/Ward Manager, who must inform the Senior Manager immediately in order for appropriate steps to be taken to safeguard patients, staff and visitors where necessary.

For all safeguarding concerns a referral should be made verbally to the appropriate Children's Social Care in line with local multi-agency safeguarding procedures, this should

be the local authority where the child usually resides, and locally this is usually either Children's Advice and Duty Service (Stoke) or Staffordshire Child Advice and Support (Staffordshire). Concerns should be shared in a clear and concise manner whilst ensuring you give a comprehensive overview of your reasons for concern. All Safeguarding Boards/Partnerships have a threshold document to support professionals in making referral to the appropriate level of support.

Remember for all referrals except child protection (Sec 47) parental consent is required. Consent should always be gained as best practice unless this places the child at increased risk, specific examples of known increased risk are where there is a suspected risk of fabricated illness, female genital mutilation and forced marriage, in these cases consent should not be sought, and a child protection referral should always be made.

Safeguarding incidents must also be reported on the Trust electronic incident reporting system and must be submitted as soon as practicable, when assessing the level of severity consideration must be given to the psychological impact of the incident on the victim alongside any physical injuries.

As part of the electronic incident reporting process a child safeguarding referral should also be completed by selecting yes to the radio button asking "is this a child protection concern" within the reporting form. You will be asked to complete a Child Safeguarding Questionnaire at the end of the form.

Child safeguarding procedures should not be invoked as a means to escalate or resolve professional disagreements or interpersonal issues unless a risk to the child is clearly indicated.

8. Safeguarding Adults

If as part of a disclosure concerns regarding potential or actual abuse, neglect or exploitation are raised regarding an adult with care and support needs, then an adult safeguarding referral should be considered in line with the Safeguarding Adults at Risk Policy (1.12a).

9. Child Safeguarding Practice Reviews

The purpose of serious child safeguarding case reviews, at local and national level, is to identify improvements that can be made to safeguard and promote the welfare of children. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations, or agencies to account, and there are other processes for that purpose.

(Working Together to Safeguarding Children 2023)

The objectives of a Child Safeguarding Practice Review include establishing;

- Lessons that can be learnt from how professionals and their agencies work together.
- How effective the local safeguarding procedures are.
- Both learning and good practice.
- How to improve local inter-agency working.

- Service improvements or development needs for one or more service or agency.

The Safeguarding Team will complete a chronology and independent management review or summary report of NSCHT knowledge of the family being reviewed. Clinical staff who have worked with the child (or identified significant others in the case) may be invited to attend review panels.

If staff are invited to participate in a CSPR, they will be supported by the Safeguarding Team throughout.

10. Supporting Staff with Child Safeguarding Concerns

The Trust aims to respond sympathetically, effectively and confidentially to any member of staff who receives a disclosure where there are child safeguarding concerns within their professional role and is committed to supporting our staff. The Trust will work with the member of staff, and where agreed other agencies, to identify what actions can be taken to support them throughout the safeguarding process.

Members of staff who are experiencing child safeguarding concerns in their personal lives may choose to disclose, report to or seek support from a staff side representative, a manager, or colleague.

Employee's right to confidentiality and discretion around personal details of employees will be respected. However, in cases where there are believed to be safeguarding concerns either relating to children or adults with care and support needs there is a statutory obligation upon the Trust to share this information with certain other statutory agencies such as the police and adult or children's social care and confidentiality cannot be guaranteed.

The Named Nurse for Safeguarding, and other practitioners within the Trust Safeguarding Team, are also available to provide support to all members of staff.

11. Advice and Supervision

All staff who work directly with patients and service users should access safeguarding supervision. All other areas of the trust can access if required.

Safeguarding supervision is available at different levels upon request from the Safeguarding Team as detailed below:

Level 1 - Staff can access safeguarding support and advice from their peers and line managers.

Level 2 - Safeguarding support and advice is available from the Safeguarding Team (Safeguarding Practitioner, Senior Safeguarding Nurse, Named Nurse for Safeguarding and Named Doctor for Safeguarding). This is one off advice regarding a specific safeguarding concern. Contact can be made via the phone, email or on Microsoft Teams.

Level 3 - Staff can access planned face to face individual supervision from the safeguarding professionals for more complex discussions.

Level 4 - Teams can access planned face to face group supervision from the Safeguarding Professionals. All clinical teams are expected to access Level 4 safeguarding supervision on a minimum of 6 monthly basis (more often as identified by line managers in response to clinical requirements)

Safeguarding supervision is mandatory for staff working with child protection cases, whether this is with the child/children or their parent's or carers.

All practitioners who are involved in working with a child or children or their parents/carer where there is a child in need plan, a looked after child, adult safeguarding Section 42 enquiry or counter terrorism involvement will have access to an identified advice from the Safeguarding Team to supervise this element of their work. It is the responsibility of the practitioner to contact the Safeguarding Team.

Safeguarding supervision forms are now available to record these discussions in the clinical record if necessary (Lorenzo only, other systems may need to record this separately).

Child safeguarding can be a rare occurrence for some staff and some staff will work with complex caseloads where there may be a number of safeguarding cases at various levels of need and complexity. Working with children at risk can be emotionally demanding and it is important that staff access the relevant support.

12. Duties and Responsibilities

12.1 Chief Executive and Other Executive Directors

It is the responsibility of the Executive Directors to ensure that this policy is enforced. The Chief Nursing Officer has Board level responsibility for safeguarding children.

12.2 Line Managers, Senior Medical Staff, Senior Nursing Staff, Senior Managers

It is the responsibility of senior members of staff to ensure that the policy is implemented.

12.3 Safeguarding Team

The Safeguarding Team will provide assurance to the Trust Board that all necessary measures are taken to safeguard children and provide advice, training, information and support to clinical staff regarding child safeguarding concerns.

12.4 Professionally Registered Clinical Staff

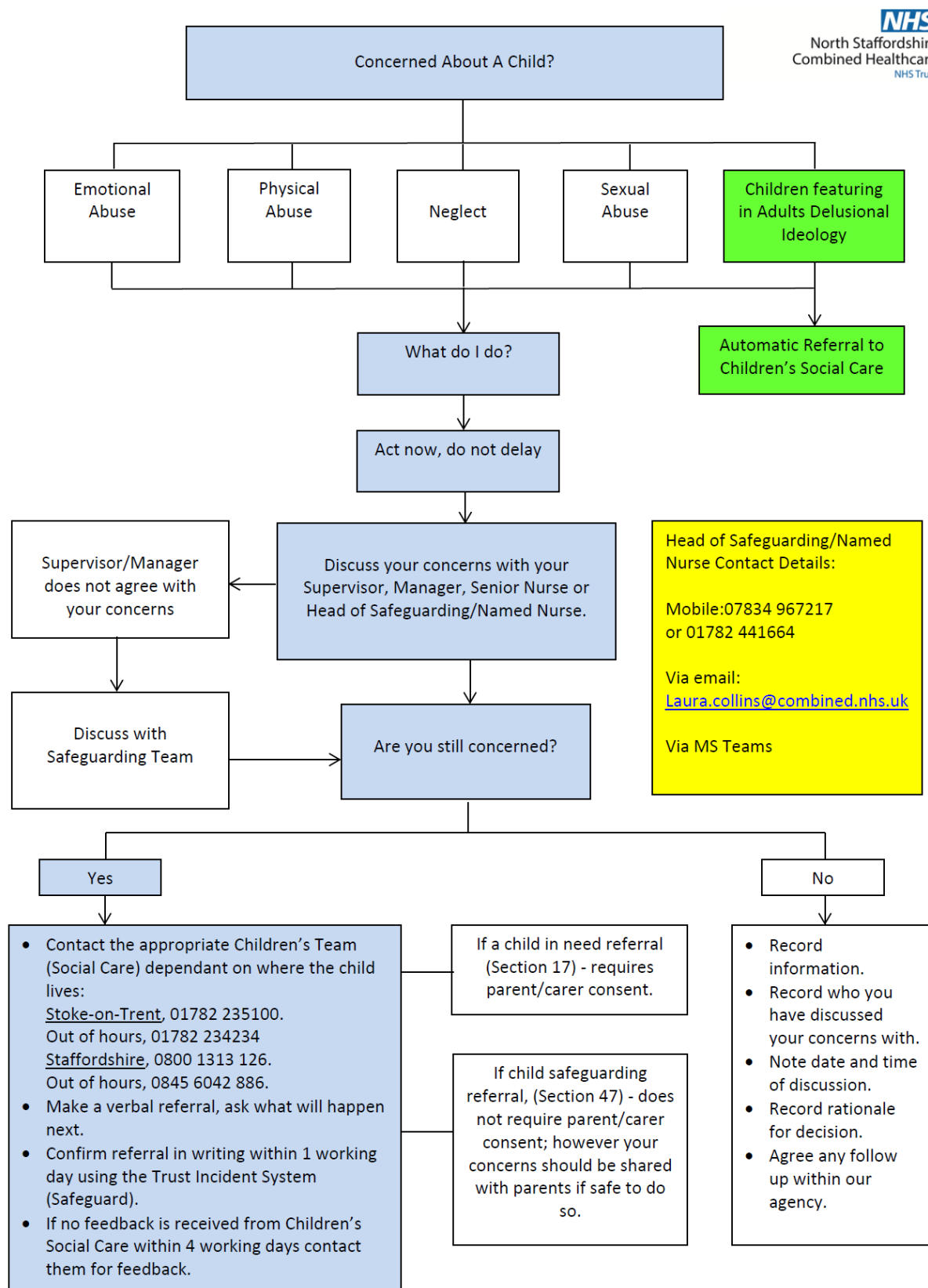
All professionally registered clinical staff have a responsibility to ensure they access training and support and are compliant with the Intercollegiate Document and their professional Code of Conduct in relation to maintaining competencies to allow them to identify and respond to child safeguarding concerns appropriately and in line with Trust policy. Additionally, all staff have a responsibility to seek advice and support in relation to any safeguarding concerns, access safeguarding supervision and attend

planned team safeguarding supervision. All staff have a responsibility to participate in statutory safeguarding processes and ensure that they are working collaboratively with partner organisations to promote outcomes for children at risk of abuse or neglect.

12.5 All Members of Staff

All members of staff have a duty to respond appropriately to child safeguarding concerns and should access available training and support as appropriate to their role in line with the requirements outlined in the Intercollegiate Document.

13. Appendix 1: Child Safeguarding Referral Process



If an emergency call 999

14. Appendix 2: Training Needs Analysis

Training Needs Analysis for the policy for the development and management of Trust wide procedural/approved documents

There is no specific training requirements- awareness for relevant staff required, disseminated via appropriate channels (Do not continue to complete this form-no formal training needs analysis required)	
There is specific training requirements for staff groups (Please complete the remainder of the form-formal training needs analysis required-link with learning and development department.	✓

Staff Group	✓ if appropriate	Frequency	Suggested Delivery Method (traditional/ face to face / e-learning/handout)	Is this included in Trust wide learning programme for this staff group (✓ if yes)
Career Grade Doctor	✓	3 yearly	eLearning/Face to face	✓
Training Grade Doctor	✓	3 yearly	eLearning/Face to face	✓
Locum medical staff	✓	3 yearly	eLearning/Face to face	✓
Inpatient Registered Nurse	✓	3 yearly	eLearning/Face to face	✓
Inpatient Non-registered Nurse	✓	3 yearly	eLearning/Face to face	✓
Community Registered Nurse	✓	3 yearly	eLearning/Face to face	✓
Community Non Registered Nurse / Care Assistant	✓	3 yearly	eLearning/Face to face	✓
Psychologist / Pharmacist	✓	3 yearly	eLearning/Face to face	✓
Therapist	✓	3 yearly	eLearning/Face to face	✓
Clinical bank staff regular worker	✓	3 yearly	eLearning/Face to face	✓
Clinical bank staff infrequent worker	✓	3 yearly	eLearning/Face to face	✓
Non-clinical patient contact	✓	3 yearly	eLearning	✓
Non-clinical non patient				

contact				
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Please give any additional information impacting on identified staff group training needs (if applicable)

All front-line clinical staff will be required to complete child safeguarding level 1 and 2 eLearning. All professionally qualified staff are required to complete face to face Level 3 training in addition to eLearning (Exception of Acute Adult ward staff that are not likely to form part of a Core Group, support will be given by the Safeguarding Team if ward staff are invited to Child Protection Conference).

The Training Department will maintain records of training and report on levels of compliance.

Additional subject specific Level 3 multi-agency training is available through the Stoke on Trent and Staffordshire Safeguarding Children Board.

Please give the source that has informed the training requirement outlined within the policy i.e. National Confidential Inquiry/NICE guidance etc.

Any other additional information

Completed by	Named Nurse for Safeguarding	Date	22/07/2024
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