Reference Number: FOIAH2425/106
From: Other

Date: 20 May 2024

Subject: Violence policy and trust self-assessment

Q1 Copies of all trust policies related to violence by patients and/or their visitors against staff. Please include all policies related to the following:
• Any physical, verbal, or sexual aggression, assault, or stalking.
• Violence both experienced and witnessed by staff.
• Any separate policies for different types of violence, different staff groups, or different phases of violence, e.g. during and following the event.

A1 See attached:
- Preventing and Managing Violence and Aggression at Work Zero Tolerance Process and Protecting Lone Worker Policy
- Tier 4 Service - Guidance for Managing Violence and Aggression

Q2 Copies of all trust policies/procedures related to the following post-violence measures, if not included within the above (1):
• Immediate sanctions for aggressor(s) (e.g. discharge)
• Processes for incident reporting
• Processes for debrief with staff member(s) and/or aggressor(s)
• Follow-up with aggressor(s) (e.g. accountability letter, behaviour contract)
• Counselling or similar longer-term psychological support for staff member(s)
• Incident investigation (e.g. root cause analysis) and feedback to relevant parties
• Longer-term sanctions for aggressor(s) (e.g. card system)
• Examples of processes for tailored management plans for patients with a known history of aggressive behaviour (including use of a flag/alert system)
• Staff sickness absence and/or returning to work following work-related injury

A2 See attached:
- Duty of Candour Policy
- Incident Reporting and Management Policy
- Patient Safety Incident Response Policy
- Sickness Management Toolkit, Supporting Sickness and Attendance Policy
- Supporting Staff Policy

Please note:
- The Incident Reporting and Management Policy and the Duty of Candour Policy are in date and are currently being reviewed, in line with current PSIRF/InPhase changes with ratification due in July 2024.
- The Supporting Staff Policy's review date is May 2024 and is currently in the process of being reviewed by HR/Staff side to confirm a timeframe for completion within their Annual workplan.

Q3 The trust's most recent self-assessment against the NHS Violence Prevention and Reduction (VPR) Standard, including evidence showing the criteria have been met for each indicator. The compliance assessment template can be found in the VPR Standard published by NHS England, available here (template on pages 7-14) NHS England » Violence prevention and reduction standard

A3 Information not held – the Trust does not routinely collate or hold this information centrally as part of its management or performance data.

NHS
Alder Hey Children's
NHS Foundation Trust

RM47– DUTY OF CANDOUR POLICY

A Statutory Duty to be Candid

Version:	7
Name of ratifying committee:	Safety and Quality Assurance Committee
Date ratified:	18/05/2022
Name of originator/author:	Associate Director of Nursing and Governance
Name of approval committee:	Clinical Quality Steering Group
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Date issued:	May 2022
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Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
7	May 2022	Associate Director of Nursing and Governance	Current	Modified to reflect best practice and add clarity
6	July 2018	Associate Director of Nursing and Governance	Archived	Substantially re-written
5	April 2015	Chief Nurse	Archived	
Being Open (When things go wrong) Policy – RM47				
4	March 2011	Head of Integrated Governance and Risk Management / Clinical Risk Advisor	Archived	
3	January 2010	Head of Integrated Governance and Risk Management	Archived	
2	September 2008	Medical Director / Risk Manager	Archived	
1	August 2006	Medical Director	Archived	

Record of changes made to Being Open and Duty of Candour Policy – Version 7			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
N/A	4	Minor changes to flow chart	To reflect current practice
1	5	Introduction partly rewritten	To add clarity
1	6	Additional definitions included	To add clarity
3	8	Some roles and responsibilities updated	To reflect current practice and changes in staff designations
3.13	9	Changes and additions	To add clarity
4.1	10	Modified	To add clarity
App C	23	Rewritten	To add clarity
App D	24	Modified	To add clarity

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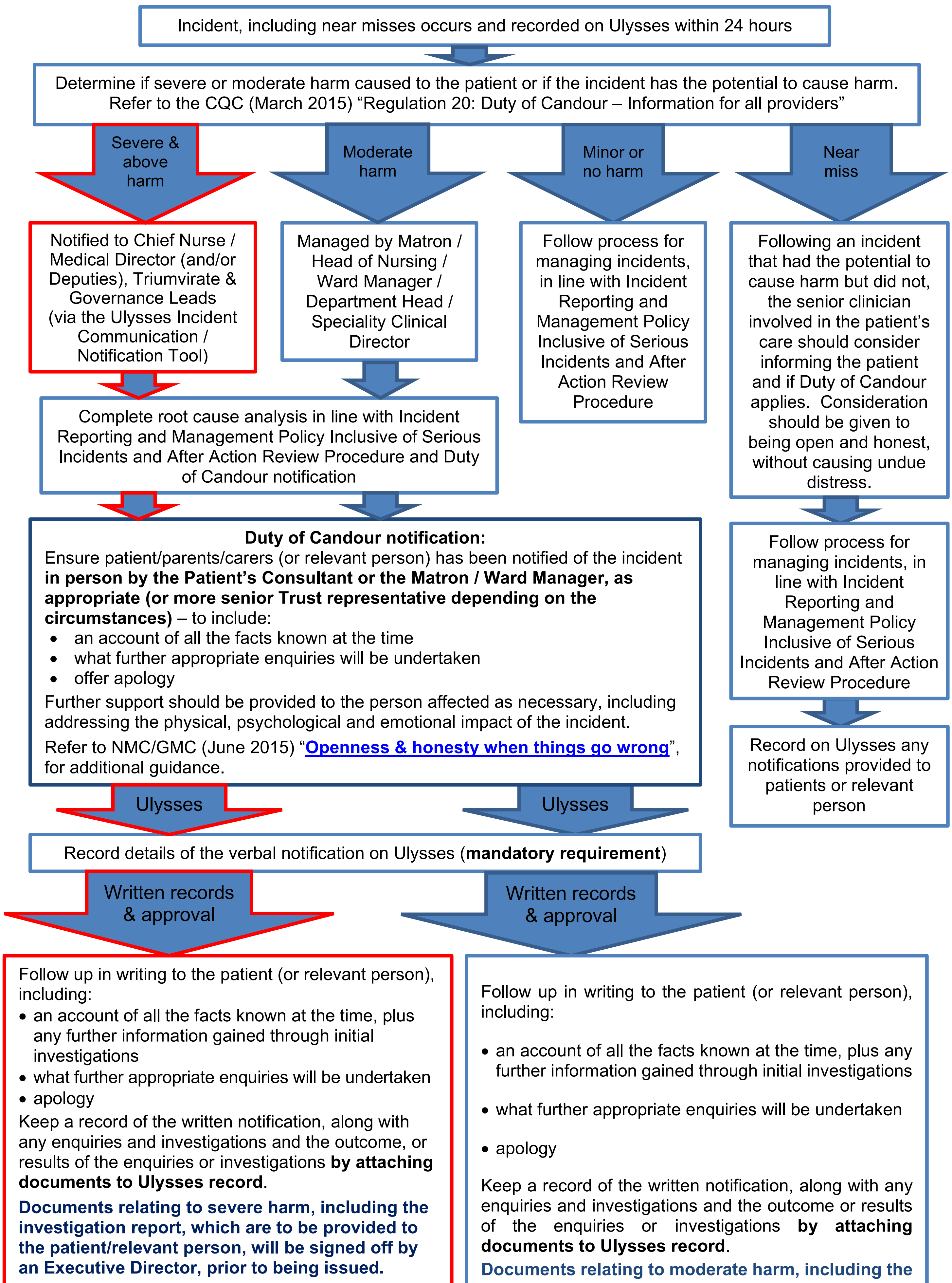
Duty of Candour Process Flowchart



1 Introduction

The purpose of this policy is to provide a best practice framework, to ensure the Trust is enabled to discharge its duty of candour by creating an environment where patients, their representatives and staff feel supported, and have the confidence to act appropriately, and to ensure that all communications with relevant people are open, honest and occur as soon as possible after an adverse event/incident, in line with regulation 20 (CQC).

The objective is to ensure that the Trust meets its statutory duty to be open and honest with patients and their families when something goes wrong, in a manner that is sensitive and focused on the needs and best interests of the child and their family

Since 27th November 2014 the Statutory Duty of Candour applies to all registered providers of both the NHS and independent bodies, as well as providers of social care. *Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities),*

'Being Open a duty to be candid' supports a culture of openness, honesty, and transparency, and includes apologising and explaining what happened after reflection, and with knowledge of all available facts. Openness and honesty at the point of an incident occurring can help prevent such events becoming complaints or litigation claims. 'Being Open' is endorsed by (among others) the Department of Health, the Care Quality Commission, NHS Resolution, the General Medical Council and the Nursing and Midwifery Council. The 'Duty of Candour' has been made a contractual requirement by the DH Operating Framework and has been included as a professional responsibility under the NHS Constitution (July 2015).

(The Nursing and Midwifery Council's The Code: Professional standards of practice and behaviour for nurses and midwives (statement 14)).

The effects of harming a patient can have devastating emotional and physical consequences for patients, their families, and carers. It can also be distressing for the professionals involved. Being open and honest about what happened and discussing the incident/complaint/claim fully, openly, and compassionately can help all those involved cope better with the consequences of harm, whether potential or actual, in managing the event and in coping in the longer term.

Being Open is a set of principles that healthcare staff should use when communicating with patients, their families and carers following a patient safety incident in which a patient has been harmed.

The scope of this document is Trust wide and applies to the staff that are employed within it and anyone representing the Trust.

The Trust is committed to 'Being Open' and candid; about communicating with patients, their relatives, and carers about any failure in care or treatment. This policy deals with the information and methods of sharing that information with patients, relatives, and their carers, staff, and other healthcare organisations.

The extent to which it is enacted will be determined on the grading of the severity of the event, (**Section 4.1**.)

2 Definitions

Act in an open and transparent way - Clear, honest, and effective communication with patients, their families and carers throughout their care and treatment, including when things go wrong, in line with the definitions below. The following definitions of openness, transparency and candour are those used by Robert Francis in his report:

Openness - Enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Transparency - Allowing information about the truth about performance and outcomes to be shared with staff, people who use the service, the public and regulators.

Candour - Any person who uses the service harmed by the provision of a service provider is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

Apology - An 'apology' is an expression of sorrow or regret in respect of a notifiable safety incident; It is not an admission of guilt.

Appropriate written records - Records are complete, legible, accurate and up to date. Every effort must be made to ensure records are updated without any delays.

Claim – "any demand, however made, but usually by the patient's legal adviser, for monetary compensation in respect of an adverse clinical incident leading to a personal injury".

Complaint - any expression of dissatisfaction with care provision, or a perceived grievance or injustice.

Event - any occurrence that results in a patient safety incident, complaint, or claim.

Cancelling treatment - Where planned treatment is not carried out as a direct result of the notifiable safety incident.

Near Miss – potential harm any unexpected or unintended occurrence or incident that did not lead to harm, loss, or damage, but had serious potential to do so and was prevented either by intervention or luck.

'Low harm' – any incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS funded care.

Moderate harm - 'Moderate harm' means harm that requires a moderate increase in treatment, and significant, but not permanent, harm, for example a "moderate increase in treatment" means an unplanned return to surgery, an

unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).

Prolonged pain - Prolonged pain' means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Prolonged psychological harm - 'Prolonged psychological harm' means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

Relevant person - This is the person who is receiving services or someone acting lawfully on their behalf in the following circumstances: on their death, or where they are under 16 and not competent to decide in relation to their care or treatment or are 16 or over and lack the mental capacity in relation to the matter in accordance with the Mental Capacity Act 2005.

Severe harm - 'Severe harm' means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

'Catastrophic or Death' – any incident that directly resulted in the death of one or more persons receiving NHS funded care. Death must be related to the incident rather than the underlying condition or illness.

Written Notification - A written notification is one given or sent to the relevant person in written form containing the information provided in any initial notification made in person, details of any enquiries to be undertaken, advise of any appropriate enquiries to be undertaken by the registered person, the results of any further enquiries into the incident, and an apology (as defined above).

Never Event – Are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by the healthcare provider.

NRLS – National Reporting and Learning System - the electronic system that all NHS Trusts inform the NHS Commissioning Board Special Health Authority of patient safety incidents. Where a patient safety incident is discovered through a complaint, concern or claim that has not previously been reported, case by case consideration should be given as to whether the incident is reflected on the NRLS retrospectively. It may be considered that the delay in reporting be reported as an incident itself.

StES Incident - is any incident occurring in relation to care that is reportable to the Commissioners and other regulators including the Care Quality Commission (CQC).

3 Duties Accountabilities and Responsibilities

3.1 Chief Executive as accountable officer has the responsibility to ensure there are systems in place regarding openness and communication with patients, relatives, and visitors and that this responsibility is delegated to an appropriate Executive Director. Make a public commitment to being open.

3.2 Chief Nursing Officer (CNO) & Chief Medical Officer (CMO) are the responsible delegated Executive Directors for Risk Management. The Chief Nursing Officer has the responsibility to report any moderate or serious incidents and ensure that they are actioned in line with this policy.

3.3 Associate Director of Nursing and Governance is responsible for ensuring the Being Open process for incidents is followed. The Associate Director of Nursing and Governance will report compliance with the Being Open process to the Clinical Quality Steering Group and by exception to the Safety and Quality Assurance Committee.

3.4 Division Triumvirate are responsible for ensuring the staff they line manage follow the processes outlined in this policy, and where non-compliance is identified, ensure this is addressed effectively. In addition, the triumvirate are responsible for providing assurance to the Trust Board of compliance with Duty of Candour in their Division.

3.5 Division Governance & Risk Leads are responsible for overseeing compliance with the processes in this policy, and ensuring the triumvirate are assured of compliance, including escalating non-compliance in a timely manner.

3.6 Clinical Directors and Matrons / Heads of Nursing are responsible for ensuring staff they line manage follow the processes outlined in this policy and providing assurance to their line managers, as required, of compliance, including escalation of non-compliance, in a timely manner.

3.7 Consultants and Ward Managers are responsible for ensuring staff they line manage follow the processes outlined in this policy and providing assurance to their line managers as required of compliance including escalation of non-compliance.

3.8 Named Consultants (or their representative consultant in their absence) responsible for patients care and treatment, are responsible for leading the duty of candour requirements for patients in their care, as outlined in this policy, or delegating to appropriate member of their team.

3.9 Trust employees and staff acting on behalf of the Trust will:

Follow the legal duties pertaining to 'duty of candour' outlined in this policy.

3.10 Trust Board

Ensure and demonstrate Trust commitment to Being Open principles and standards.

- Make a public commitment to Being Open.
- Require all staff to meet Being Open standards and to learn from incidents.

- Ensure arrangements are in place for implementation of the Duty of Candour.

3.11 Safety and Quality Assurance Committee is responsible for overseeing the activities of the Clinical Quality Steering Group, and as such will monitor by exception compliance with the Duty of Candour Policy.

3.12 Clinical Quality Steering Group is responsible for overseeing the Trust Duty of Candour' assurance, and as such will monitor compliance with this policy, and escalate by exception to the Safety and Quality Assurance Committee.

3.13 Culture

Being Open and Duty of Candour is integral to the incidents, complaints and claims processes and clinical governance framework. They are also fundamental to an open, just, learning culture. A learning and improvement culture is fundamental to minimising risk to patients, staff, and others safety.

A Trust culture of being open benefits patients, their families, and carers, staff, and the Trust:

The Trust and Teams	Trust Staff	Patients/Parents and/or Carers
Reputation of respect and trust	Confidence in communicating when things go wrong	Receiving a meaningful apology and explanation
Reinforce a culture of openness	Supporting in apologising and explaining to patients/parents and/or carers	Feel their concerns and distresses have been heard
A reputation of supporting staff when things go wrong	Satisfaction that communication has been handled in the best way possible	Improve patient/parents and or carer experience and satisfaction
Embodies the NHS constitution England	Improved understanding of incidents, complaints and claims from the perspective of the patient, parents and/or carer	Reassured that the organisation will learn lessons to prevent harm happening to someone else
Opportunity to learn when things go wrong and action from improvement to prevent recurrence	Know that lessons learned will prevent them recurring	Reduce the trauma when things go wrong
Potentially reduce the cost of litigation		Have greater respect and trust for the organisation
		Reassured they will continue to be cared for and treated according to their needs

4 Process for Implementing this Policy

The principles of Being Open are outlined at **Appendix A** and the Duty of Candour process is described in the flow diagram at the front of this policy (Page 4).

4.1 Grading Triggers to Implement the 'Being Open' Process

This policy does not require all incidents to be discussed with patients/parents or carers; incidents which did not result in harm or low harm are not directly referenced as requiring an apology within the statutory duty of candour, however it is considered best practice to offer an apology in all situations when something goes wrong with a patient's treatment or care. Professional judgement should be used when considering informing patients about near miss incidents. In some circumstances, patients do not need to know about something that has not caused them harm and telling them may distress or confuse them unnecessarily. However, incidents leading to no harm or low harm do provide useful learning opportunities and should be acknowledged and discussed with the patient/carers as appropriate. In many cases this may be beneficial, but the decision should be at the discretion of the local healthcare team based on the circumstances of the patient and the nature of the incident,

Moreover, there is a professional duty to be open, honest, and transparent and as such the GMC/MC (link below) have provided clear guidance about the expectations for professionals to adhere to, which is equally relevant for other professional groups working for or on behalf of the Trust. Fundamentally the management of candour, should always be carried out in a manner that is sensitive and focused on the needs and best interests of the child and their family and in keeping with the law (regulation 20)

https://www.gmc-uk.org/-/media/documents/openness-and-honesty-when-things-go-wrong--the-professional-duty-of-cand____pdf-61540594.pdf

(2015 GMC/NMC)

Grade of Incident	Level of response
No harm (including near miss patient safety incident)	Patients are not usually contacted or involved in investigations and these types of incidents are outside the scope of the *Being open* policy. Individual professionals decide whether 'no harm' events (including near miss patient safety incidents) are discussed with patients/families and/or carers as appropriate, depending on local circumstances and what is in the best interest of the patient.
Low harm	Unless there are specific indications or the patient/parents and or carers requests it, the communication, investigation and analysis of the event, and the implementation of changes will occur at local service delivery level with the participation of those directly involved in the event. Reporting to the Governance and Quality Assurance Team will occur through incident reporting mechanisms and be analysed locally to detect themes and associated learning for improvement.

Moderate harm	A higher level of response is required in these circumstances. The division Triumvirate and the governance leads will be notified within 24 hours (working day) , they will ensure duty of candour is appropriately instigated and provide support to staff as required. The Associate Director of Nursing and Governance will be notified and either she/he or a member of their team is available to provide support and advice during the *being open* process if required. Once the level of harm is validated to be moderate the 'Being Open' process will be applied. **Apply the *Being Open* process**
Severe, Catastrophic harm or death (SIRI, NE)	A higher level of response is required in these circumstances. The division's triumvirate and the governance leads will be notified within 24 hours (working day), they will ensure duty of candour is appropriately instigated and provide support to staff as required. The Associate Director of Nursing and Governance will be notified and either she/he or a member of their team is available to provide support and advice during the *being open* process if required. Where the level of harm is severe or catastrophic/death, the CMO and CNO or their deputies in their absence will be informed VIA Ulysses, email and verbally, who will advise and monitor compliance with duty of candour and ensure the CEO and Board are kept informed about compliance. **Apply the *Being open p*rocess**
Complaints	For specific information on complaints being open processes refer to Trust Complaint's Policy.
Claims	Information on claims being open processes refer to the Claims Handling Policy.

4.2 Initial Discussion

Every healthcare professional will be open and honest with patients when something that goes wrong with their treatment or care causes harm and is triggered by the table above.

This means that healthcare professionals will:

- Inform the patient/parents (or, where appropriate, the patient's advocate, or carer) when something has gone wrong as soon as reasonably practicable after the incident has been reported and confirmed as a moderate harm or above.
- Apologise to the patient/parents (or, where appropriate, the patient's advocate, or carer)
- Offer an appropriate remedy or support to put matters right (if possible).
- Explain fully to the patient/parent (or, where appropriate, the patient's advocate, or carer) the short- and long-term effects of what has happened.

When working in multidisciplinary teams, you must make sure that an appropriate person from the team is taking responsibility for talking to the patient or those close to them about what has happened. Not every member of a team will need to speak to the patient.

4.3 Apologising to the Patient/Parent (or, where appropriate, the patient's advocate, or carer).

A sincere expression of sympathy and regret made verbally by those providing the care at an early stage, based on the facts known at the time, should be made even if an investigation is being carried out prior to findings being shared formally with the patient/parent (or, where appropriate, the patient's advocate, or carer). A delay in saying sorry is often the cause of anger and frustration and is a common reason given for patients seeking medico-legal redress.

4.4 The Process

Note: The initial discussion and all subsequent discussion and correspondence (e.g., emails, letters, and reports) will be uploaded onto the Ulysses electronic risk management system.

The requirements outline where the harm threshold has been breached, as follows:

1. Notify the patient or service user, their families, or carers (including someone lawfully acting on their behalf) verbally (face to face where possible) unless the person cannot be contacted in person or declines notification, that the incident has occurred.

2. This initial notification will include an apology and must be provided as soon as is practicable within 10 working days of the incident being reported on Ulysses including in writing. (Appendix C - suggested draft letter).

3. Provide all information directly relevant to the incident which will be step by step factual explanation of what has happened

4. Advise and if possible, agree with the patient or service user what further enquiries are appropriate.

5. Provide reasonable support to the patient or service user, their families, or carers.

6. Share with the patient or service users, their families, or carers in writing of the original notification and the results of any further enquiries. A suggested introduction and closing Duty of Candour letter template is available (Appendix C and D).

7. All final incident reports will be shared with the patient within 10 working days of being ratified by a trust executive (serious incident), member of triumvirate or Executive Director (moderate harm) as complete.

4.5 Follow Up and Completion of the Process

The initial Being Open discussion is often only the first part of an on-going communication process, particularly when the patient safety incident is to be subject to further investigation and root cause analysis.

A dialogue will be maintained with the patient/parents (or, where appropriate, the patient's advocate, or carer) by sharing new information and addressing any new concerns as they arise.

On completion of the incident investigation, feedback will take the form most acceptable to the patient/parents (or, where appropriate, the patient's advocate, or carer), with a formal letter response and the option for a further meeting to discuss the report content.

See **Appendix D**: for a sample template letter informing the patient/parents (or, where appropriate, the patient's advocate, or carer) of investigation outcome(s).

4.6 Disclosure of Findings

In cases were further investigation takes place there will normally be complete disclosure of the findings of the investigation and analysis to the patient/parents (or, where appropriate, the patient's advocate, or carer).

In some cases, information may be withheld or restricted, for example where releasing certain information may adversely affect the health of the patient, where coronial investigations are pending, or where specific legal requirements preclude disclosure. In such cases advice should be sought from a member of Complaints or Claims Management teams and/or Governance and Quality Assurance team, and if necessary legal advice will be obtained.

The patient/parents (or, where appropriate, the patient's advocate, or carer) must be informed of the reasons for the restrictions.

Consideration needs to be given to the potential for adverse media interest in the incident, because of the number of people involved, e.g., a pathology screening error, or the family of a patient involved in an adverse event disclosing to the media. The senior manager or clinician managing the event / incident investigation must discuss media management with the Director of Communications.

4.7 Continuity of Care

When a patient has been harmed during treatment and requires further therapeutic management or rehabilitation, they/parents (or, where appropriate, the patient's advocate, or carer) will be informed of the on-going management plan.

Reassurance will be provided to the patient and carers that they will continue to be treated according to their clinical needs even where there is a dispute between them and the healthcare team.

Patients/parents (or, where appropriate, the patient's advocate, or carer) may also need to be advised about alternative treatment providers and consideration given to offering to hand over care to another consultant team and transfer the patient to another ward.

5 Training

Duty of Candour training is part of the Trust induction.

Employees are responsible for attending mandatory training.

6 Monitoring Compliance

The table below outlines the Trusts' Key Performance indicators and monitoring arrangements for this policy. The Trust reserves the right to commission additional work or change the monitoring arrangements to meet organisational needs.

Key Performance Indicators of the Policy

Describe Key Performance Indicators (KPIs)	Frequency of Review	Lead
All incidents of patient harm rated moderate or above will be recorded via Ulysses as will a record of compliance with the regulation 20 process steps outlined in this policy document.	Annually	Associate Director of Nursing and Governance

Performance Management of the Policy

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
Each incident that results in moderate harm or greater will be recorded via Ulysses. Each Incident recorded as moderate harm or above will have followed the principles set out in regulation 20 of the Health and Social Care Act	Annual audit of moderate or above recorded incidents via Ulysses.	Associate Director of Nursing and Governance	Annually	Liverpool Clinical Commissioning Group Clinical Quality Steering Group	Clinical Quality Steering Group. Safety and Quality Assurance Committee (by exception) Trust Board via monthly SI and learning report

7 Further Information

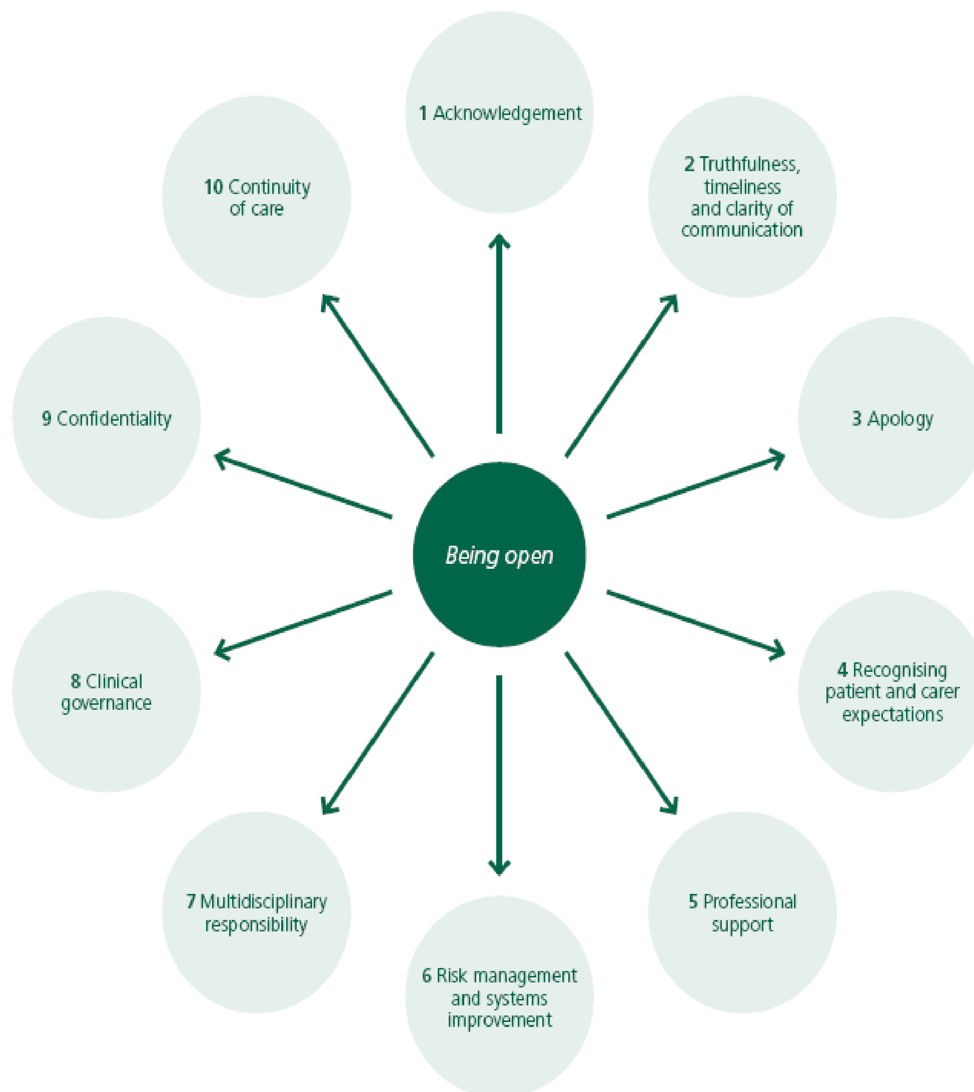
References / Bibliography

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20: Duty of Candour)
- (The Nursing and Midwifery Council's The Code: Professional standards of practice and behaviour for nurses and midwives (statement 14)
- Just culture guidance NHS Improvement March 2018

Related Trust Policy / Procedures (see on **DMS**)

- Incident Reporting and Management Policy inclusive of Serious Incident Management Procedure and After-Action Review (AAR) Procedure.
- Raising Concerns (Whistleblowing) Policy
- Complaints and Concerns Policy
- Claims Policy
- Risk Management Strategy
- Risk Management Policy / Procedure

Appendix A: Ten Principles of Being Open



1. <u>Principle of Acknowledgment</u>

   All incidents should be acknowledged and reported as soon as they are identified; ideally this should be as they occur. The Trust acknowledges that there are occasions (this may be through a complaint or claim) when an incident does not become apparent immediately, these incidents should be reported as soon as they are recognised.

   On some occasions the incident may be reported by the person involved in the incident for example the patient or staff member. In these cases, the incident must be taken seriously from the outset and not dismissed by healthcare staff. Any concerns should be treated with compassion and understanding by all healthcare professionals.

   For complaints or claims received by the Trust which identify a previously unreported serious incident, a Root Cause Analysis investigation must be considered.

2. Principle of Truthfulness, Timeliness and Clarity of Communication

The Trust values embrace the concept of open communication and honesty:

- **Respect**
  We show that we value every individual for who they are and their contribution
- **Excellence**
  We pride ourselves on the quality of our care, going the extra mile to make Alder Hey a safe and special place for children and their families
- **Innovation**
  We are committed to continually improving for the benefit of our patients
- **Together**
  We work across the Alder Hey community in teams that are built on friendship, dedication, care, and reassurance
- **Openness**
  We are open and honest and engage everyone we meet with a smile

It is important to remember that not all patients, staff members, other persons or families will want to know every aspect of what went wrong. In this case the wishes of the patient, staff member, other person or their families must be respected. Staff must inform them that the information will be available if they change their mind later. Where it is likely that an incident has occurred due to the possible negligence on the part of the Trust or there is an indication that legal proceeding will be commenced the Claims Handler must be informed.

The need for translation and advocacy services must be considered when planning communication in relation to an incident, for example if the person involved in the incident or their family cannot speak English or if the culture makes it difficult for a female to discuss intimate issues with a male. In this case staff should refer to the Policy for the use of Interpreters and Translators for advice.

Information about a moderate to severe incident must be delivered in a clear and honest way by an appropriate person in a timely manner. Any information given must be based on the facts established at the time of communication. Staff will inform the person involved in the incident that more information may emerge as an investigation progresses and that they will be kept up to date on the progress of any investigation. The person involved in the incident, or their relatives should be given a single point of contact to ensure that they do not receive conflicting information.

In the case of an incident which may have contributed to the death of a patient, communication will need to be sensitive and empathetic. Information must be given to the family on the process to be undertaken to establish the cause of death. Any discussions with the family and internal investigations would normally be undertaken prior to a coroner's inquest but in certain circumstances it may be more appropriate to wait until after the inquest if the coroner's post-mortem would assist in the internal investigation.

Information given to patients, staff members, other persons or families should include who can provide assistance and support to the person affected by the

incident. Staff will be aware that they will not pass clinical information on to support agencies without the consent of the person involved in the incident or their appointed next of kin without consent.

3. Principle of Apology

Patients, their families, and carers should receive a meaningful apology, one that is a sincere expression of sorrow or regret for the harm that has resulted from a patient safety incident. This should be in the form of an appropriately worded and agreed manner of apology as early as possible. Clinical Business Unit (CBU) General Managers and Clinical Directors should decide on the most appropriate member of staff to give both verbal and written apologies to patients, their families, and carers. This decision should consider seniority, relationship to the patient, and experience and expertise in the type of patient safety incident that has occurred.

Verbal apologies are essential because they allow face-to-face contact between the patient, their family and carers and the healthcare team. This should be given as soon as staff are aware an incident has occurred.

A written apology, which clearly states the healthcare organisation is sorry for the suffering and distress resulting from the incident, must also be given. It is important not to delay giving a meaningful apology for any reason, including setting up a more formal multidisciplinary *Being Open* discussion with the patient, their family, and carers; fear and apprehension; or lack of staff availability. Delays are likely to increase the patient's, their families and their carers' sense of anxiety, anger, or frustration. Patient and public focus groups reported that patients were more likely to seek medico-legal advice if verbal and written apologies were not delivered promptly.

Staff should be aware that saying sorry to a person involved in an incident or their family is not an admission of liability.

4. Principle of Recognising the Person Involved in the Incident or their Family's Expectations

If the person involved in the incident requires ongoing care within the Trust, they must be reassured that this will not be affected by the incident or investigation. An ongoing plan of care must be agreed with the patient and followed through.

Patients, staff members or families involved in an incident will expect to be fully informed of all issues involved in an incident and the consequences of those issues. This would be best handled through a face-to-face meeting with staff from the Trust.

5. Principle of Professional Support

The Trust must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report patient safety incidents. Staff should feel supported throughout the incident investigation process because they too may have been traumatised by being involved. They should not be unfairly exposed to punitive disciplinary action, increased medico-legal risk, or any threat to their registration. To ensure a robust and consistent approach to incident investigation, healthcare organisations are advised to use the NRLS's Incident

Decision Tree. It should be remembered that NCAS can be contacted for advice on handling the concern and whether an assessment of the individual's practice would be helpful.

Senior managers should also encourage staff to seek support from relevant professional bodies such as the GMC, royal colleges, the MDU, the MPS and the Nursing and Midwifery Council (NMC).

6. Principle of Risk Management and Systems Improvement

Root Cause Analysis and Significant Event Audit (SEA) should be used to uncover the underlying causes of a patient safety incident. These investigations should focus on improving systems of care, which will then be reviewed for their effectiveness. This policy should be seen as an integral part of the local incident reporting and risk management policies and processes of the Trust. *Being open* is one part of an integrated approach to improving patient safety following a patient safety incident. It should be embedded in an overarching approach to risk management that includes local and national incident reporting, analysis of incidents using Root Cause Analysis or Significant Event Audit; decision-making about staff accountability using the Incident Decision Tree and an organisational approach that follows *seven steps to patient safety*.

7. Principle of Multi-Disciplinary Responsibility

This policy on openness applies to all staff that have key roles in the patient's care. Most healthcare provision is through multidisciplinary teams. This should be reflected in the way that patients, their families, and carers are communicated with when things go wrong. This will ensure that the *being open* process is consistent with the philosophy that incidents usually result from systems failures and rarely from the actions of an individual. To ensure multidisciplinary involvement in the *being open* process, it is important to identify clinical, nursing, and managerial opinion leaders who will support it. Both senior managers and senior clinicians who are local opinion leaders must participate in incident investigation and clinical risk management.

8. Principle of Clinical Governance

Being open requires the support of patient safety and quality improvement processes through governance frameworks in which patient safety incidents are investigated and analysed to find out what can be done to prevent their recurrence. These findings will be disseminated to healthcare professionals through the Clinical Business Meetings and through the Clinical Quality Steering Group, so that they can learn from patient safety incidents.

The Clinical Quality Steering Group is a Board subcommittee with delegated powers to enable a process of accountability through the Director of Nursing and Medical Director to the Board to ensure these changes are implemented and their effectiveness reviewed.

9. Principle of Confidentiality

This policy for *being open* gives full consideration of, and respect for, the patients', their families', carers' and staff privacy and confidentiality in line with the Care Quality Commission's (CQC) guidance. Details of a patient safety incident should always be considered confidential.

The consent of the individual concerned should be sought prior to disclosing information beyond the clinicians involved in treating the patient, in line with the CQC's guidance. Where this is not practical, or an individual refuses to consent to the disclosure, it may still be lawful if justified in the public interest, or where those investigating the incident have statutory powers for obtaining information.

Communications with parties outside of the clinical team should also be on a strictly need-to-know basis and, where practicable, records should be anonymous. In addition, it is good practice to inform the patient, their family, and carers about who will be involved in the investigation before it takes place and give them the opportunity to raise any objections.

10. Principle of Continuity of Care

Patients are entitled to expect that they will continue to receive all usual treatment and continue to be treated with dignity, respect, and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.

Appendix B - CQC Regulation 20 Duty of Candour

(1) A health service body must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.

(2) As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must—

(a) notify the relevant person that the incident has occurred in accordance with paragraph (3), and
(b) provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

(3) The notification to be given under paragraph (2)(a) must—

(a) be given in person by one or more representatives of the health service body,
(b) provide an account, which to the best of the health service body's knowledge is true, of all the facts the health service body knows about the incident as at the date of the notification,
(c) advise the relevant person what further enquiries into the incident the health service body believes are appropriate,
(d) include an apology, and
(e) be recorded in a written record which is kept securely by the health service body.

(4) The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—

(a) the information provided under paragraph (3)(b),
(b) details of any enquiries to be undertaken in accordance with paragraph (3)(c),
(c) the results of any further enquiries into the incident, and
(d) an apology.

(5) But if the relevant person cannot be contacted in person or declines to speak to the representative of the health service body—

(a) paragraphs (2) to (4) are not to apply, and
(b) a written record is to be kept of attempts to contact or to speak to the relevant person.

(6) The health service body must keep a copy of all correspondence with the relevant person under paragraph (4).

(7) In this regulation—

"**apology**" means an expression of sorrow or regret in respect of a notifiable safety incident.

"**Moderate harm**" means—

(a) harm that requires a moderate increase in treatment, and
(b) significant, but not permanent, harm.

"**Moderate increase in treatment**" means—

an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).

"**Notifiable safety incident**" means—

Any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in—

a) the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or
b) severe harm, moderate harm, or prolonged psychological harm to the service user.

"**Prolonged psychological harm**" means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days.

"**Relevant person**" means the service user or, in the following circumstances, a person lawfully acting on their behalf—

(a) on the death of the service user,
(b) where the service user is under 16 and not competent to decide in relation to their care or treatment, or
(c) where the service user is 16 or over and lacks capacity (as determined in accordance with sections 2 and 3 of the 2005 Act) in relation to the matter.

"**Severe harm**" means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

Appendix C – Template 1 - Sample Duty of Candour Initial Disclosure Letter

Alder Hey Children's
NHS Foundation Trust

Direct Dial: 0151 – add number
email: add @alderhey.nhs.uk
email: add @alderhey.nhs.uk

Eaton Road
Liverpool
L12 2AP
Telephone: 0151 228 4811
www.alderhey.com

Duty of Candour Initial Disclosure Letter

Date:

Ref:

Private & Confidential

Name and Address

Dear Name of patient / relative,

As discussed with you, add name, has been involved in an incident, which related to Alder Hey NHS Foundation Trust on add date.

On behalf of the Trust, I would like to extend a sincere apology that this occurred. An investigation will now be completed to identify learning and improvements to prevent re-occurrence. We aim to provide a quality service to patients and families, and to investigate incidents promptly and share findings with those involved. When our investigation is complete you will be contacted, and a meeting offered to discuss findings and lessons learned and a copy of the report provided to you. Alternatively, you may wish to receive a copy of the report in the first instance and then a meeting arranged to discuss findings.

To support you, Alder Hey Children's Hospital NHS Foundation Trust has a Duty of Candour policy. In line with this policy, you will be contacted by the investigation lead, add name and designation who will discuss the investigation process and progress with you. If you have any questions which you would like to be addressed, add name and designation will ensure they are included as part of the investigation and in the final report. Name and designation can be contacted directly via email add name and email address.

Please be assured that it is not our intention to intrude upon you or your family at what must be a very difficult time, however it is important to keep you informed.

Yours sincerely

CMO

Appendix D – Template 2: Sample Duty of Candour Final letter

Alder Hey Children's
NHS Foundation Trust

Date:
Ref: Ulysses number/StEIS

Name, address & Telephone number of letter author

Private & Confidential

ADDRESS

Dear Patient/Relative (as appropriate inserting title & name)

As agreed, following our initial letter dated add date, and subsequent discussions with add name and designation who I understand advised you the investigation has been completed, please find attached a copy of the completed investigation, including findings, lessons learned, and actions being taken to minimise the risk of the same or similar incidents occurring in the future

I appreciate this is a difficult time for you, but I hope this will help to reassure you that appropriate steps have been taken to identify the care and treatment issues relevant to your child and that recommendations and actions for improvement have been prioritised.

If you wish to discuss the investigation further, please contact (add name & designation and telephone number) who will arrange a meeting.

Yours sincerely

CMO

Note: Enclose copy of investigation as appropriate.

Appendix E – Support Groups

Support Group Information

Find out more about local services at Patient UK - www.patient.co.uk

National organisations

The Child Bereavement Trust
Aston House, West Wycombe, High Wycombe, Bucks HP14 3AG Information and support service line: 0845 357 1000 enquiries@childbereavement.org.uk

www.childbereavement.org.uk
A national UK charity, providing specialised training and support for professionals to help them respond to the needs of bereaved families.
Resources and information for bereaved children and families as well as the doctors, nurses, midwives, teachers, police, emergency services and voluntary sector support services.

Cruse Bereavement Care
Cruse Bereavement Care, Cruse House, 126 Sheen Road, Richmond TW9 1UR
Tel: 0870 167 1677 www.supportline.org.uk
A helpline providing confidential emotional support to children, young people and adults on any issue - referring callers to sources of help in their immediate area.

British Association for Counselling and Psychotherapy
1 Regent Place, Rugby, Warwickshire CV21 2PJ Tel: 0870 443 5252
www.bacp.co.uk
The 'Seeking a Therapist' section of the website gives lists of qualified counsellors and psychotherapists available in your area. This service is also available over the phone.

Jewish Bereavement Counselling Service
PO Box 6748, London N3 3BX
Tel: 020 8349 0839/020 8343 8989 www.jvisit.org.uk/jbcs/
The service is offered to any member of the Jewish community at no charge.

Royal College of Psychiatrists
www.rcpsych.ac.uk/info/help/bereav/
In-depth information about the emotions you may feel during bereavement.

Depression Alliance
35 Westminster Bridge Road, London SE1 7JB Text phone/Minicom: 020 7928 9992
www.depressionalliance.org
A UK charity offering information to people with depression; run by sufferers.

Samaritans
Helpline: 08457 90 90 90 (24 hours) www.samaritans.org 24-hour confidential emotional support for anyone in a crisis.

If I Should Die
www.ifishoulddie.co.uk .This website looks at all aspects of bereavement from the practical to the emotional.

Support for carers

The Princess Royal Trust for Carers
142 Minories, London, EC3N 1LB Tel: 020 7480 7788 www.carers.org
Information, support and practical help for all carers through a network of Princess Royal Trust for Carers centres.

Carers UK/ Carers National Association
20-25 Glasshouse Yard, London EC1A 4JS
Helpline: 0808 808 7777 (freephone, 10am-12noon and 2pm-4pm, Mon-Fri)
www.carersuk.org.uk/about/main.htm
Runs a helpline and provides support, encouraging carers to recognise their own needs. There is also an information officer to answer enquiries from professionals.

Help for young people

www.rd4u.org.uk
rd4u Cruse Bereavement Care, Cruse House, 126 Sheen Road, Richmond, Surrey TW9 1UR
Helpline: 0808 808 1677 (answered by trained volunteers aged between 16-25, 4pm-7pm, Mon-Wed)
The youth branch of Cruse set up to help young people after the death of someone close.

Winston's Wish
The Clara Burgess Centre, Gloucestershire Royal Hospital, Great Western Road, Gloucester GL1 3NN
Helpline: 0845 2030405 (9.30am-5pm, Mon-Fri; 9.30am-1pm, Sat)
www.winstonswish.org.uk
Charity that offers support to young people who have experienced bereavement.

ChildLine
Helpline: 0800 1111 www.ChildLine.org.uk. Free, 24-hour helpline for children and young people who need to talk about any problem they may have.

Childhood Bereavement Network
www.childhoodbereavementnetwork.org.uk
Huntingdon House, 278-290 Huntingdon Street, Nottingham NG1 3LY Tel: 0115 911 8070.
A national resource for bereaved children and young people, their parents and care givers.

Equality Analysis (EA) for Policies		
The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the for need to achieve the following objectives in carrying out their functions: a) Eliminate discrimination, harassment, victimisation, and any other conduct that is prohibited by or under the Equality Act 2010. b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Please refer to Equality Analysis Step-Wise Guide for Policies when completing this for Form.		
Policy Name	RM 47 – Duty of Candour Policy – A Statutory Duty to be Candid	
Policy Overview	The Policy sets out the framework for Duty of Candour in line with the legal requirements as set out in CQC regulation 20 and the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014	
Relevant Changes (if any)	General review and changes to add clarity to the requirements stated in the legal framework. The policy sets out the responsibilities and procedure for all Alder Hey staff who are involved in practice where duty of candour applies.	
Equality Relevance Select LOW, MEDIUM, or HIGH	LOW	
If the policy is LOW relevance, you **MUST** state the reasons here.	The policy does not impact differently on any groups sharing a protected characteristic	
Form completed on:	Date: 03/05/2022	
Form completed by:	Name: Cathy Umbers	Job Title: Associate Director of Nursing and Governance

Approval & Ratification of Equality Analysis		
Policy Author:	Name: Cathy Umbers	Job title: Associated Director of Nursing and Governance
Approval Committee:	Clinical Quality Steering Group	Date approved: 10/05/2022
Ratification Committee	Safety and Quality Assurance Committee	Date ratified: 18/05/2022
Person to Review Equality Analysis:	Name: Associate Director of Nursing and Governance	Review Date: 18/05/2025
Comments:	Click here to enter text.	

NHS
Alder Hey Children's
NHS Foundation Trust

RM2 – INCIDENT REPORTING AND MANAGEMENT POLICY

Version:	11
Ratified by:	Safety and Quality Assurance Committee
Date ratified:	14/12/2022
Name of originator/author:	Associate Director of Nursing and Governance
Name of approval committee:	Clinical Quality Steering Group
Date approved:	13/12/2022
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Date issued:	December 2022
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Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
11	December 2022	Associate Director of Nursing and Governance	Current	Minor changes made to Policy
10.1	June 2020	Associate Director of Nursing and Governance	Archived	After Action Review (AAR) added to Policy title
10	December 2019	Associate Director of Nursing and Governance	Archived	
9.5	March 2019	Associate Director of Nursing and Governance	Archived	Extension
9.4	November 2018	Associate Director of Nursing and Governance	Archived	Minor edits to linked documents
9.3	October 2018	Associate Director of Nursing and Governance	Archived	Interim extension
9.2	March 2018	Associate Director of Nursing and Governance	Archived	1.2 Just culture added 7.6 inclusion of link to mortality and morbidity review process
9.1	June 2017	Head of Risk	Archived	7.3. Inclusion of 72 hour review requirement
9	August 2016	Head of Risk	Archived	
8	May 2016	Head of Risk	Archived	
7	April 2015	Head of Risk	Archived	
6	February 2012	Clinical Risk Advisor	Archived	
5	December 2009	Head of Integrated Clinical Governance and Risk Management	Archived	Section 9, Page 19 – section made clearer. Sections 16, 17, 18, pages 26-29. These sections provide a consistency of approach across the management and trend analysis of claims, complaints and incidents
4	July 2008	Risk Manager	Archived	Serious Critical Incident Policy (RM3) incorporated
3	October 2006	Risk Manager	Archived	
2	June 2005	Risk Manager	Archived	

Record of changes made to Incident Policy – Version 11			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
Various	Various	Minor changes to policy. Serious Incident Procedure incorporated, After Action Review (AAR) Procedure now standalone document.	To maintain version control of related procedures

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Introduction

Alder Hey Children's NHS Foundation Trust is committed to providing high quality safe care and treatment to all children using Trust services, ensuring high standards of Health and Safety, by providing a system and process of incident reporting, which enables all staff to record any incident which causes harm, loss or damage, or has the potential to do so.

Incident reporting presents an important opportunity to learn from past events and ensure steps are taken through the incident management process to minimise the risk of recurrence.

There is significant evidence that NHS organisation's with a high level of incident reporting are more likely to learn and subsequently increase safety for people using their services, staff and visitor's.

The management of incidents is a fundamental component of good risk management. The Trust has developed systems to identify, monitor and mitigate risks to safety and it is important that all staff play their appropriate part in complying with these systems. Despite these safeguards, the size and complex nature of the Trust's operations mean that from time to time, adverse incidents occur and it is important that the Trust has appropriate systems in place to manage such incidents. The incident reporting process enables the Trust to identify, manage, communicate and analyse risks identified as a result of incidents. It is a systematic approach to firstly ensure that those affected by the incident are supported in a timely and effective way, secondly to evaluate what has gone wrong, learn from this and ensure action is taken to minimise the likelihood of recurrence.

Most incidents are the result of systems failures rather than only human error; consequently the Trust will adopt a systems centered approach to evaluating incidents. However, in rare cases disciplinary action may be required in cases where serious professional misconduct (as defined by the GMC, NMC and other professional bodies), such as a serious breach of the Data Protection Act, reckless acts, criminal acts and repeated misdemeanors has occurred.

Compliance with this policy will ensure that incidents are systematically identified, recorded, reported and appropriately investigated. This will result in learning and thus improving safety for future children and young people using Trust services, staff and visitors.

Safety is everybody's business. All staff will ensure they report incidents/near miss events, and that they are familiar with policies, procedures and protocols which are essential to delivering a safe service.

This policy covers the management of incidents in general and also the management of 'Serious Incidents Requiring Investigation' (SIRI).

The Trust promotes an open and honest process of incident management and duty of candour. The Duty of Candour statutory requirements are adopted for

all incidents of moderate harm and above. See **Duty of Candour Policy – RM47** on DMS.

Just Culture

The Trust supports a 'just culture', adapting a fair and consistent approach by using the NHSI 'Just Culture Guide' Appendix C (March 2018), replacing the Incident Decision Tree (NPSA 2003).
https://improvement.nhs.uk/resources/just-culture-guide/.

2 Objectives

This policy sets out the Trust systems, processes and expectations in relation to incident reporting and learning to include the process for:

- Maintaining the safety of patients, staff or anyone else coming into contact with the Trust and its service.
- Reporting all incidents involving children and young people using Trust services, staff and others, in a timely manner.
- Reporting to external agencies i.e. Local Commissioner, the Care Quality Commission (CQC), nationally through the National Reporting and Learning System (NRLS) and other stakeholders as required.
- Investigating incidents according to level of harm.
- Involving and communicating with internal and external stakeholders to share safety lessons.
- Ensuring the Trust achieves local and organisation wide learning and changes in practice resulting from individual incidents through aggregated analysis.
- Ensuring communication is open, honest, occurs as soon as possible and is well documented.
- The training requirements for staff are met.
- Effective feedback occurs to those directly involved in incidents or those reporting incidents.
- Ensuring that the requirements of Duty of Candour (CQC regulation 20) are applied and that there is effective, open and honest communication with patients, parents and carers with regard to incidents involving moderate and higher levels of harm.
- Providing an early warning of potential for litigation or complaints.

3 Duties and Responsibilities for Incident Reporting

3.1 The Chief Executive

The Chief Executive has overall accountability for patient safety and risk management, with responsibility for incident management delegated to the Chief Nurse and Trust Medical Director as the Trust Executive Lead's. The Chief Executive is responsible for promoting an effective safety and reporting culture in the organisation.

3.2 The Chief Nurse and Trust Medical Director

The Chief Nurse and Trust Medical Director are the Executive Lead's for incident management and as such are accountable for incident management within the Trust and for ensuring that management arrangements are in place to comply with this policy. Moreover, the Chief Nurse and Trust Medical Director ensure there is a robust reporting structure in place via the Trust Quality Assurance Committee and the performance report to the Board of Directors.

3.3 The Associate Director of Nursing and Governance

The Associate Director of Nursing and Governance is responsible for the Trust policies for the management of incidents inclusive of serious incidents and will support the monitoring processes in relation to compliance and implementation.

3.4 The Governance and Quality Assurance Team

- Maintain the Safeguard Ulysses Risk Management System updates with Organisational changes and National policy changes from NHS England.
- Provide training, advice and support to staff as required.

3.5 First On Call Manager (out of hours)

The first on call manager is responsible for ensuring that the patient(s) and staff are made safe with respect to any potential serious incident reported to them out of hours and that the incident is escalated to the second on call.

3.6 Second On-Call Manager

The second On-call is responsible for ensuring that the Chief Executive is informed of any serious incidents as soon as reasonably possible. They must liaise with media and publications department regarding any/potential adverse publicity. They must ensure that the Chief Nurse and Trust Medical Director are informed of any serious incidents the next working day.

3.7 Division Triumvirate are responsible for:

- Ensuring there are local governance systems and process for managing incidents.
- Ensuring there is a system in place for entering risks arising from Incidents onto the division risk register and escalated on the Corporate Risk Register (CRR) as appropriate.
- Ensuring Root Cause Analysis reports are completed and by the deadline.
- Agreeing risk reduction action plans, ensuring that appropriate preventative action has been taken, in all cases to reduce or eliminate the risk.
- Ensuring feedback is given to all staff completing incident forms, including details of any changes made as a result for their division.
- Ensuring that Being Open and Duty of Candour requirements have been met, where appropriate electronically.
- Ensuring lessons learned and actions for improvements are shared and discussed via governance processes.

3.8 Matrons / Clinical Directors / Ward Managers are responsible for:

- Ensuring that the patient, relatives and other persons who should have details of the events, receive timely and adequate explanations from appropriate members of staff in line with the Being Open and Duty of Candour requirements. See **Duty of Candour Policy – RM47** on DMS.
- Ensuring that all incidents / near misses are reported on Ulysses (Risk Management System) **within 24 hours** of the incident occurring.
- Conducting an investigation of the incident in line with this policy
- Monitoring incident/accident trends.

3.9 All staff responsibilities

Every member of staff is responsible for reporting incidents or near misses when they occur **within 24 hours** and adhering to the requirements of this policy. Support the investigation process of incidents in line with this policy including providing statements in a timely manner and support actions for improvement to minimise the risk of recurrence of incidents.

3.9 Trust Board responsibilities:

- To receive a monthly report on any new SIRIs arising and immediate actions to minimise risk of recurrence of the same or similar incidents.

- To ensure that relevant incidents are reported to the appropriate bodies. The Trust has a legal requirement to ensure that reportable incidents, particularly those with health and safety or patient safety implications, are reported externally, as appropriate.

- Ensure adequate allocation of resources is available for the management and investigation of incidents including implementation of any remedial actions.

3.10 Clinical Quality Steering Group responsibilities:

Receiving and reviewing assurance reports for the management of lessons learned including actions for improvement

3.11 Safety Quality Assurance Committee responsibilities:

Receiving and monitoring exceptions reports for incident management

3.12 Hospital Mortality Review Group

The Mortality Review Group is responsible for ensuring that any adverse events they review that highlight a serious harm concern are escalated via the serious incident requiring investigation process

4 Process for Implementing this Policy Document

4.1 Process for Reporting Incidents and Near Misses Involving Staff, Patients and Others

- A step by step guide to reporting incidents is available via the link on the home page of Ulysses and on the Trust intranet site: Governance and Quality Assurance pages.

- If a patient is involved, ensure the patient is reviewed, to minimise risk of harm.

- The Team Leader in charge of the shift or department manager must be informed as soon as possible (**within 24 hours**) following an incident/near misses.

- All incidents are to be reported on the Web Based Incident Report form (Ulysses) **within 24 hours**. Where it is not possible to report onto the system within 24 hours a rationale will be included on the incident form at time of reporting.

- All Incidents must be coded to their relevant type, category (cause group) and sub-category (sub-cause group). A list of the categories and sub categories is available via the drop downs on the incident menu. If an incident does not fit into a category or sub-category contact the Governance and Quality Assurance team at governanceandqualityassurance@alderhey.nhs.uk, for advice.

- Ensure that the incident date reflects the date that the incident was identified and not a retrospective date that something should have or did not occur.

  For example, notification of a delay in a patient being added to a theatre waiting list 3 months after the initial referral. The incident date would be the date identified it was not done, not the date it should have been done.

- No names or personal identifiable data should be included within the description section of the incident form, this is a mandated requirement issued by the NRLS (National Reporting and Learning System) and the CQC (Care Quality Commission).

- Any witnesses to the incident/near miss should have their details included on the form.

- Information provided on the incident reporting form must be factual and not based on opinion. Incident investigation reports, emails and any correspondence pertaining to an incident is disclosable, and may be used in a court of law including a coroners court and as evidence in litigation.

- Any incident where harm has been caused entirely by another organisation will be recorded as no harm. If there is suspected or partial harm caused by Alder Hey Trust then this will be reported accordingly.

- Any remedial action identified should be taken and documented on the reporting form.

- Any equipment/medical devices and packaging involved in the incident should be kept for further investigation if required.

- Consideration should be given to whether an area needs to be secured/ preserved for example for police investigation or for safety reasons

- Consideration should be given to the need for photographs. Consent should be taken prior to taking the photographs in line with Trust policy

- Once the electronic form has been submitted, it will be reviewed **within 5 working days** by the department manager/ward manager or nominated delegate. Incidents that have not been reviewed within this timeframe will show as overdue and a reminder will be sent on day 5 and every day thereafter until the incident is reviewed and actioned.

- If an incident is moved into the 'being reviewed by manager or investigator' section, these incidents will remain overdue. It is therefore the responsibility of the incident handler to ensure this is investigated and processed through the system in a timely manner.

- All incidents will be investigated within **10 working days** unless declared as a Serious Incident, Never Event or Moderate harm incident.

- A step by step guide for managing incidents is available from the link at the home page, and on the Trust intranet site: Governance and Quality Assurance pages and as part of this review the nominated next line approver e.g. ward manager, department manager or nominated delegate.
  - ✓ categorise the incident to determine the severity (no harm, low harm, moderate injury, severe injury, death)
  - ✓ notify as a RIDDOR (if applicable)
  - ✓ complete the sections for action taken and lessons learnt
  - ✓ Save the incident and close within **30 working days.**

- The Ulysses system administrator will final check all administrative details to ensure a timely upload to the National Reporting and Learning System (NRLS) within **30 working days**.

- Where an incident resulting in severe harm or death (SIRI) or is classified as a never event is identified, the Chief Nurse and the Trust Medical Director, or their deputies must be informed within **24 working hours**.

- Where an incident resulting in severe harm or death (SIRI) or is classified as a never event is identified out of hours then the 1st on call must be informed who will then contact the 2nd on call, who will inform the Chief Nurse and the Trust Medical Director at the earliest opportunity.

For both occasions the Standard Operating **Procedure for the Management of Serious Incidents** must be followed (see on DMS).

4.2 Process for Reporting Incidents to External Agencies

Certain incident types and categories are required to be reported to external agencies by the Trust within a set timeframe. The external agencies, type of incidents that require reporting, the designation of individuals who must report and the timeframes is outlined in the **Procedure for the Management of Serious Incidents** (see on DMS).

4.3 Investigation Process

4.3.1 Categorising Severity of Incident and Initiating Appropriate Level of Investigation

The severity of an incident is determined from assessment on the outcome of actual patient/staff harm or harm to the organisation. Incidents can be re-categorised as more details relating to the incident are identified or the condition of the person harmed changes.

4.3.2 Levels of severity of Patient Safety Incidents (PSI)

Every NHS organisation should ensure that the degree of harm recorded for each incident describes the actual harm to the patient as a direct result of the incident. The ‘degree of harm’ on incident reports should relate to the actual harm resulting directly from the incident itself. It is therefore incorrect to record potential harm rather than actual harm.

Similarly it is inaccurate to record the degree of harm in relation to the outcome of the medical condition rather than the direct result of the incident itself, e.g. “severe” should only be recorded when the patient has been permanently harmed as a result of the PSI and “death” should only be recorded when the incident has resulted in the death of the patient.

Table 1

Severity of Harm	Definition
Near Miss	A near miss is an unintentional incident that could have caused damage, injury or death but was narrowly avoided. In the context of safety, a near miss may be attributed to human error, or might be a result of faulty safety systems or processes in an organisation. A near miss may also be called a close call, near collision or near hit.
None/No harm/Near Miss	A situation where no harm occurred: either a Near Miss i.e.Prevented Patient Safety Incident or a No Harm Patient Safety Incident.
Low/Minor	Any unexpected or unintended incident which required extra observation or minor treatment and caused minimal harm, to one or more persons.
Moderate	Any unexpected or unintended incident which resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area and which caused short term harm, to one or more persons.
Severe/Serious	• Severe harm (patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care); • Chronic pain (continuous, long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in pain after trauma or surgery); or • Psychological harm, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. has lasted, or is likely to last for a continuous period of at least 28 days).
Death/Catastrophic	Any unexpected or unintended incident which caused the death of one or more persons.
Never Event	Never Events are patient safety incidents that are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Table 2 - Incident investigation level and responsibility for investigation.

Severity (caused by incident)	Investigation Required	Investigation Lead
Death as a result of a patient safety incident.	Root Cause Analysis **Comprehensive Level 2**	The investigation lead will be appointed by the Division Director and Associated Chief Nurse for the Division involved. The investigation will be overseen by the Trust Medical Director and Chief Nurse
All serious harm (Permanent Harm) to a patient or staff and including but not limited to: • Cluster of alert infections • Pressure Ulcer (Category 3 or 4) • A major aberration from the desired standard of care. • Critical infection outbreak • Serious failing in child safeguarding • Multiple permanent injuries or irreversible health effects • An event which impacts on a large number of patients. • Pandemic Influenza	Root Cause Analysis **Comprehensive Level 2**	
Never Event	Root Cause Analysis **Comprehensive Level 2**	

All moderate harm (non- permanent taking up to 28 days to heal) to a patient or staff and including but not limited to: • Alert infections • Identified cluster of no/low harm incidents • Unexpected return to theatre	Will require local investigation undertaking root cause analysis **Concise Level 1**	Local investigation undertaken by appropriate staff member with support from clinical expert. The Investigation will be overseen at Division Level by the Division Director and the Associate Chief Nurse
Low harm incidents Example Fall resulting in a minor injury – cut or bruise requiring first aid treatment only.	Trended and reported in Division quarterly Governance report and reflected in Quality Assurance Round presentation with actions taken to address trends	Person reporting incident to consider immediate action to be taken and to inform Line Manager. Consider conducting After Action Review (AAR) The management of the incidents will be overseen by the matron and the Clinical Director where the incident occurred
No harm/Near Miss Example - No Harm Medication administered to the wrong patient but no harm caused. Example - Near Miss: A medication error is picked up prior to causing harm i.e. the drug dose was incorrectly prescribed but this was identified prior to administration of the drug to the patient.	Trended and reported in Division quarterly Governance report and reflected in Quality Assurance Round presentation with actions taken to address trends	Person reporting incident to consider immediate action to be taken and to inform Line Manager. Consider conducting After Action Review (AAR) The management of the incidents will be overseen by the matron and the Clinical Director where the incident occurred
MRSA/MSSA Bacteraemia (hospital acquired)	A Post Incident Review toolkit (PIR) will be undertaken utilising the NHS Commissioning Board template	Director of Infection Prevention and Control or delegate.

4.3.3 Level 3 Investigations

A Level 3 investigation may be instructed by Commissioners or by NHS England for concerns of extremely high public interest attracting media attention, these are conducted independently to the Trust

4.3.4 Level 2 Investigations

All level 2 incidents must be investigated using the Alder Hey level 2 template documents available on the Trust intranet site: Governance and Quality Assurance pages. Ensure that any level 2 investigation reviews if the incident involves any patients who have a known learning disability or mental health issues. This is done through the reporting template, if there are issues identified; please inform the Alder Hey safeguarding team.

4.3.5 Level 1 Investigations

The standard level 1 RCA form must be used to investigate moderate harm e.g. Incident cluster of low or no harm incidents and for safeguarding concerns that need investigation raised within or external to the organisation.

This document is available on the Trust intranet site: Governance and Quality Assurance pages.

For infection control RCA documents please refer to the Infection Prevention and Control intranet pages (Incidents).

4.3.6 After Action Review (AAR)

'After Action Review' (AAR) is a structured review process for analysing what happened, why it happened, and how it can be done better by the participants, in the future. The AAR review process is not an investigation process, but its purpose is to learn, support effective teamwork, motivation and implement improvements in a timely manner. The AAR should be conducted immediately after the event where possible, while memories are still fresh, or within a maximum of 2 weeks. The AAR is not a replacement for detailed evaluation or investigation, but enables immediate learning (See **After Action Review Procedure** on DMS).

4.3.7 Storage of Completed RCA Investigations & AARs

Once the RCA investigation has been concluded it is the responsibility of the lead author to ensure the document is attached to the incident in the electronic Ulysses system. This will facilitate easy access for those who require it.

4.4 Duty of Candour

The organisations requirement of staff when following these principles can be found in the organisations Duty of Candour Policy. The process must be applied where incidents have been graded as moderate, serious including never events or where a death has occurred as a direct result of an incident. The patient and or family must be informed of the incident verbally initially **within 10 working days** and this must be followed up by a written letter. The responsibility for being open where a level 2 incident has been initiated lies with the lead appointed author, the responsibility for level 1 incident lies with the clinical ward team. The process can be found in the **Duty of Candour Policy – RM47** (see on DMS)

Candour is defined in the Robert Francis' report as:
'The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.'

The principles of the regulation are:

Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

4.5 Analysis of Incidents

4.5.1 Locally

- Each Division/ Department is expected to have established systems to analyse incidents, instigate an investigation in line with this policy and where deficits are identified develop action plans and monitor in line with committee/group reporting schedule until all actions are completed.

- Each Division and department will discuss incident trends monthly at the appropriate governance forum. These discussions will be documented in the minutes, recorded during the meeting, where issues or gaps are identified action plans will be developed and monitored until all actions are completed and added to risk register where risks are identified.

- All risks identified through the incident reporting process must be given a risk rating score and highlighted within the Division to facilitate action plan review and adding to the risk register as appropriate.

4.5.2 Serious Incidents

- On conclusion of level 2 investigations conducted at Division level, the actions are reviewed at Clinical Quality Steering Group (CQSG) through the monthly Divisions and Quality report; lessons are expected to be shared between Divisions and at the weekly Patient Safety Meeting (PSM).

- All actions from StEIS reportable incidents are reviewed at the Divisions Integrated Governance group meetings. The findings and recommendations of the level 2 investigation together with the action plan are discussed to ensure that the Divisions can be satisfied that the SIRI process has been followed and that the action plan is robust enough to support changes in practice and ensure that lessons are learnt.

- A SIRI status report will be presented monthly to the Trust Board to provide assurance that monitoring of action plans are ongoing and that SIRI's are closed internally in the Trust once it has been determined that the implementation of actions has been completed.

- The Trust has 60 working days to complete an investigation relating to a moderate or major/severe or catastrophic harm incident requiring investigation.

4.5.3 Informing External Agencies

Liverpool PLACE and Care Quality Commission will be informed about all serious incidents including Never Events via the StEIS reporting system and via

email **within 48 hours** of the incident being recognised. Consideration needs to be given to informing/involving other external agencies/external stakeholders as appropriate.

For information Governance incident's the information commissioner's office may need to be informed. The Trust SIRO (Director of Corporate Affairs) will need to be informed at the earliest opportunity if there is a serious data breach. Refer to **Information Risk Policy – RM71** on DMS for further guidance.

4.5.4 Initial Clinical Review ('72 Hour Review')

An initial incident review (characteristically termed as a '72 hour review') will be undertaken by a clinician appointed by the Division Director where the incident occurred, or delegated other, with relevant expertise who is not involved in delivery of care to the patient. This is to confirm whether a serious incident has occurred and if applicable, the level of investigation required and to outline immediate action taken (including where other organisations / partners have been informed). This will be completed **within 3 working days** of the incident being identified. See the Trust **72 Hour Review Template** on DMS.

In exceptional circumstances the timeframe may be extended. However this will be at the discretion of the Trust Medical Director or the Chief Nurse and signed off accordingly.

The aim of the initial review is to:

- Identify and provide assurance that any necessary immediate action, minimising risk, to ensure the safety of patients staff, and the public.
- Assess the incident in more detail (and to confirm if the incident does still meet the criteria for a serious incident and does therefore require a full investigation); and
- Propose the appropriate level of investigation.

The information submitted as part of the initial review will be reviewed by the appropriate stakeholders and the investigation team (once in operation) in order to inform the subsequent investigation.

The completed 72 hour review will be submitted to the local commissioner i.e. Liverpool PLACE and if required the Care Quality Commission within **5 working days** via the Governance and Quality Assurance team.

4.5.6. Gathering the Information

All information and relevant evidence will be gathered to inform the investigation. This information will be stored securely in line with the Trust's **Data Protection and Confidentiality Policy – RM44** (see on DMS)

Information relevant to each incident will be stored within the Incident Reporting System (Ulysses) as attachments for future reference as required. If an incident has occurred that results in a complaint or claim being made, then the incident form will be 'linked' to the complaint and/or claim within the Ulysses Risk Management system, for ease of reference.

4.5.7 Process for Implementation and Evaluation of Improvement Actions

Following an investigation, lessons learned and recommendation will inform the action plan for improvement, including named responsible individuals with clear timeframes for completion.

Action resulting from the investigation of an incident will be referenced within the Incident Reporting System and monitored by the relevant division all associated actions are completed. Trends arising from incidents including associated actions required will be reported via division governance processes.

The Medical Director for the division will ensure actions arising from root cause analysis investigations are implemented and monitored via the governance processes in the Division.

Any immediate actions identified during the incident investigation will be implemented by the relevant division to prevent reoccurrence of the incident.

Completion of action plans, implementing changes and sharing throughout the organisation will ensure that an active learning organisation is developed and lessons learnt are embedded into the organisation's culture and practice.

4.5.8. Mortality and morbidity reviews

For Departmental and/or HMRG Mortality Reviews, where an incident is logged on Ulysses following a patient's death (e.g. due to the death being deemed avoidable, the Trust process detailed in this policy will be followed.

The chairperson of the HMRG will be informed, and the resulting RCA will form part of the HMRG group's consideration. Where applicable, the death will be reported on the Strategic Executive Information System (STEIS). Likewise, where a reported incident has been recognised via the mortality review process, the Trust process detailed in this policy will be followed.

5 Further Information

References

Department of Health (2009) Listening, Responding, Improving – A guide to better customer care

General Medical Council (GMC) (2012) Raising concerns about patient safety: Guidance for doctors

Health and Safety Executive (HSE) (2013) Reporting injuries, diseases and dangerous occurrences in health and social care: Guidance for employers

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013)

NHS England (2015) Serous Incident Framework: Supporting learning to prevent recurrence

NHS England (2018) Revised Never Events Policy and Framework

HSE Website

Associated Documentation (see on DMS)

Duty of Candour and Being Open Policy – RM47

Risk Management Strategy

Hospital Mortality Review Policy – RM57

Accidents and incidents reportable to HSE

Ulysses Incident reporting

Information Commissioners Office

Appendix A - Serious Incident Management Procedure

See on DMS

Appendix B - After Action Review Procedure

See on DMS

Appendix C - Just Culture Guide

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 tendancy 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?

2c. Are there indications of mental 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**

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?

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

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

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**

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?

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 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**

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

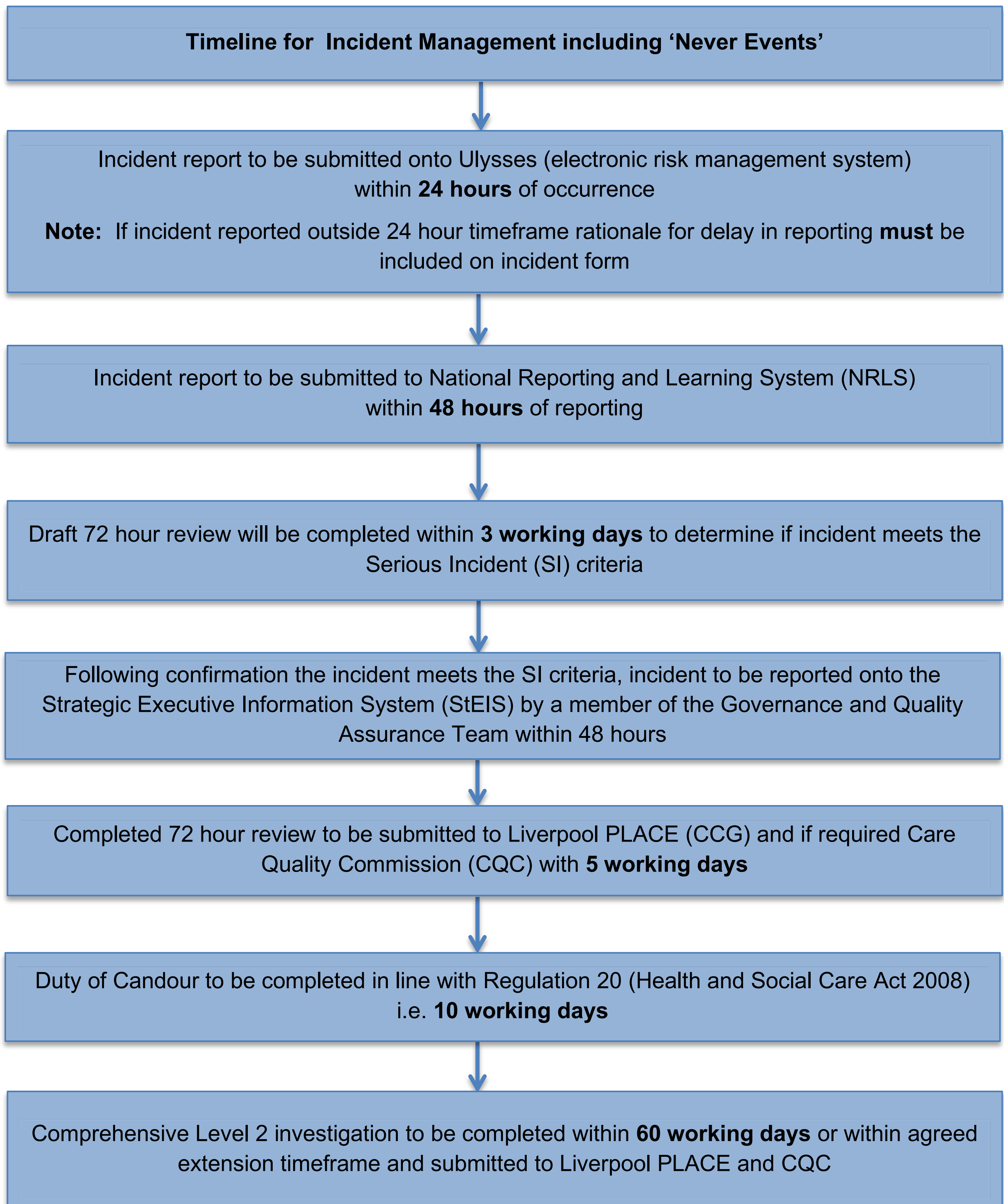
Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

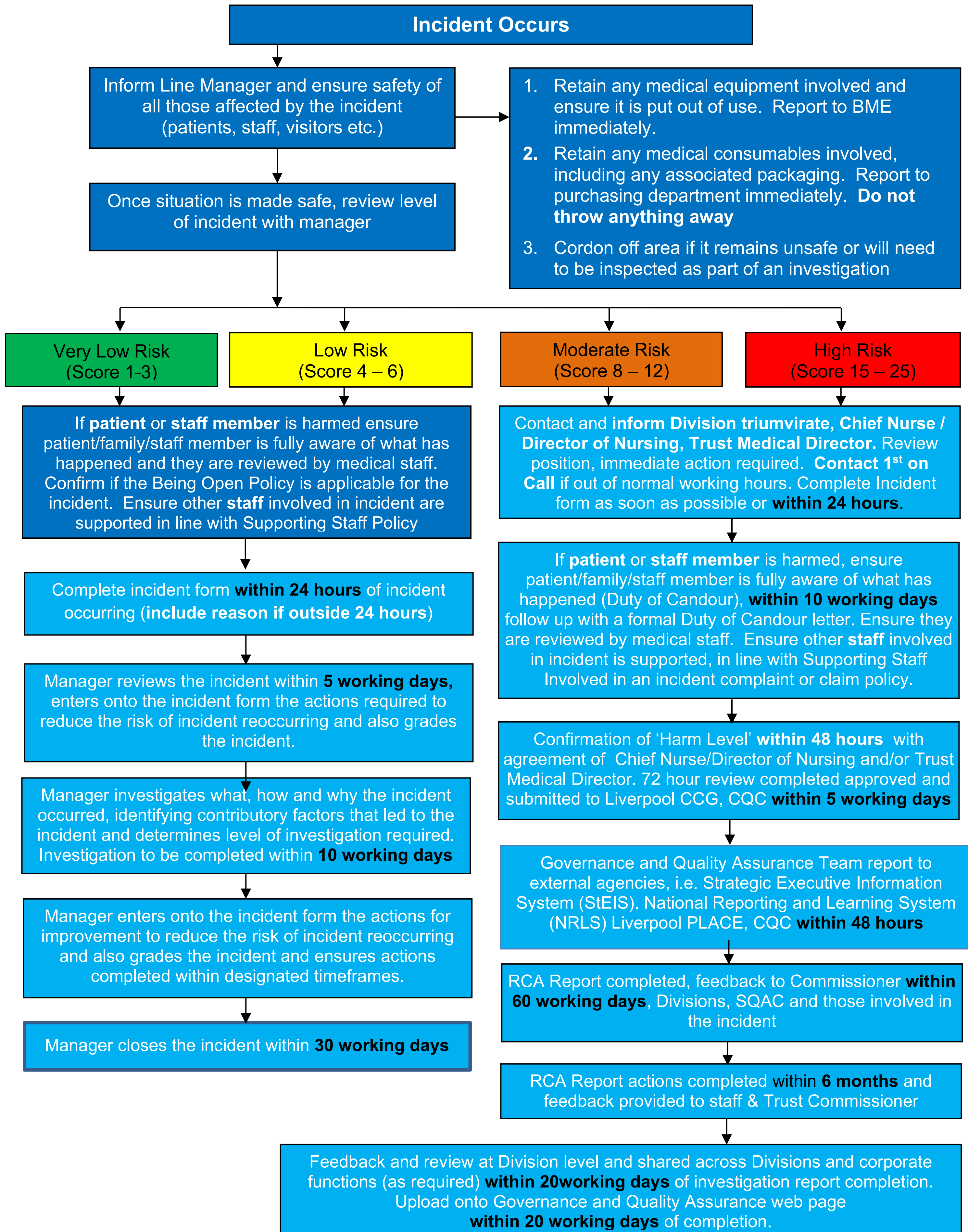
collaboration trust respect innovation courage compassion

Appendix D

Incident Management Flow Chart



Appendix E: Action: Staff involved in or witnesses an incident



Appendix F - Never Events (hyperlink to NHS Improvement)

Appendix G - Risk Grading Matrix

Purpose

The purpose of the risk matrix is to provide a consistent approach to the grading of risk within the Trust, however and wherever, they are identified.

All risks, whether identified from a health and safety risk assessment, a clinical incident, a legal claim or a risk management standard self-assessment, should be graded in a consistent manner against the same generic criteria. The Trust Board (and its sub-committees) can then be confident that risks have been assessed using a consistent method and criteria. This will enable valid comparisons to be made between different types of risk, and for judgments and decisions to be made using a consistent methodology.

Method

Risk can be measured using a combination of the consequence or impact of an event and the likelihood or probability of it occurring.

The accepted formula for grading risk is***: Consequence x Likelihood***

This involves making a judgment both as to the ***Consequence*** (or the severity of the impact) if the risk is realised, and the ***Likelihood*** (or probability) of the risk occurring, or recurring. To measure the risk a score is allocated from 1 to 5 for both Consequence and Likelihood with each number defining a different degree of severity or probability. Multiplying the two scores will give an overall risk score which is shown in the form of a matrix in Table 3.
A brief guide to the scores is provided below for both Consequence and Likelihood:

Consequence:
1 = negligible
2 = minor
3 = moderate
4 = major
5 = catastrophic

Likelihood:
1 = rare
2 = unlikely
3 = possible
4 = likely
5 = almost certain

Incident Risk Grading Matrix:

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use **Table 1** to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Table 1 - Consequence Scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 - Likelihood Score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	***Little chance of occurrence*** (can't believe this event would happen – will only happen in exceptional circumstances **(5-10 years))**	***Probably won't occur*** (not expected to happen, but definite potential exists – unlikely to occur **(2-5 years)**	***May occur*** (may occur occasionally, has happened before on occasions –reasonable chance of occurring **(annually)**	(***Probably will occur)*** (strong possibility that this could occur – likely to occur **(quarterly)**	(this is expected to occur frequently/ in most circumstances – more likely to occur than not. **(daily/weekly/monthly))**

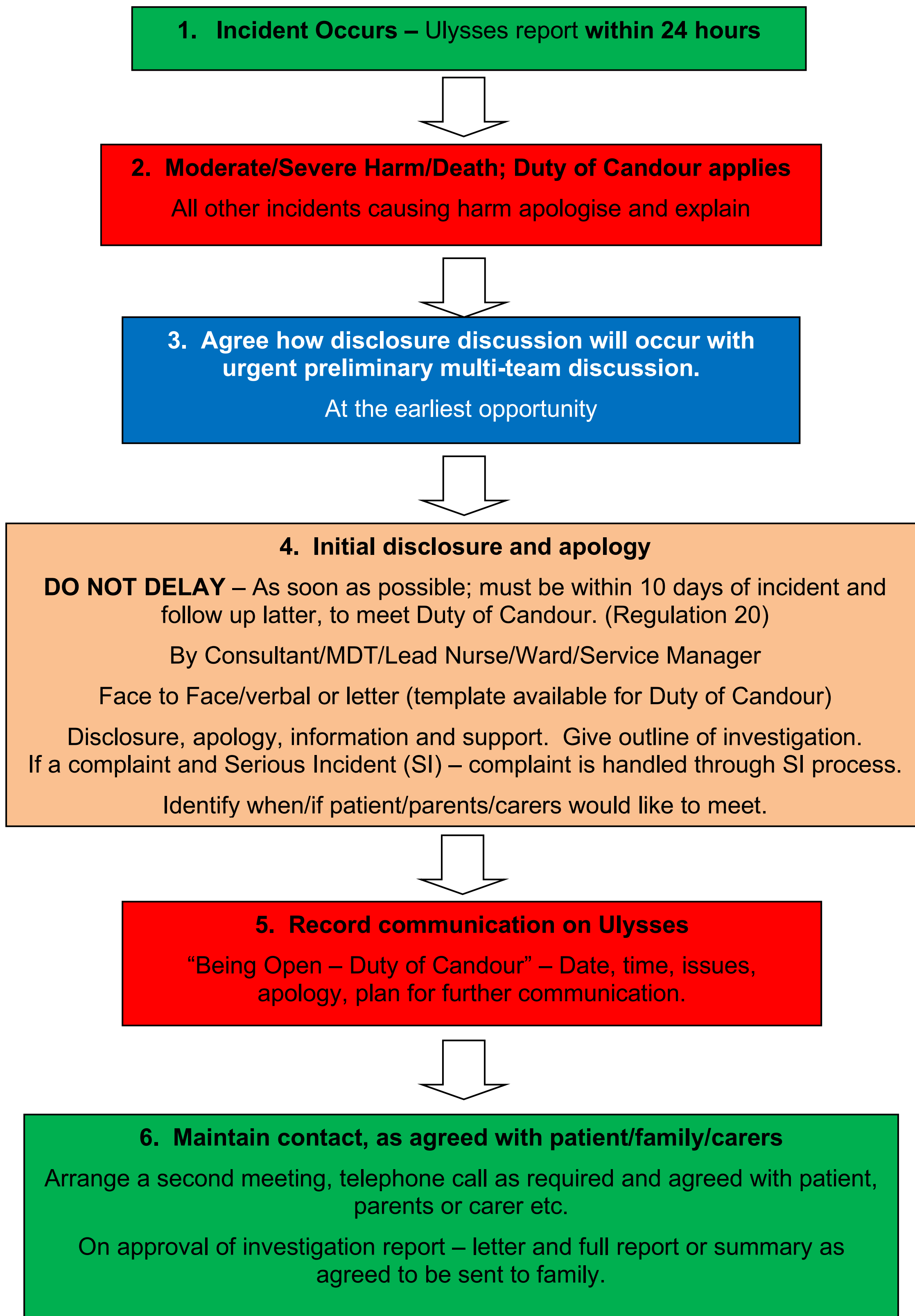
Table 3 - Risk Scoring Matrix = Consequence x Likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Very Low
4 - 6	Low
8 - 12	Moderate
15 - 25	High

Appendix H **Duty of Candour Flowchart**



Initial Equality Impact Assessment (EIA) Form	
This section must be completed at the development stage i.e. before approval or ratification. For further support please refer to the Equality Impact Assessment (EIA) Policy on DMS.	
Part 1	
Name and Job Title of Responsible Person(s): Jackie Rooney, Associate Director of Nursing and Governance	**Contact Number:** via Teams
Department(s): Corporate Governance	**Date of Assessment**: 06/12/2022
Name of the policy / procedure being assessed: Incident Reporting and Management Policy	
Is the policy new or existing? New ☐ Existing ☑	
Who will be affected by the policy (*please tick all that apply*)? Staff ☑ Patients ☑ Visitors ☑ Public ☑	
How will these groups / key stakeholders be consulted with? Minor updates to established policy	
What is the main purpose of the policy? This policy sets out the Trust systems, processes and expectations in relation to incident reporting and learning, to maintain the safety of patients, staff and anyone coming into contact with the Trust and its service.	
What are the benefits of the policy and how will these be measured? Maintaining the safety of patients, staff or anyone else coming into contact with the Trust and its service. Reporting all incidents involving children and young people using Trust services, staff and others, in a timely manner. Reporting to external agencies i.e. Local Commissioner, the Care Quality Commission (CQC), nationally through the National Reporting and Learning System (NRLS) and other stakeholders as required. Investigating incidents according to level of harm. Involving and communicating with internal and external stakeholders to share safety lessons. Ensuring the Trust achieves local and organisation wide learning and changes in practice resulting from individual incidents through aggregated analysis. Ensuring communication is open, honest, occurs as soon as possible and is well documented. Providing an early warning of potential for litigation or complaints.	
Is the policy associated with any other policies, procedures, guidelines, projects or services? Yes ☑ No ☐ *If yes, please give brief details:* Duty of Candour and Being Open Policy – RM47, Risk Management Strategy, Hospital Mortality Review Policy – RM57	

What is the potential for discrimination or disproportionate treatment of any of the protected characteristics?

*Please use the **Equality Relevance** guidance (see on DMS) to specify who would be affected (e.g. patients with a hearing impairment, staff aged over 50).*

Please tick either positive, negative or no impact then explain in reasons and include any mitigation e.g. requiring applicants to apply for jobs online would be negative as there is potential disadvantage to individuals with learning difficulties or older people (detail this in the reason column with evidence) however applicants can ask for an offline application as an alternative (detail this in the mitigation column)

Protected Characteristic	**Tick either positive, negative or no impact**			**Reasons to support your decision and evidence sought**	**Mitigation / adjustments already put in place**
	Positive Impact *(benefit)*	**Negative *(disadvantage or potential disadvantage)***	**No Impact**		
Age	☐	☐	☑	This policy sets out the Trust systems, processes and expectations in relation to incident reporting and learning, to maintain the safety of patients, staff and anyone coming into contact with the Trust and its service. There is no differential impact on any groups sharing a protected characteristic	
Sex	☐	☐	☑		
Race	☐	☐	☑		
Religion or belief	☐	☐	☑		
Disability	☐	☐	☑		
Sexual orientation	☐	☐	☑		
Pregnancy and maternity	☐	☐	☑		
Gender reassignment	☐	☐	☑		
Marriage and civil partnership	☐	☐	☑		
Other (specify)	☐	☐	☑		

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.)
The policy ensures the safety of patients, staff and anyone coming into contact with the Trust and its service.

Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? Yes ☐ No ☑
*See **Equality Relevance** guidance (on DMS) for more details (NB if an absolute right is removed or affected the policy will need to be changed. If a limited or qualified right is removed or affected the decision needs to be proportional and legal)*

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete a Full Equality Impact Assessment. Please speak to the Head of Equality, Diversity and Inclusion and see the Full Equality Impact Assessment (EIA) Form on DMS.			
Action	**Lead**	**Timescale**	**Review Date**
N/A	N/A	N/A	N/A

Declaration	
I am satisfied this document / activity has been satisfactorily equality impact assessed and the outcome is:	Tick one box
Continue – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken	☑
Justify and continue – EIA has identified an adverse impact but it is felt the policy cannot be amended. ***You must complete a Full Equality Impact Assessment (EIA) Form before this policy can be ratified***.	☐
Make Changes – EIA has identified a need amend the policy in order to remove barriers or to better promote equality ***You must ensure the policy has been amended before it can be ratified.***	☐
Stop – EIA has shown actual or potential unlawful discrimination and the policy has been removed	☐
Name: Jackie Rooney Date: 06/12/2022	

Approval & Ratification		
Policy Author:	Name: Jackie Rooney	Job title: Associate Director of Nursing and Governance
Approval Committee:	Clinical Quality Steering Group	Date approved: 13/12/2022
Ratification Committee:	Safety & Quality Assurance Committee	Date ratified: 14/12/2022
Person to Review Equality Analysis:	Name: Jackie Rooney	Review Date: 14/12/2025
Comments:		

Alder Hey Children's NHS Foundation Trust

Patient Safety

RM74 - PATIENT SAFETY INCIDENT RESPONSE POLICY

Document Properties	
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1. Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
1	January 2024	Jackie Rooney	Current	

Record of changes made to Patient Safety Incident Response Policy- Version 1			
Section Number	**Page Number**	**Change/s made**	**Reason for change**

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2. Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Alder Hey Children's NHS Foundation Trust (the Trust) will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

This policy should be read in conjunction with our current patient safety incident response plan (PSIRP), which sets out how this policy is to be implemented.

3. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error,' are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement.

Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

4. Our Patient Safety Culture

Safety culture is one of the two key foundations of Alder Hey's and the wider NHS Patient Safety Strategy. We define a positive safety culture as one where the environment is collaboratively crafted, created, and nurtured so that everybody (individual staff, teams, patients, service users, families, and carers) can flourish to ensure brilliant, safe care by:

- Continuous learning and improvement of safety risks
- Supportive, psychologically safe teamwork
- Enabling and empowering speaking up by all.

Within safety culture, context is everything and improving safety culture is not just about what interventions happen, it is also about how these interventions happen i.e., how change is implemented.

With the introduction of PSIRF, there is continued emphasis on engaging and involving patients, families and staff following a patient safety incident. This supports the Just culture guide which encourages the treatment of staff involved in a patient safety incident in an open, consistent, constructive, and fair way.

We know that positive patient safety and healthy organisational culture are two sides of the same coin. A culture in which staff are valued, well supported, and engaged in their work leads to safe, high-quality care. We are exploring how a focus on staff safety can support patient safety. This means both psychological safety and physical safety, including considering staff wellbeing, engagement, fatigue, burn-out, presenteeism, and the impact these can have on risks to patients and staff alike.

It does not matter whether a staff member is clinical or non-clinical; everyone has a right to feel safe from harm, and to feel safe about speaking up. It's paramount that we move on from a more traditional focus on failure, to also learning from what goes well. In this way, and in the context of a psychologically safe culture, we can all hear more, learn more, and act together to improve patient care.

The Alder Hey staff voice can be viewed as an early warning system where leaders are given an opportunity to understand in detail where improvements can be made and where best practice can be shared.

Psychological Safety, which is explicitly measured in the Staff Survey (and smaller, more safety focused derivatives of it), will therefore play a critical role in helping us to continuously improve. We will extrapolate our findings from the survey metrics to determine if we are sustaining our ongoing progress in improving our safety culture.

By embedding Psychological Safety across Alder Hey, with open discussion, and support from one another, we can take the next step to achieving a safer working environment for our staff and safer care for our patients.

5. Patient Safety Partners

At Alder Hey Children's NHS Foundation Trust, we are excited to welcome Patient Safety Partners (PSP) who will offer support alongside our staff, patients, families/carers to influence and improve safety across our range of services.

PSPs can be patients, young people, carers, or family members and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

At Alder Hey Children's NHS Foundation Trust the main purpose of the role is to be a voice for our children and young people who utilise our services and ensure that patient safety is at the forefront of all that we do.

The Trust is currently in a process to recruit Patient Safety Partners in line with the NHSE (NHS England) guidance Framework for involving patients in patient safety .

Patient Safety Partners (PSP) will have a fundamental role in supporting PSIRF providing a perspective through a patient lens to support developments and innovations to drive continuous improvement in respect of quality and safety of services.

The PSP will be involved in the designing of safer healthcare at all levels in the organisation, to promote safety in the Trust and maximise opportunities for effective and embedded learning. They will use their experience as a patient, patient representative or member of the local community to provide support, guidance, and challenge.

PSPs will be part of the Alder Hey family and will work alongside all staff, volunteers, and patients. They will attend quality and safety focussed meetings (face-to-face and online) and be intrinsically involved in patient safety and quality initiatives.

Full role descriptions have been developed and will be provided for PSPs along with any training and support requirements identified so that they can fulfil their role to its' full potential and ensure the best patient safety outcomes for all patients.

We will ensure that we use available tools such as easy read, translation and interpretation services and other methods such as age-appropriate feedback and literature to meet the needs of those concerned and maximise their potential to be involved in our patient safety incident response.

5.1 Addressing Health Inequalities.

Alder Hey Children's NHS Foundation Trust is one of Europe's biggest and busiest children's Trust, caring for over 330,000 children, young people, and their families every year.

As a specialist provider of health care, Alder Hey has a key role to play in tackling health inequalities in partnership with local partner agencies and services. Through the implementation of PSIRF, we will seek to utilise data gained from our incident reporting system and learning from investigations to identify actual and potential health inequalities and make recommendations to our Trust Board and partner agencies on how to tackle these.

The more holistic, integrated approach to patient safety under PSIRF will require the Trust to be more collaborative with the patient experience and inclusivity agenda and ensure investigations and learning do not overlook these important aspects of the wider health and societal agenda.

Our engagement with children, young people and their families following a patient safety investigation must also recognise the diverse needs of the communities that the Trust serves and ensure inclusivity for all. Any potential inclusivity or diversity issues must always be identified through the investigation process and engagement with patients and families, for example, during the duty of candour / being open process.

Alder Hey recognises that some groups of society can experience prejudice and discrimination. The Equality Act 2010 specifically recognises the protected characteristics of age, disability, sex, race, religion or belief, sexual orientation, transgender, pregnancy/maternity, and marriage/civil partnership. However, the Trust also acknowledges that other minority groups may also experience unfair treatment and discrimination.

When considering our safety actions in response to any incident we will consider if there are any inequalities, and this will be built into our governance and action planning process. We will use our reporting systems to monitor and identify any variations that identify any inequalities. By doing this we can identify any safety improvement work.

5.2 Engaging and Involving Patients, Families and Staff following a Patient Safety Incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including our children, young people, their families, carers, and staff).

This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required. Those affected by a patient safety incident may have a range of needs (including clinical needs) as a result and these must be met where possible. This is part of our duty of care. Meeting people's needs not only helps alleviate the harm experienced, but also helps avoid compounding the harm. While we cannot change the fact that an incident has happened, it is always within our gift to compassionately engage with those affected, listen to, and answer their questions and try to meet their needs.

Processes for engaging and involving those affected by patient safety incidents will be applied as follows:

- Apologies are meaningful. Apologising is a crucial part of the Duty of Candour.
- Approach is individualised.
- Timing is sensitive.
- Those affected are treated with respect and compassion.
- Guidance and clarity are provided. Patients, families, and healthcare staff can find the processes that follow a patient safety incident confusing.
- Those affected are heard. Everyone affected by a patient safety incident should have the opportunity to be listened to and share their experience.
- Approach is collaborative and open.
- Subjectivity is accepted.
- Strive for equity.

5.3 Involving Patients, Families and Patient Representatives

The Trust is committed to involving children, young people, their families, and carers following patient safety incidents, engaging them at the earliest opportunity and throughout in the ongoing investigation process, fulfil the duty of candour statutory and non-statutory requirements.

Children, young people their families and carers often provide a unique, or different perspective to the circumstances around patient safety incidents and may have questions or needs to that of the organisation that will need to be incorporated into the investigation ensuring that the process is patient centred throughout.

This policy prioritises the existing guidance relating to the Duty of Candour and 'being open and honest' and recognises the need to involve children, young people their families and carers as soon as possible in all stages of any investigation, or improvement planning, unless they express a wish not to be involved.

Further guidance in relation to involving patients and families following a patient safety incident is available from NHSE here.

A network of staff acting as Family Support Leads within our Divisions will continue to guide children and young people their families and carers through any investigation or learning review.

Anyone with a concern, comment, complaint or compliment about care or any aspect of the Trust services are encouraged to speak with a member of their care team in the first instance.

We are committed to providing safe compassionate and joined up care for all our children, young people and their families and will work to achieve compliance with recommendations [1 and 2] outlined in Marthas Rule .

In addition, Alder Hey Children's NHS Foundation Trust has a patient advice and liaison service (PALS). Should the care team be unable to resolve the concern then PALS can provide support and advice to our children, young people their families, carers, and friends. PALS is a free and confidential service and the PALS team act independently of clinical teams when managing concerns raised by our children, young people, and their family/carer or friends. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

PALS, located in the Trusts atrium near the Treehouse, is available from 9am to 5pm, Monday to Friday.

Or you can:

- Call 0151 252 5161
- Write to PALS, Alder Hey Children's NHS Foundation Trust, Eaton Road, Liverpool L12 2AP.

If the team are helping other families, they may not be able to answer the phone and you may need to leave a voicemail and they will return your call as soon as they are able to.

We also recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with our children, young people their families, and carers to signpost to their preferred source for this.

5.4 National Guidance for NHS Trusts

Marthas Rule

Engaging with bereaved families

Learning from deaths - Information for families

Child death support:

Child Bereavement UK

Lullaby Trust

Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.

The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings, and review information given during the complaints

Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters.

Parliamentary and Health Service Ombudsman makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

Citizens Advice Bureau provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

5.5 Involving Staff and Partner Agencies

Involvement of staff and partner agencies at the earliest opportunity and throughout an investigation is fundamental when responding to a patient safety incident ensuring that there is a process of openness and transparency throughout.

The Trust recognises the significant impact being involved in a patient safety incident can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place.

Alder Hey Children's NHS Foundation Trust is committed to the principles of the NHS Just Culture Guide for ensuring the fair, open and transparent treatment of staff who are involved in patient safety incidents. We have embedded these principles into our procedures for the review of incidents.

5.6 Corporate Teams

The Trust's Patient Safety and Corporate Risk and Governance Teams will advise, and signpost staff involved in patient safety incidents to the most appropriate information about the patient safety incident review process and further support functions.

5.7 Staff Advise and Liaison Service

SALs is an open access listening service available to all staff and learners at Alder Hey Children's NHS Foundation Trust. The service has been developed and is delivered by Alder Hey staff for Alder Hey staff and is underpinned by the principles of person-centred compassionate care whereby staff are provided with the experience of being listened to, understood, empowered, and supported to take intelligent action.

5.8 Occupational Health service

The Occupational Health service for Alder Hey is provided by Team Prevent UK Ltd, who have a dedicated team of Occupational Health professionals based on site on the interim site to help protect and promote the health and wellbeing of staff in the workplace.

5.9 Schwartz Rounds

Schwartz Rounds provide a structured forum and safe space where staff come together to discuss the emotional and social impact of working in healthcare. You can join the conversation, share your experience, or simply listen to their stories. Sessions are themed with invites to Trust wide Schwartz rounds distributed by the Communications Team.

5.10 Freedom to Speak Up

Freedom to Speak Up (FTSU) is an NHS England wide programme that supports you to identify issues and find ways to resolve them.

We know that an open and responsive raising concerns culture, where all our staff feel confident to speak up when things go wrong, is a huge part of what makes Alder Hey the caring organisation it is, every day. Freedom to Speak up Guardians can be contacted via FTSU@alderhey.nhs.uk

5.11 Support from Patient Safety Incident Investigators

All staff with knowledge of the events being reviewed are encouraged to actively participate in the learning response. That may be through submitting written information, joining a debrief meeting or a one-to-one conversation with the incident review team.

Review teams will agree with staff the timescales for feedback of progress and findings in accordance with the type of review method being utilised.

Staff in engagement roles will be trained in line with the PSIRF standards as outlined in section 8.1.

6. Patient Safety Incident Response Planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

By taking this approach we can focus on our resources, or groups of incidents that provide the greatest opportunities for learning and improving patient safety. Planning needs to consider other sources of information such as complaints, risks, legal claims, mortality reviews and other forms of direct feedback from staff and patients. PSIRF guidance specifies the following standards that the Trust plans should reflect:

- A thorough analysis of relevant organisational data
- Collaborative stakeholder engagement
- A clear rationale for the response to each identified patient safety incident type.

They will be:

- Updated as required and in accordance with emerging intelligence and improvement efforts.
- Published on the Trust external facing website.

6.1 Resources and Training to Support Patient Safety Incident Responses.

It is essential that Alder Hey Children's NHS Foundation Trust ensures that it uses capacity and resources effectively to deliver the plan. The PSIR Plan provides the current level of resource required for Patient Safety Responses (PSRs) to be undertaken.

Currently the Patient Safety Leadership Team, led executively by the Chief Nursing and Chief Medical Officers has the following posts to support and facilitate delivery and embedding of the PSIRF framework:

- Patient Safety Specialist
- Associate Director of Nursing Governance and Risk
- Medical Services Director
- Programme Manager

In addition, the following posts support the Patient Safety Leadership Team:

- Governance Risk Manager
- Divisional Governance Managers
- Head of Quality/Quality Hub

There is a pool of trained investigators, working in substantive clinical or governance roles, who can undertake comprehensive investigations. Appropriate allocation of time to allow for completion learning responses will be given to trained staff.

The Trust has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England Patient Safety Incident Response Standards (2022) to frame the resources and training required to allow for this to happen.

Responsibility for the proposal to designate leadership of any learning response sits within the senior leadership team of the relevant Division.

A learning response lead for a PSII will be nominated by Patient Safety Review Panel and should have an appropriate level of seniority and influence within the Trust – this may depend on the nature and complexity of the incident and response required and will be staff at Band 8a and above.

The Patient Safety team will support learning responses wherever possible and can provide advice on cross-system and cross-divisional working where this is required.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All staff will work within our Just Culture principles. Divisions will have processes in place to ensure that managers work within this framework to ensure psychological safety.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise and advice.

6.2 Training

All staff are aware of their responsibilities in reporting and responding to patient safety incidents.

The Trust has, following approval by Alder Hey Education Governance Committee, mandated the completion of NHSE Patient Safety Training Syllabus Level one – essentials for patient safety for all clinical and non-clinical staff within the Trust.

Furthermore, Level one – essentials of patient safety for board and senior leadership teams has been mandated to all executive members of the Trust.

Level one is a standalone module with currently no expiry/renewal date set for staff. This module is available as an eLearning package via ESR (Electronic Staff Record) access. The overall Trust compliance is monitored through the Integrated Performance Report.

Any future iterations, and national recommendations will be considered and implemented, as necessary.

6.3 Learning Response Leads Training and Competencies.

Training: Any Trust learning response will be led by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and experience of patient safety response.

Records of such training will be maintained the Patient Safety Leadership Team.

Learning response leads must have completed Levels one and two of the national patient safety syllabus.

Learning response leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise the Trust will undertake an annual networking event for all learning response leads via our Trust-wide leadership forums.

Learning response leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the relevant Divisional risk and Governance teams and the Patient Safety team will support this.

Competencies: As a Trust we expect that those staff leading learning responses will:

- Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
- Summarise and present complex information in a clear and logical manner and in report form.
- Manage conflicting information from different internal and external sources.
- Communicate highly complex matters and in difficult situations.

Support for those new to this role will be offered from Divisional senior managers, Divisional risk and Governance teams and the Patient Safety Leadership team.

6.4 Engagement and Involvement Training and Competencies

Training: Engagement and involvement with those affected is led by those with at least six hours of training in involving those affected by patient safety incidents in the learning process.

Records of such training will be maintained the Patient Safety Leadership Team.

Engagement leads must have complete Level one and two of the national patient safety syllabus.

Engagement leads will undertake appropriate continuous professional development on incident response skills and knowledge.

To maintain expertise the Trust will undertake an annual networking event for all engagement leads via our Trust-wide leadership forums.

Engagement leads will need to contribute to a minimum of two learning responses per year. Records for this will be maintained by the Patient Safety team and supported by Divisional Risk and Governance leads.

Competencies: As a Trust we expect that those staff who are engagement leads to be able to:

- Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
- Listen and hear the distress of others in a measured and supportive way.
- Maintain clear records of information gathered and contact those affected.
- Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation.
- Recognise when those affected by patient safety incidents require onward signposting or referral to support services.

6.5 Oversight Roles Training and Competencies

Training: All patient safety response oversight will be led/conducted by those who have had a minimum of two days formal training and skills development in learning from patient safety incidents and one day training in oversight of learning from patient safety incidents.

At least six hours of training in involving those affected by patient safety incidents in the learning process is also required.

Records of such training will be maintained by the Patient Safety Leadership Team.

Those with an oversight role on our Trust Board and leadership team (i.e., executive leads) must have completed the appropriate modules from the national patient safety syllabus; Level one – essentials for patient safety and essentials of patient safety for boards and senior leadership teams.

All those with an oversight role in relation to PSIRF will undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

Competency: As a Trust we expect staff with oversight roles to be able to:

- Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
- Apply human factors and systems thinking principles.
- Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
- Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.
- Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
- Summarise and present complex information in a clear and logical manner and in report form.

7. Our Patient Safety Incident Response Plan

Our plan sets out how Alder Hey Children's NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 months. The plan is not a permanent set of rules that cannot be changed.

We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

The current PSIRF is based on a thorough analysis of themes, patterns, and trends from:

- Patient safety incident reports
- Clinical and non-clinical incident data
- Top 10 incident cause groups
- Complaint's themes
- Legal claims
- Staff survey results
- Mortality and in patient death thematic reviews
- Trust wide quality improvement and harm reduction workstreams

Additional resources reviewed included: Freedom to Speak up reports, Annual Quality Accounts, Trust wide Quality Round and Quality Assurance Round insight reports and presentations, complaints and PALs reports, child deaths and mortality review reports, safeguarding data, patient safety quality improvement dashboards via our quality improvement programme Brilliant Basics, risk data, and direct consultation with children, young people and their families via open forums and through a range of children and young person's forums that we have in place.

A copy of our current plan can be found at:
https://www.alderhey.nhs.uk/about/publications/patient-safety-incident-response-plan/

7.1 Reviewing our Patient Safety Incident Response Policy and Plan.

Our patient safety incident response policy and plan are 'living documents' that will be appropriately amended and updated as we use it to respond to patient safety incidents.

We will review the plan every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every 2 years and more frequently if appropriate (as agreed with our integrated care board (ICB) to ensure efforts continue to be balanced between learning and improvement.

This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

8. Responding to Patient Safety Incidents

8.1 Safety Incident Reporting Arrangements

Patient safety incident reporting will follow the Trust Incident Reporting and Management Policy (see on DMS). All staff are responsible for reporting any potential or actual patient safety incident on the Trust incident reporting system InPhase and will record the level of harm they know has been experienced by the person affected (Appendix B).

These reports will then be routinely uploaded to the national data base (Learning from Patient Safety Events-LFPSE) to support national learning. Locally, support is available on how to report an incident via the Trust intranet or with the Risk and Governance team.

Reporting of serious incidents (SIs) to the Strategic Executive Information System (StEIS) will also be superseded by LfPSE (Learn from Patient Safety Events). However, to reduce complexity during the transition period and to maintain data flows it has been agreed nationally that organisations will continue to use StEIS to record any incidents that are subject to PSII. A new incident type has been added to StEIS that allows organisations to record incidents which are responded to using PSII.

Daily Divisional incident review mechanisms are currently in place to ensure that patient safety incidents can be responded to proportionately and in a timely manner. This includes consideration and prompting to service teams where Duty of Candour applies.

Whilst the statutory obligation for the Trust to complete Duty of Candour (DoC) for moderate harm and above remains, under PSIRF, the timescale for DoC to be completed within 10 days has been removed: however, Alder Hey will continue to adhere to the 10-day timescale to ensure compliance with DoC legislation.

Most incidents will only require local review within the Divisions/services, but in line with our approved governance process (Appendix A), all incidents reported as moderate physical harm or above, together with any local rapid review undertaken in the preceding week, plus any patient safety incident where it is felt that the opportunity for learning and improvement is significant, will be presented by the relevant Division and reviewed collectively at the weekly Patient Safety Incident Response Investigation (PSIRI) Panel to determine the appropriate learning response required (PSII or PSR). Divisions will also escalate any identified trends, clusters or patient safety risks which cannot be actioned, plus any incident which appears to meet the criteria to be reported eternally to the weekly PSIRI panel.

Patient Safety Incident Investigations (PSIIs) include a range of techniques (such as interviews and observations) to systematically identify the circumstances surrounding incidents. Any PSII undertaken by our organisation will use the national PSII template (Appendix C).

All PSRs are conducted locally by our organisation with different PSR techniques adopted depending on the intended aim and required outcome. There are five broad categories of PSRs agreed with stakeholders to be utilised at Alder Hey Childrens NHS Foundation Trust (Appendix C)

- Rapid Review
- Situation, Background Assessment, Recommendation (SBAR) review
- Thematic Review
- Multi-disciplinary team (MDT) review
- Safety Huddle incorporating a Hot/Cold debrief.

Our approved governance process allows the Trust to work in a transparent and collaborative way with our ICB or regional NHS teams if an incident meets the national criteria for PSII or if supportive co-ordination of a cross system learning response is required.

8.2 Patient Safety Incident Response Decision-Making

In line with our approved PSRIF governance arrangements the Trust has arrangements in place to allow it to meet the requirements for review of patient safety incidents under PSIRF. Some incidents will require mandatory PSII, others will require review by, or referral to another body or team depending on the event. These are set out in our PSIRP.

The Trust has established governance and assurance systems in place to ensure oversight of patient safety incidents at both Divisional and Trust wide level allowing for a clear 'Ward to Board' oversight of incident management and our PSIRF response.

Corporate and Divisional Governance teams will continue to work collaboratively to ensure the following arrangements are in place:

- Identification and escalation of any incidents that have, or may have caused significant harm (moderate, severe or death)
- Identification of themes, trends, or clusters of incidents within a specific service
- Identification of themes, trends or clusters of incidents relating to specific types of incidents
- Identification of any incidents relating to local risks and issues (e.g. – CQC (Care Quality Commission) concerns)

- Identification of any incidents requiring external reporting or scrutiny (e.g. – Never Events, Neonatal deaths, RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrence Regulations))
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures.

This data will be reviewed regularly against the identified priorities in the PSIRP to determine whether any shift in focus is required, which will be agreed by the Patient Safety Board and Safety Quality Assurance Committee if required.

The process for completion of a Patient Safety Incident Review, currently identified as a rapid review, to determine further investigation or escalation required will remain with other tools as outlined in section 8.1 and available in Appendix C.

The principles of proportionality and a focus on incidents that provide the greatest opportunity for learning will be central to this decision making under the Trust's PSIRP. This may often mean no further investigation is required, especially where the incident falls within one of the improvement themes identified in the PSIRP and this will be considered on a case-by-case basis with justification where necessary.

8.3 Responding to Cross-System Incidents / Issues.

If more than one organisation is involved in the care and service delivery in which a patient safety incident has occurred, the organisation that identifies the incident is responsible for recognising the need to alert relevant stakeholders to initiate discussions about subsequent investigation and actions. All relevant stakeholders involved should work together to undertake one single investigation wherever this is possible and appropriate.

The PSIRI Panel and Corporate Governance team will act as liaison with external bodies and partner providers to ensure effective communication via a single point of contact for the Trust via the following email address: governanceandqualityassurance@alderhey.nhs.uk

The ICS (Integrated Care Systems) should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process.

We will also continue to collaborate with our paediatric peers to share any-cross paediatric patient safety themes and trends for learning purposes.

8.4 Timeframes for Learning Responses

Learning responses must balance the need for timeliness and capture of information as close to the event as possible, with thoroughness and a sufficient level of investigation to identify the key contributory factors and associated learning for improvement.

Our PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident reported but initial investigation should be started within 5 working days of being reported.

PSIIs: Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and the time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of terms of reference, provided they are willing and able to be involved in that decision.

However, all PSIIs should be completed within three months of their start date with no local PSII taking longer than six months.

PSRs: Where other forms of PSRs should be started within 5 working days of being reported and completed within one month of their start date.

Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion within six months or the agreed timeframe, the PSII leads should work with all the information they have to complete the response to the best of their ability; it may be revisited later should new information indicate the need for further investigative activity.

In some incidences, longer timeframes may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

8.5 Safety Action Development and Monitoring Improvement.

PSIRF moves away from the identification of 'recommendations' and shifts its focus to describing 'areas for improvement.'

The Trust will use the process for development of safety actions as outlined in the NHS England safety action development guide as follows:

- Agree areas for improvement.
- Define the context.
- Define safety actions to address areas of improvement.
- Prioritise safety actions.
- Define safety measures to demonstrate improvement.

Safety actions will be written following the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and have a named designated owner.

Completion and effectiveness of safety actions will continue to be monitored through established organisational and divisional governance processes. Divisional reporting on the progress with safety actions will be made to Patient Safety Board and were applicable Quality Safety Assurance Committee.

The Corporate Governance Team will maintain an overview across the organisation to identify themes, patterns, and trends via the Aggregated Analysis Report on a quarterly basis.

Areas for improvement will be identified via the Patient Safety Board. In collaboration with our Brilliant Basics quality improvement team, service or teams will be supported using our A3 Quality Improvement methodology to identify and embed learning and improvement following a patient safety investigation to improving patient safety outcomes.

8.6 Safety Improvement Plans

As referred to throughout the policy, the Trust has developed a plan (PSIRP) that clarifies what our improvement priorities are. The PSIRP details how we will ensure patient safety incidents are investigated in a more holistic and inclusive way, to identify learning and safety actions which will reduce risk and improve safety and quality.

The Trust has several overarching safety quality improvements plans already in place including individual safety improvement plans that focus on specific services.

Where overarching system issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan may be developed. These will be identified through the weekly Divisional patient Safety Meetings and PSIRI panel. Monitoring of progress will be overseen by the Patient Safety Group with oversight and reporting to Safety Quality and Assurance Committee.

8.7 Oversight Roles and Responsibilities

Responsibility for oversight of the PSIRF for provider organisations sits with the Trust Board as outlined in the Oversight roles and responsibilities specification

At Alder Hey the Board through the Executive Medical Director and Chief Nurse have joint responsibility for the effective monitoring and oversight of PSIRF.

As designated Trust Executive Patient Safety Leads, the Chief Nursing Officer and Chief Medical Officer will:

- Delegate all incidences reported as moderate harm or above to the Patient Safety Incident Response Investigation (PSIRI) Panel for review and agreement of action as per agreed Trust PSRIF process.
- Delegate authority for the approval of downgrading of any moderate harm incident following divisional review of rapid review findings to the PSIRI panel.
- Receive a weekly tracker from PSIRI of all incidences received by PSIRI panel, including the decisions made for each incident presented plus any areas/incidences for escalation.
- Receive all completed PSIIs for oversight and approval for presentation to Trust Board

It is important that under PSIRF there is a paradigm shift from monitoring of process, timescales, and outputs to meaningful measures of improvement, quality and safety, and outcomes for patients.

It should be noted that similarly the ICB's role will focus on oversight of PSIRF plans / priorities and monitoring progress with improvements. There will no longer be a requirement to 'declare' an SI (Serious Incident) and have individual patient safety responses 'signed off' by commissioners.

However, they will wish to seek assurances that improvements and priorities under PSIRF are progressing and delivering improvements in quality and safety. The metrics, measures (objective and subjective) and evidence required to do this will need to be defined within the PSIRP for each priority which will be agreed in discussion with the ICB.

9. Mortality Issues

Our Trust has an established monthly Mortality Review Group (MRG) to provide oversight of compliance with the mortality review process and will provide the Trust with the assurance that causes, and contributory factors of the inpatient deaths of all children and young people including neonates have been reviewed, considered, and are appropriately responded to in an open and transparent manner.

If relevant, any child death will be referred to the child death overview panel (CDOP) via the Trust's safeguarding team for investigation in line with statutory and operational guidance.

Our Safeguarding team will liaise with CDOP as locally led PSII may be required and respond to recommendations from external parties for learning purposes.

If a PSII is undertaken regarding a death that will be reviewed by a coroner, the coroner will receive the PSII report. If a different learning response is undertaken, the output from the response will also be shared with the coroner.

Any neonatal death will be referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation (https://www.hsib.org.uk/maternity/)

All perinatal deaths will be referred to MBRRACE and any relevant recommendations and/or actions from external referred agency will feed into the Patient Safety Board to be considered as part of QI process.

10. Complaints and Appeals.

The Trust recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided by the Trust. When this occurs, they may wish to raise a local concern, an informal PALS concern or a formal complaint and the Trust has a duty to listen to their concerns, investigate them fully in a timely and responsive manner, provide a full and appropriate response, and seek a resolution.

Formal complaints from children, young people or families can be lodged through the Trust's complaints procedure. The Quick Reference Guide provides flow charts for the management of complaints which should be used in conjunction with the Complaints and Concerns Policy.

Any complaints relating to this policy, or its implementation can be raised informally with the Corporate Governance team, initially, who will aim to resolve any concerns as appropriate.

11. Appendices

See on DMS

Appendix A – PSIRF Governance Process

Appendix B – PSIRF Harm Grading Guidance

Appendix C:

PSIRF Tools - PSII Report Template

PSIRF Tools - Terms of Reference for Investigation

PSIRF Tools - Rapid Review Template

PSIRF Tools - SBAR Template

PSIRF Tools - Thematic Review Guide

PSIRF Tools - MDT Review Guide

PSIRF Tools - Safety Huddle Incorporating Hot / Cold Debrief

PSIRF Tools - SEIPS Worksheet and Guide

PSIRF Tools – Incident Timeline

<table>
<tr><th colspan="2">Initial Equality Impact Assessment (EIA) Form</th></tr>
<tr><td colspan="2">This section must be completed at the development stage i.e. before approval or ratification. For further support please refer to the Equality Impact Assessment (EIA) Policy on DMS.</td></tr>
<tr><td colspan="2">Part 1</td></tr>
<tr><td>Name and Job Title of Responsible Person(s): Jackie Rooney, Associate Director of Nursing Governance</td><td>Contact Number: jackie.rooney@alderhey.nhs.uk</td></tr>
<tr><td>Department(s): Corporate</td><td>Date of Assessment: 03/01/2024</td></tr>
<tr><td colspan="2">Name of the policy / procedure being assessed: Patient Safety Incident Response Policy</td></tr>
<tr><td colspan="2">Is the policy new or existing?
New ☑ Existing ☐</td></tr>
<tr><td colspan="2">Who will be affected by the policy (please tick all that apply)?
Staff ☑ Patients ☑ Visitors ☐ Public ☐</td></tr>
<tr><td colspan="2">How will these groups / key stakeholders be consulted with? Key stakeholders have been consulted with as part of the development and insight of the local Patient Safety Incident Plan process</td></tr>
<tr><td colspan="2">What is the main purpose of the policy? A key element and requirement of the national implementation of PSIRF</td></tr>
<tr><td colspan="2">What are the benefits of the policy and how will these be measured? Based on our local patient safety profile</td></tr>
<tr><td colspan="2">Is the policy associated with any other policies, procedures, guidelines, projects or services? Yes ☑ No ☐
If yes, please give brief details: Patient Safety Incident Response Plan and Patient Safety Strategy</td></tr>
<tr><td colspan="2">What is the potential for discrimination or disproportionate treatment of any of the protected characteristics?
Please use the Equality Relevance guidance (see on DMS) to specify who would be affected (e.g. patients with a hearing impairment, staff aged over 50).
Please tick either positive, negative or no impact then explain in reasons and include any mitigation e.g. requiring applicants to apply for jobs online would be negative as there is potential disadvantage to individuals with learning difficulties or older people (detail this in the reason column with evidence) however applicants can ask for an offline application as an alternative (detail this in the mitigation column)</td></tr>
</table>

Protected Characteristic	Tick either positive, negative or no impact			Reasons to support your decision and evidence sought	Mitigation / adjustments already put in place
	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact		
Age	☑	☐	☐		
Sex	☑	☐	☐		
Race	☑	☐	☐		
Religion or belief	☑	☐	☐		
Disability	☑	☐	☐		
Sexual orientation	☑	☐	☐		
Pregnancy and maternity	☑	☐	☐		
Gender reassignment	☑	☐	☐		
Marriage and civil partnership	☑	☐	☐		
Other (specify)	☑	☐	☐		

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.)
Click or tap here to enter text.

Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? Yes ☐ No ☑
*See **Equality Relevance** guidance (on DMS) for more details (NB if an absolute right is removed or affected the policy will need to be changed. If a limited or qualified right is removed or affected the decision needs to be proportional and legal)*

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete a Full Equality Impact Assessment. Please speak to the Head of Equality, Diversity and Inclusion and see the Full Equality Impact Assessment (EIA) Form on DMS.			
Action	**Lead**	**Timescale**	**Review Date**
N/A	N/A	N/A	N/A

Declaration	
I am satisfied this document / activity has been satisfactorily equality impact assessed and the outcome is:	Tick one box
Continue – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken	☑
Justify and continue – EIA has identified an adverse impact but it is felt the policy cannot be amended. ***You must complete a Full Equality Impact Assessment (EIA) Form before this policy can be ratified***.	☐
Make Changes – EIA has identified a need amend the policy in order to remove barriers or to better promote equality ***You must ensure the policy has been amended before it can be ratified.***	☐
Stop – EIA has shown actual or potential unlawful discrimination and the policy has been removed	☐
Name: Jackie Rooney Date: 03/01/2024	

Approval & Ratification		
Policy Author:	Name: Jackie Rooney	Job title: Associate Director of Nursing Governance
Approval Committee:	Patient Safety Board	Date approved: 19/10/2023
Ratification Committee:	SQAC	Date ratified: 15/11/2023
Person to Review Equality Analysis:	Name: Jackie Rooney	Review Date: 15/11/2026
Comments:		

Alder Hey Children's
NHS Foundation Trust

RM9 – PREVENTING & MANAGING VIOLENCE & AGGRESSION AT WORK, ZERO TOLERANCE PROCESS & PROTECTING LONE WORKER POLICY

Version:	7.4
Name of ratifying committee:	Workforce and Organisational Development
Date ratified:	02/03/2020
Name of originator/author:	Greg Murphy and Pauline Brown
Name of approval committee:	Employment Policy Review Group
Date approved:	17/12/2019
Name of Executive Sponsor:	Chief Operating Officer
Key search words:	Violence, aggression, lone, worker, security, zero, tolerance, inappropriate, unacceptable, drug, drugs, alcohol, aggressive, abuse, police
Date issued:	April 2024 (Extension)
Review date:	October 2027

Quick Reference Guide – Preventing and Managing Violence & Aggression at Work, Zero Tolerance Process and Protecting Lone Worker Policy

This policy applies to all Trust staff, contractors, volunteers, students and those on placements or work experience.

Key responsibilities of the Local Security Management Specialist (LSMS):

- Ensure all physical and non-physical assaults are reported via the Trust Ulysses incident reporting system.
- Ensure all reported incidents are thoroughly investigated and the most appropriate action taken against offenders.
- Provide advice on security matters relating to lone workers, training and other security related matters.
- Advise on appropriate and proportionate physical security, technology and support systems that improve personal safety of staff.
- Identify hazards, assessment and management of risks, ensuring that all possible preventative action is taken to minimise the risk of further incidents occurring.

Key responsibilities of Ward / Department Managers

- Nominate an appropriate staff member as risk assessor and arrange their training.
- Ensure Trust's Violence and Agression Checklist is completed by nominated trained risk assessor, with guidance from the Trust LSMS (Appendix B).
- Ensure risk assessments take account of any risk of violence to staff, children / young people and visitors and implement any control measures to reduce further occurences.
- Ensure lone worker risk assessments include external and environmental factors, for example the risk from the patient and where appropriate, the childs home and community if a home visit is necessary. Lone workers should have use of appropriate lone worker device devices.
- Ensure all incidents of violent, aggressive, inappropriate or unacceptable behaviour are managed in line with the Zero Tolerance Process.
- Ensure all violent and aggressive incidents are reported and investigated and that staff are supported. Near misses should also be reported and investigated.
- Assess and implement appropriate preventative control measures to minimise the risk of occurrence and recurrence of incidents.
- Monitor the number of incidents and any increases in incidents reported on Ulysses.

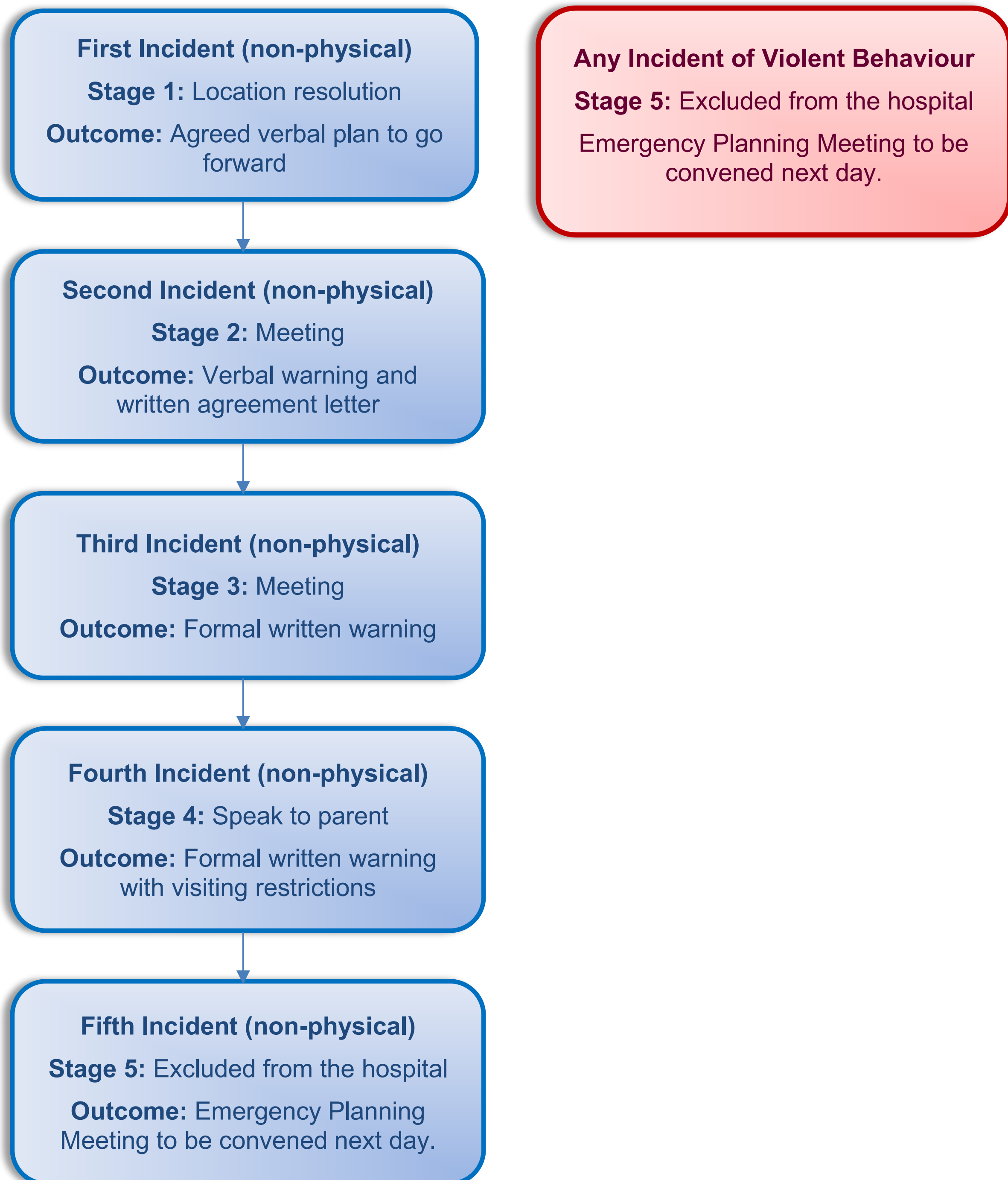
Key Responsibilities for Staff

- Report non-physical and physical assaults to line manager and on Ulysses.
- Report near misses when feeling unsafe, even if it is not a tangible event / experience. Failure to report an incident may put others at risk.
- Ensure all incidents of violent, aggressive, inappropriate or unacceptable behaviour are managed in line with the Zero Tolerance Process (Appendices G to N).
- Lone workers implement any control measures identified by risk assessment and monitor effectiveness.
- The Trust has a zero tolerance approach to any abuse of staff. This means that action of some form will be taken in every event of violence, aggression, unacceptable or inappropriate behaviour.

Training

- Violence and aggression / lone worker training is part of induction, and included in Health & Safety Awareness mandatory training. Conflict Resolution Training, Positive Behavioural Support training, and training in the Zero Tolerance Process is provided for relevant staff as identified by Training Needs Analysis.

Flowchart of Zero Tolerance Process for Non-Physical Inappropriate or Unacceptable Behaviour and/or Violent Behaviour



Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
7.4	April 2024	Greg Murphy,	Current	6 month Extension to allow policy to be reworked with new Zero Tolerance Policy.
7.3	January 2024	Greg Murphy, Pauline Brown	Archived	Extension
7.2	June 2023	Greg Murphy, Pauline Brown	Archived	6 month extension
7.1	March 2020	Greg Murphy, Pauline Brown	Archived	Formally ratified by Workforce & Organisational Development Committee.
7	December 2019	Greg Murphy, Pauline Brown	Archived	Ratified subject to staff side agreement. Agreed by HR Policy Review Group on 17/12/2019. Executive sign off on 23/12/2019.
6.1	June 2017	Greg Murphy	Archived	CAMHS Guidance hyperlinks added
6	December 2016	Greg Murphy	Archived	
5	March 2013	Mark Jump	Archived	Minor edits
4	November 2009	Joe Murray	Archived	Includes M44 Lone Workers Policy & RM18 Substance Abuse Policy
3	July 2006	Mark Jump	Archived	
2	November 2003	Margaret Fitzhugh	Archived	
1	March 1995	Unknown	Archived	Was known as Management of a Violent or Potentially Violent Incident
Lone Workers Policy M44				
2	October 2006	Jayne Shaw	Archived	Incorporated into V&A Policy November 2009
1	May 2001	Sharon Bird	Archived	
Substance Abuse Policy RM18				
1	June 2002	Julie Knowles	Archived	

Record of changes made to Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy – Version 7.3			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Dates updated.	Extension pending ratification of new Safe and Respectful Behaviour Policy which will include Zero Tolerance content from this policy.

Record of changes made to Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy – Version 7.2			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Dates updated. Links updated to DMS.	6 month extension

Record of changes made to Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy – Version 7.1

Section Number	Page Number	Change/s made	Reason for change
All	All	Dates updated	Formally ratified by WOD

Record of changes made to Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy – Version 7			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Policy title changed to include Zero Tolerance Process. Significant amends, previous version re-ordered, including Appendices. Includes new section on Zero Tolerance Process to outline the staged escalation process for inappropriate or unacceptable behaviour. Includes expanded section regarding children / young people with challenging behaviour. No changes to lone worker guidance.	To provide staff with clear guidance and escalation process to manage inappropriate or unacceptable behaviour by parents or visitors. To provide staff with clear guidance when a patient brings an object known to be a weapon (for example a knife) to the Trust

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1 Introduction

1.1 The Trust recognises and welcomes that it has an obligation under the Health and Safety at Work Act (1974) 1, and the Management of Health and Safety Regulations (1999) 2, for the health, safety and welfare at work of our staff.

1.2 This policy is designed to provide comprehensive guidance and advice to all Trust staff in order to support positive behaviour within the Trust and minimise the risk of violence and / or abuse towards our staff from parents, visitors or children / young people, and to provide guidance for managing any incidents in a fair, appropriate and consistent manner.

1.3 Alder Hey is dedicated to delivering world class outstanding care for children, young people and their families, and the Trust is staffed by people who are highly committed, caring, empathetic and compassionate. In doing so, it is acknowledged that the staff may be exposed to and at times tolerate or excuse behaviour defined or felt to be inappropriate or unacceptable in order to achieve the best outcome for their child. This policy is designed to provide comprehensive guidance and advice to all Trust staff to manage any incidents in a fair, appropriate, supported and consistent manner to ensure the safety of all our children, families, visitors and staff.

1.4 This policy applies to all Alder Hey Children's NHS Foundation Trust staff, temporary and agency staff, contractors, volunteers, students and those on placements or work experience.

1.5 This policy concerns all children / young people who have been admitted for care to a ward either as an in-patient or day case, attend the Emergency Department, or who attend an outpatient clinic appointment either on the main site or at a satellite Alder Hey community clinic appointment.

1.6 This policy concerns all children / young people, parents, carers, legal guardians, family, friends, or any other individuals who are attending with or visiting a patient, visiting family or entering the public spaces of the Trust.

1.7 The NHS Constitution brings together what staff, children / young people and the public can expect from the NHS. It also explains what relatives and visitors can do to help support the NHS, help it work effectively, minimise violence and aggression and help ensure that our resources are used effectively.

1.8 The Trust expects that any visitor to the hospital will behave in an acceptable and appropriate manner. Staff have a right to work, as children / young people have a right to be treated, free from fear of assault and abuse in an environment that is safe and secure in order that the highest possible standards of clinical care can be delivered to children / young people. The Trust will not condone, nor tolerate any aggressive, abusive or violent behaviour towards our employees engaged in their lawful duties from any source, be they children / young people or visitors.

1.9 The Trust has devised the Visitors and Relatives Charter in line with both the NHS Constitution and the Trust values, to assist visitors and staff to work together in partnership with clear pledges and expectations for the benefit and

safety of children / young people, visitors and staff (Appendix A). The Visitors and Relatives Charter should be read in conjunction with this policy.

1.10 Violence, abuse, inappropriate or unacceptable behaviour towards staff may be exhibited by the child / young person themselves, their parent / carer / legal guardian or other family, friends or visitor.

1.11 The Trust has a zero tolerance approach to any abuse of staff. This means that action of some form will be taken in every event of violence, aggression, inappropriate or unacceptable behaviour. This is set out in the Zero Tolerance Process outlined in section 6.4.

1.12 The Trust recognises that as part of the services it provides there is a necessity for staff to work alone. To meet the Trust's statutory and strategic objectives this policy and associated documentation aims to minimise the risk to lone workers to its lowest level, in so far as is reasonably practicable, to meet the needs of the child / young person.

1.13 This policy, procedures and associated working groups will enable the organisation to fulfil its responsibilities to report under the relevant statutory requirements.

1.14 This policy will help improve our performance for staff with characteristics protected by the Equality Act 2010 and specifically in relation to the Workforce Race Equality Standard (WRES) Metric 5, Workforce Disability Equality Standard (WDES) Metric 4 and Equality Delivery System (EDS2) outcome number 3.4

1.15 The objectives of this policy are to:

- Assist staff to recognise causes and early warning indicators for potential inappropriate or unacceptable behaviour from children / young people, parents and visitors in order to minimise the risk of incidents occurring, and to practice positive behaviour support in the recognition and management of inappropriate or unacceptable behaviour.

- Provide staff with guidance on how to effectively resolve and manage inappropriate behaviours and potential conflict in a safe and proactive way whenever possible.

- Provide staff with guidance on how to manage violent and aggressive behaviour in the workplace, including a clear Zero Tolerance Process, procedures and formal letters to invoke following any incident of violent, aggressive, inappropriate or unacceptable behaviour.

- Promote effective reporting of violent, aggressive, inappropriate or unacceptable incidents through the Trust's Ulysses incident reporting system.
- Promote a culture that promotes positive behaviours, that utilises appropriate proactive and positive management strategies that are cognisant of risk, security and safety for al to reduce conflict.

- Actively identify and promote the identification, recording and investigation of incidents that will support the reduction of incidents through proactive critically reflective management strategies.
- Identify and reduce the incidents of violence and aggression to all staff, including lone workers, to its lowest level, in so far as is reasonably practicable, wherever the staff member is working.
- Ensure all lone working activities are suitably risk assessed.

2 Definitions

2.1 *Parent:* The term will refer to parents, carers and legal guardians who have parental responsibility.

2.2 *Other visitors:* The term will refer to family, friends and other visitors.

2.3 *Physical Assault:* The term will refer to the intentional application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort.

2.4 It is recognised that staff may use various terminology to describe behaviours related to physical assault such as ‘violent’, ‘aggressive’, ‘threat of violence’. Therefore for the purpose of this policy all such words apply in this context.

2.5 *Non-physical Assault:* The term will refer to the use of inappropriate words or behaviour causing distress and / or constituting harassment. See Section 3 for examples of inappropriate behaviour.

2.6 It is recognised that staff may use various terminology to describe behaviours related to non-physical assault such as ‘unacceptable’, ‘inappropriate’, ‘challenging’, ‘intimidating’, ‘abusive’, ‘manipulative’, ‘offensive’. Therefore for the purpose of this policy all such words apply in this context.

2.7 C*hallenging behaviour:* The term will refer to behaviour of such intensity, frequency or duration that the physical safety of the person or others is placed in serious jeopardy.

2.8 *Lone Worker:* The Trust defines a lone worker as any individual who, in the process of carrying out their duties on behalf of the Trust, may find themselves working alone or in an area isolated from colleagues

This will include, but is not exhaustive to, staff:

- On home visits
- Working in a community setting, for example school
- Working from home
- Working out of hours
- Attending the site when on-call
- Working separately from others
- Working in buildings on their own
- Patrolling on their own

3 Duties

3.1 Divisional Associate Chief Operating Officers

i. Responsible to the Board for the effective implementation of this policy and all associated procedures.

ii. Ensure that an appropriate assessment of the risk to lone workers has been carried out, including external factors. Review risk assessments and ensure trends are reported to the LSMS.

iii. Delegate to nominated line managers the responsibility of implementing this policy at local level.

iv. Support staff in managing incidents of inappropriate or unacceptable behaviour in line with the Zero Tolerance Process (see section 6.4).

3.2 Risk Management Team

i. Ensure that systems are in place to assess the risk of lone workers, and provide advice and support.

ii. Provide advice in both the completion of the risk assessment and the identification of hazards and control measures.

3.3 Local Security Management Specialist (LSMS)

i. Ensure the Trust has up to date policies and procedures for the management and control of security related issues and, in liaison with line managers, ensure that they are disseminated to all relevant staff.

ii. Carry out formal security risk assessments for the Trust, with the assistance of staff working in the assessed area. Risk assessments to include all site buildings and wards / departments and all external buildings owned by the Trust.

iii. Provide advice and guidance on security matters relating to lone workers, training and other security related issues, including departmental risk assessments and checklists.

iv. Undertake an active role in identifying hazards, assessment and management of the risks. Advice on the appropriate security provision needed to mitigate the risks and protect staff.

v. Undertake audit to ensure that all checklists and assessments are reviewed at the minimum annually.

vi. Ensure all reported incidents are thoroughly investigated and the most appropriate action taken in line with the Zero Tolerance Process outlined in section 6.4 and reported to the Police as appropriate.

vii. Provide a quarterly written report to the Health & Safety Committee outlining any lone worker incidents and action to prevent a re-occurrence.

viii. Advise the organisation on appropriate and proportionate physical security, technology and support systems that improves personal safety of staff.

ix. Liaise and co-operate with, and monitor cases, of non-physical assault that have been referred to and are being handled by the police.

x. Consider whether the Trust should initiate private prosecution and / or civil proceedings where the matter has been reported to the police and the police have decided not to pursue the matter.

3.4 Ward / Departmental Managers / Service Leads / Heads of Service

i. Ensure staff at all levels understand the requirements of this policy in order to maintain a safe environment and to ensure compliance with the Trust's legal obligations.

ii. Ensure all staff attend Conflict Resolution Training incorporating Positive Behavioural Support training in line with the Trust **Mandatory Training Policy – E21** (see on DMS) and the local Training Needs Analysis. Identify any further associated training needs within the team and ensure they are met.

iii. Ensure that all parents and visitors are welcomed and orientated to the ward and that they are provided with key information in line with the **Hospital Visiting Policy - C25** (see on DMS)

iv. Ensure appropriate resources and support is available and accessible to parents and visitors in order to maintain a safe environment for visiting. This includes, though is not limited to:

- Welcome posters / signage
- Ward information leaflets / booklets
- Visiting arrangements posters / signage
- Use of mobile phones, filming, recording and photography posters / signage
- Vistors and Relatives Charter (Appendix A)
- Zero tolerance posters / signage

v. Ensure an appropriate staff member within the team is trained and competent to undertake risk assessments in their area.

vi. Ensure the Trust's Violence and Agression Checklist (Appendix B) is completed on an annual basis by a trained risk assessor.

vii. Ensure all appropriate security risk assessments have been conducted, which take into account any risk of violence to staff, identify any proactive

control measures designed to reduce the risk of violence, and appropriate action plans are implemented accordingly.

viii. Ensure appropriate individual child / young person risk assessments are conducted with specialist input as required for example learning disability, CAMHS, Safeguarding.

ix. Ensure all checklists and risk assessments are reviewed annually and monitored in accordance with this policy and **Risk Assessment Policy - RM4** (see on DMS)

x. Identify which staff work alone, or could potentially work alone, and ensure a risk assessment is undertaken.

xi. Ensure lone worker risk assessments include external factors, for example the risk from the child / young person, the home, the community setting, other individuals present. Where appropriate or indicated, undertake a home visit to assess the risk in conjunction with the LSMS or identified suitable staff member.

xii. Ensure appropriate control measures are in place for lone workers in line with the risk assessment.

xiii. Ensure that staff who work in a community setting and defined as lone workers have access to the use of the lone working personal safety monitoring devices (see Appendix C).

xiv. Submit lone worker risk assessments to the Divisional Management Team and report any trends to the LSMS.

xv. Ensure the ward / department is safely and appropriately staffed at all times. Ensure that workforce requirements are reviewed in line with the relevant risk assessment where concerns regarding potential or actual unacceptable behaviours are raised, for example increasing the level of security presence in the area.

xvi. Ensure all violent and aggressive incidents are reported via Ulysses and investigated.

xvii. Ensure all incidents of inappropriate or unacceptable behaviour are documented and managed in line with the Zero Tolerance Process outlined in section 6.4.

xviii. Ensure all staff are supported following any violent, aggressive, inappropriate or unacceptable incident by initiating the **Supporting Staff Involved in Traumatic / Stressful Incidents, Complaints or Claims Policy – E31** (see on DMS). Staff support can include, but is not limited to:

- Local team support
- Debrief session with appropriate staff

- Support from site manager
- Support from senior leadership team
- Reflective conversation
- Referral to Occupational Health
- Referral to the Alder Centre
- Support from Psychology department
- Support from Health and Safety team
- Support from Human Resources
- Advice from Legal Services Manager
- Support from Police

3.5 **All Staff**

i. Staff have a duty to comply with the requirements of this policy.

ii. All employees have a duty to assist their employers in complying with their statutory duties.

iii. Where a member of staff identifies themselves as a lone worker either majoritively, or for periods of time, inform line manager in order that a risk assessment can be undertaken.

iv. Ensure that proactive controls measures identified in any risk assessment are implemented as appropriate, for example complying with a lone worker risk assessment.

v. Report to their line manager or supervisor any problems or difficulties that they are aware of caused by working alone or where control measures are absent or inadequate.

vi. Attend Conflict Resolution training incorporating Positive Behavioural Support training in line with the Trust **Manadatory Training Policy – E21** (see on DMS) and the local Training Needs Analysis.

vii. Ensure safe and supportive visiting arrangements are enabled in line with the **Hospital Visiting Policy – C25** (see on DMS)

viii. Ensure that all parents and visitors are welcomed and orientated to the ward / department and that they are provided with key information to ensure safe and supportive visiting arrangements in line with the **Hospital Visiting Policy – C25** (see on DMS)

ix. As a staff member, always act in a professional manner that reflects and demonstrates the Trust values, particularly “Respect”, “Openness”, “Together” and “Excellence”.

x. As a staff member, always act in line with the Visitors and Relatives Charter (Appendix A) regarding “What we (the staff) will do for you”.

xi. Be aware of, and alert to, the potential risk factors and early warning signs of inappropriate or unacceptable behaviour by parents, children / young people or other visitors.

xii. Ensure all incidents of behaviour deemed to be unacceptable or inappropriate are escalated appropriately to the Nurse in Charge / Team Leader / Ward Manager / Department Manager Line Manager / Matron and are documented and managed in line with the Zero Tolerance Process outlined in section 6.4.

xiii. Report any violent or abusive incidents via the Ulysses incident reporting system.

3.6 Temporary, Agency Staff or Contractors

i. Comply with the requirements of all Trust policies applicable to the area of operation.

4 Behaviour Deemed Inappropriate or Unacceptable

It is difficult to provide a comprehensive and definitive description of all types of incidents that may be considered inappropriate or unacceptable. Section 3.1 outlines some examples for guidance however is not an exhaustive list. Therefore if a behaviour makes you feel in any way unsafe for yourself and / or others, scared, threatened, intimidated or offended then it is deemed inappropriate or unacceptable.

If staff feel their safety or the safety of others is compromised at any point they should call Security on 3181 (CHP) or 2004 (Catkin) and / or the Police on 999.

Any members of staff who receive a bomb threat must act in line with the Trust Bomb Threat Plan (see on DMS).

4.1 Examples of Physical Assault

Physical assault of any description as defined in sections 2.3 and 2.4. This can include:

i. Being hit by a strike or punch

ii. Being pushed or shoved

iii. Being spat at

iv. The use or possession of a weapon or an object intended to be used as a weapon.

v. Attempted assault

4.2 Examples of Non-Physical Assault

Non-physical assault incidents that may be considered inappropriate or unacceptable include:

i. Verbal abuse, shouting and / or swearing which prevents or negatively impacts on staff's ability to do their job and / or makes them feel unsafe.

ii. Offensive, prejudiced or obscene language or behaviour related to a person's race, gender, nationality, religion, disability, age or sexual orientation.

iii. Inappropriate sexual language or behaviour or offensive gestures.

iv. Malicious language and / or threats to a member of staff, children / young people or visitors.

v. Unreasonable behaviour and non-cooperation such as repeated disregard for requests not to film, record or photograph staff / children / young people without permission.

vi. Bullying, victimisation, intimidation and / or invasion of personal space which feels intimidating.

vii. Harassment and / or stalking.

viii. Brandishing weapons or objects which could be used as weapons.

ix. Inciting individuals to attend the Trust which results in disruption to the safe workings of the hospital by affecting access or egress to and within buildings.

x. Intentionally or unintentionally affecting the ability of children and families to access care and treatment at the Trust.

xi. Intentionally or unintentionally hindering or obstructing access or egress to the Trust buildings.

xii. Damage to buildings, equipment or vehicles.

4.3 Regardless of precise definitions, staff should report any incident they consider to be inappropriate or unacceptable behaviour.

4.4 Inappropriate words or behaviour can occur either in person face to face, by telephone, letter, e-mail, text, social media or another form of communication such as graffiti on personal or NHS property.

5. Prevention and Minimising the Risk of Behaviour Deemed Violent, Aggressive Inappropriate or Unacceptable

5.1 Staff Training Requirements

5.1.1 All staff will receive violence and aggression and lone worker awareness training on Trust induction and mandatory training as part of the Health and Safety Awareness training.

5.1.2 Awareness of lone worker devices is discussed at all mandatory training and Trust induction.

5.1.3 All staff identified in the Trust's Training Needs Analysis to undertake Conflict Resolution training which includes maintaining personal safety (see **Mandatory Training Policy - M31** on DMS)

5.1.4 All front line staff identified in the Trust's Training Needs Analysis to undertake training in Positive Behavioural Support (PBS).

5.1.5 All staff identified in the Trust's Training Needs Analysis to undertake training to apply this policy, including practical examples of how to use the Zero Tolerance Process.

5.2 Potential Causal Factors

It is important to recognise the potential causes of unacceptable or inappropriate behaviour. This is not to accept, condone or excuse such behaviour, however an understanding of the potential triggers can enable staff to identify the potential risks and appropriate actions to minimise or prevent such behaviours from either occurring in the first instance or assisting individuals to stop exhibiting certain behaviours.

Potential causes may include, though are not limited to:

5.2.1 Parents

i. **Stress and anxiety due to admission / attendance:** The staff recognise and understand that having a child admitted to or attending hospital can be a stressful and worrying time for families. It is understood that the effects of stress and anxiety can result in a parent behaving in a way that is not their normal behaviour which could be considered threatening, violent, aggressive or intimidating by staff, children / young people and other visitors. An example of a parent's unusual behaviour might be uncharacteristic shouting.

ii. **Concern or complaint:** A parent may exhibit unacceptable behaviour where they are dissatisfied with the level of care, treatment or service the Trust is providing, concerned for the safety and wellbeing of their child, or frustrated by their issue of concern and how they perceive the Trust has responded to their concern. An example of this is a parent telephoning the Trust for help and advice and being transferred from department to department with no resolution leading to the parent becoming irate on the telephone.

iii. **Language barriers or cultural differences:** May result in a difference or lack of understanding or appreciation.

iv. **Unrealistic expectations:** The staff work hard to ensure that the experience of children / young people and their families is as positive as possible. However there may be occasions where a particular request or requirement of a parent cannot be met and is considered unrealistic, unsafe or inappropriate by the staff.

v. **Disagree with proposed management plan:** The staff recognise and value the importance of working in partnership with children and their

parents. There may be occasions that despite working together, parents and health care professionals do not agree on the proposed management plan.

vi. **Long term child / young person:** Where a child requires a prolonged admission to hospital, long term care in the community, or frequent attendances to clinic appointments, there becomes an increased likelihood of the factors described in 3.2.1 i-iv.

vii. **Additional needs:** Parents who may experience higher levels of distress due to, for example, mental ill health, Autistic Spectrum Disorder, learning disability, communication difficulties, sensory needs.

viii. **Misuse of substances:** Drug or alcohol misuse, or dependence on methadone, may lead to a parent behaving in an unpredictable manner.

ix. **Parent who is under the age of 16 years:** A young person may lack the emotional intelligence of a more mature adult and be less able to cope emotionally.

x. **Looked after Child:** A parent who has restricted or no access to their child may behave in an unpredictable manner.

xi. **Differing value sets:** All staff are inducted and trained to demonstrate the Trust values of “Respect”, “Together” and “Openness”. Differing members of society are raised and live in different ways which may lead to a higher threshold for behaviour that Trust staff deem inappropriate or unacceptable. An example of this is a parent who uses expletives as part of everyday conversation and does not recognise they are using language that may cause offense to others.

Whilst the Trust acknowledges the emotional impact of having a child in hospital, it is not acceptable for any staff member to feel unsafe due to the behaviour of a parent.

5.2.2 Other Visitors

Other visitors may exhibit unacceptable behaviours for the reasons cited in sections 5.2.1 and 5.2.32.

5.2.3 Child / Young Person

i. **Stress, anxiety and fear due to admission / attendance.**

ii. **Needle phobia:** Fear and anxiety may lead to a child / young person trying to avoid a procedure taking place by hitting / kicking out.

iii. **Emotional immaturity:** A child / young person may lack the emotional intelligence of a more mature adult and be less able to cope emotionally.

iv. **Additional needs:** Children and young people who may experience higher levels of distress due to, for example, mental ill health, Autistic Spectrum Disorder, learning disability, communication difficulties, sensory needs.

v. **Stress and anxiety:** due to trauma

vi. **Challenging behaviour:** Child / young person may be known to have challenging behaviours which may or may not have been exhibited previously either in the Trust, the school or the home setting. A previous Risk Assessment may be available for any known challenging behaviour from previous admissions / attendances or from partner agencies such as Social Services. An updated Risk Assessment will be required. Refer to **Absconsion Policy – RM59** (see on DMS) and **Looked After Children Standard Operating Procedure** (see on DMS)

vii. **Effects of prescribed medication:** For example disorientation following anaesthesia or weaning from analgesia and sedation.

viii. **Acquired head injury:** Leading to altered or unpredictable behaviours which may be temporary, longer term, changing and evolving. A dynamic Risk Assessment will be required.

ix. **Looked after Child:** A child / young person may have experienced a life of less stability, structure, guidance and love which affects their behaviour and increases likelihood of risk taking behaviours. Refer **to Looked After Children Policy – M65** (see on DMS)

x. **Misuse of substances and / or smoking cessation:** Drug or alcohol misuse, or child / young person who smokes and is unable to leave the hospital site to smoke, may lead to unpredictable behaviour.

5.3 Recognising Early Warning Signs of Escalating Inappropriate or Unacceptable Behaviour by Parents or Visitors

5.3.1 The likelihood of incidents of rapidly escalating behaviour can be more easily predicted in areas of known heightened anxiety states such as acute attendance to ED or admission to the Paediatric Intensive care Unit (PICU).

5.3.2 However there may be early warning signs that indicate that a parent has the potential to behave in a manner considered inappropriate or unacceptable. The list of pre-disposing factors is not exhaustive, nor does the presence of one or more of these factors mean that a parent will go on to exhibit inappropriate or unacceptable behaviour, however the presence of any of these actions may alert staff to a potential risk.

i. Refusing to engage with the multi-disciplinary team
ii. Requesting certain nurses / doctors care for their child
iii. Having recording devices at the bedside or taking extensive notes
iv. Unrealistic expectations
v. Interactions and behaviour that staff feel is manipulative
vi. Asking endless questions
vii. Attempting to or influencing the care of other children / young people
viii. Using language as a barrier
ix. Openly discussing and favouring medical opinions from social media
x. Loud and intrusive conversation

5.4 Risk Assessments

5.4.1 It is the responsibility of Ward / Department Managers / Service Leads / Heads of Service to ensure Violence and Aggression Risk Assessments are completed by a nominated trained risk assessor, in collaboration with the Trust LSMS, using the risk assessment proforma and the Trust's Violence and Aggression Checklist (Appendix B).

5.4.2 The aim of the Violence and Aggression Risk Assessment is to identify potential risks and minimise the possibility of incidents occurring. The risk assessment should include the following components:

i. Physical environment (internal)

ii. Appropriate training

iii. Management issues

iv. Human factors

v. Activities and systems of work

vi. Staff issues

vii. Physical environment (external)

viii. Proactive measures that can minimise distress and improve outcomes

5.4.3 When carrying out a Violence and Aggression Risk Assessment, the LSMS and local risk assessor should consider any previous recorded incidents of aggression or violence and refer to the **Risk Assessment Policy – RM4 (**see on DMS) for additional guidance.

5.4.4 Violence and Aggression Risk Assessments should be reviewed annually. However, if an incident occurs, the Violence and Aggression Risk Assessment should be reviewed, irrespective of when the risk assessment was last undertaken or reviewed, in order that it is a dynamic and responsive process.

5.4.5 On completion of the Violence and Aggression Risk Assessment an action plan must be devised to address any risks identified, and risks should be added to the relevant Risk Register where appropriate.

5.4.6 Dependent on the findings of the risk assessment, specific provision may need to include one or more of the following:

i. Increase staffing levels where appropriate.

ii. Access to consultation from relevant areas to support positive risk management

iii. Panic buttons

v. Personal attack alarms for staff in high risk areas / staff working in isolation

vi. Direct links to the police for high risk areas

vii. Interview rooms with reinforced glazed doors or windows

viii. Mobile phones (where appropriate)

ix. Restricted access

x. Lone worker device system (where appropriate)

5.4.7 The risks identified and the associated action plan must be reported to the Health and Safety Committee. Implementation of the action plan will be the responsibility of the relevant area / department / ward manager and will be overseen by the LSMS. Action plans should continue to be followed up through the Health and Safety Committee until all actions have been completed.

5.5 Arrangements for Ensuring the Safety of Lone Workers

See also: **CAMHS Lone Worker Guidelines (**on DMS) as appropriate.

5.5.1 The Trust recognises that any member of staff may spend a limited amount of their working time 'alone'.

5.5.2 There are some circumstances where staffs are required by law not to work alone. These situations are young persons under the age of eighteen years who must be working under direct supervision of a competent person.

5.5.3 A risk assessment (see Appendix C) is the first step in deciding what prevention or safe working arrangements (control measures) need to be taken to protect staff from harm. All staff whose work contains an element of lone working should carry out a risk assessment of the work, for example, at the time of the first contact with a new child / young person. Lone workers should not face any more risks than other staff within the organisation. They may, however, need extra measures put in place to control specific risk (see Appendix D).

5.5.4 The risk assessment will provide an indication as to whether the work can or cannot be done safely alone. If the risk assessment indicates unacceptably high levels of risk then the work should not be undertaken unless further safe working arrangements are implemented, for example, two people visiting together.

5.5.5 Risk assessment should take account of both normal work and foreseeable emergencies including fire, potential risks such as violence, aggression and containment as well as illness and accidents. The format of the assessment is a written record and will show any significant findings of any person who may be particularly at risk.

5.5.6 Risk assessments must be carried out in all areas of work where working alone poses an actual or potential risk to staff. Risk assessments should be carried out by a trained risk assessor, be recorded, evaluated by appropriate staff at managerial levels and communicated to all relevant staff. The risk assessments should be reviewed every two years.

5.5.7 The risks that lone workers face should be reduced to the lowest reasonably practicable level. Using safe working arrangements depends largely on local circumstances, local procedures and protocols. Local procedures and protocols should be put in place to provide staff with specific local guidance in relation to lone working and the associated risk reduction techniques. Issues to consider in developing safe systems of work include:

i. Having in place reporting systems to ensure that the whereabouts of staff are known.

ii. Consider working patterns and hours of work which at certain times of day or night could reduce risks

iii. Joint working and proactive planning with others for potential high-risk activities.

iv. Improvements to security arrangements in buildings.

v. Security lighting in parking areas.

vi. Communication systems for sharing information on risk with colleagues in other disciplines and agencies.

vii. Training to increase staff awareness of risk and the precautions to be taken during visits / working alone.

viii. Supervision and auditing of working practices.

ix. Using personal protective equipment or mobile phones and personal alarms and appropriate lone worker devices.

x. Removing identification from cars.

xi. Joint communications meetings with other services (Police, Social Services, Probation Service, etc).

5.5.8 Although lone workers cannot be supported through constant supervision, it is still the Trust's responsibility to ensure staff safety as far as is reasonably practical. Supervision can help to ensure that staff understands the risks associated with their work and that necessary safety precautions are carried out. Supervisory staff can also provide guidance in situations of uncertainty.

5.5.9 Supervision will also be needed when checking progress and compliance with any existing or new control measures that have been put in place as a result of the risk assessments.

5.5.10 Procedures will need to be put in place to monitor lone workers to ensure that lone workers remain safe, these may include:

i. Supervisor / line manager periodically visiting and observing people working alone.

ii. Regular contact between the lone worker and any form of supervision by telephone or face to face.

iii. Regular checking of procedures designed to raise the alarm if contact is lost with a lone worker.

iv. Regular checking of other safety devices to ensure that they still work

5.5.11 Staff must report all incidents to their line manager at the earliest opportunity. Staff should also report 'near misses', where they feel threatened, or 'unsafe', even if this was not a tangible event or experience. Failure to report an incident may put others at risk. All incidents and near misses must be reported on the Trust Ulysses incident management system.

5.5.12 The Trust Divisions provide a number of mobile phones for staff who are working alone. Local protocols outline how mobile **phones can be accessed in each locality / service in line with the Trust Mobile Phone and Data Contracts Policy - M71 (**see on DMS)

5.5.13 Staff should take precautionary measures when using a mobile phone, to avoid drawing unwanted attention to themselves or the mobile phone handset, such as making discreet phone calls. This is to minimise the risk of theft, robbery and / or potential physical assault.

5.6 Substance Misuse by Parents or Visitors

5.6.1 The Trust does not allow the abuse of substances (for example alcohol, drugs and solvents) on the premises and will take action necessary to ensure that the law is enforced. Parents and visitors will be dealt with sympathetically but firmly taking into account the safety of children / young people and the security of the Trust's premises and the needs of the abuser.

5.6.2 Parents and visitors must not use alcohol in, or bring alcohol to, the Trust's premises for consumption. Parents, visitors or staff suspected to be under the influence of alcohol or other substances may be removed from the Trust's premises.

5.6.3 Where a member of staff working in the community attending a child / young person's home suspects a person in the home is under the influence of a substance, they should undertake a risk assessment in line with sections 5.4 and 5.5 to assess the safety and appropriateness of continuing the home visit, document in the health record and report to their line manager.

5.6.4 As outlined in section 5.2, substance misuse may a potential causal factor of inappropriate or unacceptable behaviour. Where a parent or visitor suspected to be under the influence of a substance becomes aggressive, the Zero Tolerance Process (section 6.4) must be followed.

5.6.5 The procedure to be followed by staff for confirmed or suspected substance abuse by a parent or visitor is outlined in Appendix E.

6. Resolving Conflict and Managing Behaviour by Parents or Visitors Deemed Violent, Aggressive, Inappropriate or Unacceptable

6.1 Key Principles

6.1.1 The following guidance has been devised to assist staff to both resolve conflict safely wherever possible and to manage any behaviour deemed inappropriate or unacceptable.

6.1.2 As outlined in section 5.2, there are many potential causes of unacceptable or inappropriate behaviour, and it is important that these are recognised. This is not to accept, condone or excuse such behaviour, however an understanding of the potential triggers can enable staff to identify the potential risks and appropriate actions to minimise or prevent such behaviours from either occurring in the first instance, assist staff to mediate and resolve issues, or assist individuals to stop exhibiting certain behaviours.

6.1.3 The health, well being and safety of all staff, children / young people and visitors is of the utmost importance. **If staff feel their safety or the safety of others is compromised at any point they should call Security on 3181 (CHP) or 2004 (Catkin) and / or the Police on 999.**

6.1.4 The Trust has a zero tolerance approach to any abuse of staff. This means that action of some form will be taken in every event of violence, aggression, unacceptable or inappropriate behaviour. The Zero Tolerance Process outlined in section 6.4 should be followed for all incidents.

6.2 Local Resolution of Concerns and Complaints

6.2.1 Where it is felt to be safe and appropriate to do so, staff should aim to resolve issues of concern raised by a parent or visitor at local level, in line with **Complaints and Concerns Policy – RM6 (**see on DMS) and in line with Stage 1 of the Zero Tolerance Procedure Appendix G: Procedure to follow for non-physical / non-violent behaviour in person by parents / carers / legal guardians.

6.2.2 Where a parent or visitor feels the need to raise an issue of concern, they are likely to be feeling heightened emotions. The staff member receiving the concern or complaint should ensure they listen carefully to the issues raised and where possible, arrange for or take action to resolve the issue immediately in line with Stage 1 of the Zero Tolerance Procedure Appendix G: Procedure to follow for non-physical / non-violent behaviour in person by parents / carers / legal guardians. This is to ensure that there is a safe and appropriate response to immediate concerns raised by the parent.

6.3 Documentation and Documented Evidence

6.3.1 It is essential that any unacceptable or inappropriate behaviour by a child / young person, parent or visitor is documented by the member of staff who witnessed or experienced the behaviour. There may be circumstances where it is appropriate that the record is made on behalf of the staff member by a colleague.

6.3.2 It is important that all incidents are documented because what may appear to be a trivial or isolated incident, may constitute a wider pattern of unacceptable behaviour when viewed in full context. This will also enable the Trust to follow the Zero Tolerance Process (section 6.4) and ensure appropriate action is taken by escalating to the most appropriate Stage. For example, if a first incident of unacceptable or inappropriate behaviour occurs on a Ward and a second incident occurs in the Out Child / young person Department, recording the incidents will enable the Trust to escalate to the most appropriate Stage of the Process rather than both incidents being managed as first occurrences, therefore keeping children / young people, staff and visitors safe. It is therefore essential that all incidents are recorded in the child / young person's health record and an incident form completed on Ulysses.

6.3.3 Document all incidents contemporaneously in the child / young person's health record including the date, time, place, and any witnesses. Record a full account of what was said and done, documenting the actual words used as far as possible, by whom and in what circumstances. Documenting the words used

provides a full, accurate and objective account. For example, the mother said she was “angry” that “the feed has not come and I asked for one half an hour ago”, she swore at the nurse (document the words used) and said “I don’t care what you’re doing go and get the feed now”, rather than recording that “the mother was upset and angry about a delay in getting a feed and swore at me”.

6.3.4 Describe any physical behaviour displayed for example “the mother shouted at me, pointed her finger towards my face and banged her fist on the nurses station”.

6.3.5 As with all written records, such documentation may be disclosable and used as evidence by either party in the event of any legal action. The record must be clear, factual and not include any supposition or opinion. In circumstances where sanctions are to be imposed, it is necessary for the Trust to be able to provide evidence of unacceptable or inappropriate behaviour. The best evidence is a contemporaneous record of what has occurred, signed by the relevant staff member.

6.3.6 Document in the child / young person’s health record any action taken as a result of the unacceptable or inappropriate behaviour, including a record of the Stage of the Trust response and a copy of any correspondence sent to the parent or visitor.

6.4 Zero Tolerance Process

6.4.1 The Zero Tolerance Process provides guidance to staff on the appropriate action to take in the event of unacceptable or inappropriate behaviour. The guidance may differ depending upon whether the behaviour is displayed by a parent or other visitor.

6.4.2 Remember that at all times the main priority is the safety of the staff, child, other children / young people, other visitors, and the best interests of the child. Many issues can be resolved and managed safely and effectively at local level in line with section 6.2 and Stage 1 of the Zero Tolerance Process, resulting in no subsequent reported incidents of escalating behaviour.

6.4.3 **If you feel that staff or child / young person safety is compromised at any time, get help from a senior colleague, call Security on 2004, and call the Police on 999 as required.**

6.4.4 Depending upon the level of risk identified, escalate to the most appropriate Stage in the procedure. Where an individual exhibits violent behaviour, or the threat of violence is considered to be significant, escalate immediately to Stage 5 in line with Appendix I: Procedure to follow for violent behaviour by any visitor including parents.

6.4.5 An individual may display unacceptable or inappropriate behaviour in a combination of ways such as in person, by telephone or within a written communication. Where this is the case, escalate to the most appropriate Stage in that circumstance rather than attempting to manage each type of behaviour in isolation. Therefore, in all circumstances for all individuals, there will only be a maximum of five Stages in the process.

6.4.6 It is important to differentiate between the emotion that a parent or other individual may convey in writing compared to written threats of violence. For example, a parent who writes a letter of complaint to the Trust may be upset, frustrated, angry and / or anxious. This may be expressed in terms such as "does not know what they are doing", "incompetent", "negligent", or "to blame" for example. This does not constitute inappropriate or abusive language. Any written concerns submitted must be managed in line with the Trust **Complaints and Concerns Policy - RM6** (see on DMS)

6.4.7 Where a member of staff receives an aggressive or abusive phone call, they must inform the caller that their language / behaviour is not acceptable, and if they do not talk in a civil manner, the call will be terminated. Offensive or abusive language may be considered to be: prejudiced; obscene language related to a person's race, gender, nationality, religion, disability, age or sexual orientation; inappropriate sexual language; malicious; bullying; victimising; intimidating; invasive and considered to be harassment or stalking. All of these may be considered as threatening by the recipient and / or the Trust, therefore escalate to Stage 5 in such circumstances (see Appendix L: Procedure to follow for threatening or offensive language over the telephone by any individual including parents)

6.4.8 **Any members of staff who receive a bomb threat must act in line with the Trust Bomb Threat Plan (**see on DMS).

6.4.9 Staff who experience or witness the unacceptable or inappropriate behaviour must fully document in the child's health record in line with section 6.3 and complete a Ulysses incident form.

6.4.10 Ensure all staff are fully supported at every Stage of the process. It is acknowledged that there may be an element of risk assessment and discretion in regards to moving or escalating to the next Stage of the Zero Tolerance Process, as it may not always be felt appropriate to move straight to the next Stage and may be considered more appropriate to repeat the current stage. However it is important that this is jointly assessed and agreed by the relevant staff / clinical team to ensure this approach does not result in further escalation of behaviour deemed unacceptable or inappropriate, and is still managed in a consistent way in order that the parents and the staff have a clear and consistent management plan.

6.4.11 Refer to the list below or Appendix F: Quick Reference Guide to identify relevant Zero Tolerance Procedure to invoke to identify the most appropriate procedure based on whether the behaviour is being exhibited by a parent or visitor, and the manner of how the behaviour is being exhibited (in person; by telephone, in writing). **Where an individual exhibits violent behaviour, or the threat of violence is considered to be significant, escalate immediately to Stage 5.**

i. Parent: Non-physical / non-violent in person
(see Appendix G: Procedure to follow for non-physical / non-violent behaviour in person by parents / carers / legal guardians)

ii. Visitor: Non-physical / non-violent in person
(see Appendix H: Procedure to follow for non-physical / non-violent behaviour by other visitors)

iii. Parent or visitor: Violent in person
(see Appendix I: Procedure to follow for violent behaviour by any visitor including parents)

iv. Parent: Inappropriate / non-threatening by telephone, for example shouting
(see Appendix J: Procedure to follow for Inappropriate / non-threatening behaviour over the telephone by parents / carers / legal guardians)

v. Visitor: Inappropriate / Non-threatening by telephone, for example shouting
(see Appendix K: Procedure to follow for inappropriate / non-threatening behaviour over the telephone by any other individuals)

vi. Parent or visitor: Violent or offensive by telephone, for example a threat of violence; discriminatory, malicious or prejudiced language
(see Appendix L: Procedure to follow for threatening or offensive language over the telephone by any individual including parents)

vii. Parent or visitor: Offensive in writing
(see Appendix M: Procedure to follow for offensive or abusive language in writing (letter; email; social media; text) by any individual including parents)

iv. Parent or visitor: Threatening in writing
(see Appendix N: Procedure to follow for threatening behaviour in writing (letter; email; social media; text) by any individual including parents)

6.5 Emergency Planning Meeting following exclusion invoked at Stage 5 of the Zero Tolerance Process

6.5.1 Where Stage 5 of the Zero Tolerance Process has been invoked, resulting in a parent or visitor being excluded, an Emergency Planning Meeting must be set up on the next working day. Stage 5 is invoked due to either violent behaviour by any individual, continued incidents of unacceptable or inappropriate behaviour by a parent; or a second incident of unacceptable or inappropriate behaviour by a visitor.

6.5.2 The Emergency Planning Meeting should be set up by the Executive Lead who invoked the exclusion invoked in hours (usually the Medical Director, Chief Nurse or Director of Nursing, or Chief Operating Officer), or by the Second On Call Manager who invoked the exclusion out of hours.

6.5.3 The Emergency Planning Meeting must be Chaired by either the Medical Director or deputy; the Chief Nurse or Director of Nursing; or the Chief Operating Officer.

6.5.4 The core team required to attend the meeting will be:

i. LSMS
ii. Child / young person's Lead Consultant

iii. Ward / Department Manager / Service Lead / Head of Service, or deputy, where behaviours exhibited. (This may be more than one department if exclusion due to continued incidents across more than one area)
iv. Matron or Head of Nursing
v. Safeguarding team member
vi. Child / young person's case worker / key worker
vii. Other relevant staff as required

6.5.5 The Emergency Planning Meeting will review the incidents that have occurred and set out terms of access for the individual who has been excluded overnight / over the weekend. Terms of access must consider whether the parent or visitor is to remain excluded. The following considerations should be taken into account in reaching a decision:

i. The reason why Stage 5 was invoked
ii. Ongoing concern for the safety of children / young people, staff and other visitors
iii. Recommendations or instructions from external agencies: Police; Social Services
iv. The condition of the child / young person
v. Is the individual a parent or other visitor, as a lower tolerance level will be appropriate for individuals who are not the child / young person's parent / carer / legal guardian.

6.5.6 If a parent is to remain excluded, agree how long the parent will remain excluded for. There is no set duration, however it is important to consider the points above and acknowledge the strong message that exclusion of any duration gives to a family: that the safety of our children / young people, staff and visitors is of the upmost priority, and unacceptable or inappropriate behaviour will not be tolerated.

6.5.7 It is important that the duration of exclusion is proportional and that a timescale is given to the parent. An initial exclusion of one week may be given with the warning to the parent that any further incidents will result in exclusion for a longer period. The vast majority of parents want to be with their child and will then comply with the actions put in place to ensure they can have continued access. Except in circumstances of extreme concern, avoid a lengthy exclusion duration of weeks / months.

6.5.8 Where the individual who has been excluded is not the child / young person's parent / carer / legal guardian, the child / young person's parent must be kept informed of all decisions. It may be considered appropriate to apply a longer period of exclusion to an individual who is not the child / young person's parent / carer / legal guardian.

6.5.9 A review meeting during the period of exclusion must be agreed and the parents and individual involved informed of this. The review date must be within one week even if the exclusion duration has been set at two weeks to ensure a full informed review.

6.5.10 It is important to be clear regarding the terms of the exclusion:

i. Is the parent excluded from the ward / department only? Can the parent access designated areas of the building / clinic? Consider how this will be monitored and enforced. Avoid a ‘blanket’ exclusion of the site as it may be difficult to enforce this.

ii. If the parent is resident in Ronald McDonald House, inform the manager that the parent has been excluded. It may be considered appropriate that the parent continues to reside in Ronald McDonald House for the period of the exclusion; this will be at the discretion of the House Manager.

iii. Be clear that in a situation where a child needs to attend the Emergency Department (ED), and the individual excluded is the adult responsible for the child at that time, that in the interests of child / young person safety the individual is allowed on the premises to escort the child to ED. However inform the individual, verbally and in writing (letter to the child / young person’s parent) that they should inform the ED staff of the terms of the current exclusion. It is acknowledged however that unless the child brought to ED is the same child who was the child / young person at the time of the incidents, and the incidents are documented in their health record, it is likely that the individual will not inform ED and therefore this is not entirely enforceable. However, security have access to CCTV and may identify that an individual excluded from the hospital is on the premises.

6.5.11 If / when the exclusion is to be lifted, agree terms of access. These may include a restriction to visiting arrangements:

i. Time of day parent permitted to visit
ii. Limit the duration of the parent’s visit
iii. No overnight stay on the Ward / Department
iv. Visit to be supervised / supported (agree by whom)
v. Restriction to the number of other visitors to the child / young person

6.5.12 When the decision to lift the exclusion has been made, it is important to agree an ongoing plan with the parent in order to minimise the potential for further or future escalation in unacceptable or inappropriate behaviours. The outcome of the meeting should be shared with the parent either in a face to face meeting or over the telephone and followed up with a formal letter (see Appendix T) and documented in the child / young person’s health record.

6.6 CCTV Evidence

Report the incident to Security on 3181 (CHP) or 2004 (Catkin). The Security Team will review the CCTV footage where available to identify whether the incident has been recorded by the camera. The Security Team will download a copy of any relevant CCTV footage should this be required as evidence in line with the **CCTV Policy - RM52 (**see on DMS).

6.7 Supporting Staff Following an Incident of Violent, Aggressive, Inappropriate or Unacceptable Behaviour

6.7.1 Ensure all staff are supported following any violent, aggressive, inappropriate or unacceptable incident by initiating the **Supporting Staff Involved in Traumatic / Stressful Incidents, Complaints or Claims Policy - E31** (see on DMS).

6.7.2 Ensure that the staff member receives any necessary medical treatment and / or advice.

6.7.3 Where an incident occurs, the line manager / staff member in charge will provide immediate support. Out of hours the site manager / staff member in charge will provide immediate support.

6.7.4 Line Manager or most appropriate manager should arrange an immediate debrief, or debrief as soon as is practicably possible. Some staff members may also benefit from a facilitated reflective discussion in line with practice recommended by their professional body.

6.7.5 Where a student has been involved in an incident, the appropriate educational facility (example University) and the Trust educational supervisor, clinical educator or work experience lead should be informed to provide support.

6.7.6 All incidents must be escalated appropriately to the Divisional Management Team / Executive team in line with the Zero Tolerance Process (section 6.4).

6.7.7 Managers should be sensitive to the employee's need to talk about the incident and offer any assistance possible. The importance of colleague support should not be underestimated as they may be seen as primary emotional support.

6.7.8 Support is available through Occupational Health and / or access to confidential counselling through the Alder Centre. Access can be made either directly by an individual staff member or through a line manager.

6.7.9 Support is available through the Human Resources team which includes access to psychological support.

6.7.10 Support can be accessed through the Trust Freedom To Speak Up champions.

6.7.11 Further support and advice is available from the LSMS, the Health and Safety team, and / or the Legal Services Manager.

6.7.12 Where the staff member is a member of a Trade Union or Professional Association, this is a further source of support.

6.7.13 If a situation arises which requires Police attendance, the employee at risk, or other relevant person, should **contact the Police immediately**, **the LSMS on 2112 (in hours) or Security on 3181 (CHP) or 2004 (Catkin).**

6.8 Reporting Incidents of Violent, Aggressive, Inappropriate or Unacceptable Behaviour

6.8.1 All incidents involving non-physical and physical assaults must be reported to the Ward/Department Manager as soon as is reasonably practicable in line with Appendix U.

6.8.2 All incidents involving non-physical and physical assaults must be reported through the Trust Ulysses online incident reporting system in line with the **Incident Reporting and Management Policy - RM2 (**see on DMS).

6.8.3 All incidents must be appropriately investigated by the line manager and LSMS. Incidents will be reported to the Police in line with this policy and the Zero Tolerance Process (Section 6.4).

6.8.4 Incident forms will be considered as crucial evidence where any legal action is pursued.

6.9 Safeguarding Process

6.9.1 A referral must be made to the Safeguarding Team if there are any safeguarding concerns in line with the **Safeguarding Policy – M3 Safeguarding Procedures** (see on DMS)

6.9.2 In all cases where the Zero Tolerance Process has reached Stage 2 or above, a safeguarding referral must be made in line with all the Zero Tolerance procedures (Appendices G to N). However it may also be considered safe and appropriate to make a Safeguarding referral at Stage 1.

6.10 Legal Action and Prosecution

6.10.1 The police are to be contacted immediately (where appropriate) by the person assaulted, their manager or a relevant colleague. Staff should be aware that failure to report an assault to the police could adversely affect any claim for compensation under the Criminal Injuries Compensation Authority Scheme in line with Appendix V.

6.10.2The Trust will seek to take legal action in all cases of physical violence and in specified cases of verbal violence, if deemed appropriate, in line with the Directions to the NHS bodies on Zero Tolerance (1999) and Tackling Violence Against Staff (2003). The Trust will proceed with prosecutions, if supported by the staff, Police and the Crown Prosecution Service (CPS).

6.10.3 The victim of the assault will be kept informed of the progress of the investigation by the LSMS and offered such support as is necessary or desirable in the circumstances (see Appendix V).

6.10.4 Where the Trust has successfully prosecuted a parent or visitor, the Trust will consider publishing this event, as a deterrent to others (see **Duty of Candour Policy - RM47** on DMS).

7 Managing Behaviour by Children / Young People Deemed Violent or Aggressive

7.1 This section must be read in conjunction with other relevant policies, which may include Tier 4 and CAMHS policies, **Looked After Children Policy -M65**, **Absconsion Policy - RM59**, **Self Harm Reduction and Suicide Prevention Policy - RM40 (**see on DMS)

7.2 As outlined in Section 5.2.3 there are many reasons why a child / young person may behave in a manner that is considered challenging, violent or aggressive. This may be an isolated incident or more sustained behaviour.

7.3 Where a child / young person exhibits inappropriate behaviour, it is essential that a proactive and appropriate care and treatment plan is made between appropriate health care professionals and in collaboration with parents. Depending upon the reason or potential cause of the behaviour, other agencies such as social care will be consulted and involved as appropriate.

7.4 Ensure any child / young person who is displaying challenging, violent or aggressive behaviour has an individualised risk assessment undertaken and appropriate action is taken to mitigate any risks identified which will include ensuring the environment is safe in line with the Trust **Self Harm Reduction and Suicide Prevention Policy - RM40 (**see on DMS). The individualised risk assessment and plan should be agreed with parents where at all possible.

7.5 Where a child / young person with challenging behaviour is admitted to hospital, care for the child / young person in the most appropriate ward or department.

7.6 Where a child / young person with challenging behaviour is admitted to hospital, the behaviour can often be managed appropriately by the appropriate teams. Where there is any concern, or additional help, support or advice is required, escalate to the Divisional Management Team as appropriate who will also escalate to the Executive Team as appropriate. The child / young person should only be in hospital whilst requiring care and treatment. Commission a multi-disciplinary multi-agency meeting by the next working day where discharge is delayed, for example due to social reasons, and further support and help is required. The Executive Team will escalate to other agencies as appropriate.

7.7 At all times, the best interests and safety of the child / young person, and the safety of other children / young people, visitors and staff is of paramount importance. Actions to reduce the risk includes. Though is not limited to:

i. Increase ward based staffing:
   a. On to one staffing for the child / young person;
   b. Ward staff through temporary staffing; appropriate temporary redeployment of staff
ii. Increase staffing support:
   a. Security presence
   b. Specialist staff such as Learning Disability nurses / ASD nurses / CAMHS Practitioners / Psychology Team
iii. Regular clinician review; referral to other specialists for example psychiatry

iv. Environment:
   a. Consider where the child / young person is placed
   b. Consider whether all beds can remain fully open safely or need to be closed. This decision must be made by the most appropriate senior leader (Matron / Divisional Management Team).

7.8 The Trust has a duty to protect members of staff, children / young people and visitors as well as a duty to provide appropriate health care to children / young people. In certain, rare and extreme circumstances it may be considered appropriate to delay, postpone or withhold treatment from a child / young person who is violent, threatening or abusive. For example:

i. Where the Trust is made aware in advance from a Social Worker or other source, that a child / young person due to attend Alder Hey for a planned appointment is known to carry a weapon (such as a knife, gun, etc), the appointment may be postponed. The child / young person's lead clinician will be informed and involved in the decision in order to make a clinical assessment and develop a clinical management plan if it is deemed appropriate to postpone the appointment.

ii. Where a child / young person attends the Trust for an elective appointment and admits to having a concealed weapon in their possession, the appointment should be postponed. The child / young person's lead clinician will be informed and involved in the decision in order to make a clinical assessment and develop a clinical management plan if it is deemed appropriate to postpone the appointment.

iii. Where a child / young person attends the Emergency Department and admits to having a concealed weapon in their possession, except where the child / young person required immediate or emergency treatment, the appointment should be postponed. The ED Consultant and / or the child / young person's lead clinician will be informed and involved in the decision in order to make a clinical assessment and develop a clinical management plan if it is deemed appropriate to postpone the appointment.

7.9 In any circumstance other than described in section 7.8, where any consideration to withhold treatment from a child / young person is proposed, an Emergency Planning Meeting as outlined in section 6.5 must be convened to review and devise an action plan. Additional support and advice may be required from the legal team and / or the Trust Ethics Committee.

7.10 All incidents must be fully documented in the child / young person's health record in line with section 6.3.

7.11 All incidents and near misses must be reported via the Trust Ulysses incident reporting system in line with section 6.8.

7.12 Ensure all staff are supported following any violent, aggressive, inappropriate or unacceptable incident by initiating the **Supporting Staff Policy - E31 (**see on DMS) and in line with Section 6.7.

8 Monitoring

8.1 The LSMS is informed of all reported violent and aggressive incidents, security related incidents, theft and lone working incidents via the Ulysses incident reporting system.

8.2 All reported incidents are reviewed by the Divisional Management Team and may be subsequently reviewed at the Trust weekly Child / young person Safety Meeting when nominated by the Division for wider review and action.

8.3 An annual report is presented to the Health and Safety Committee outlining:

i. The number of reported violent and aggressive incidents against staff
ii. The number of lone worker related incidents
iii. Any subsequent actions taken by the Trust against offenders
iv. Any actions taken to prevent a re-occurrence
v. Conflict Resolution training compliance

8.4 The annual report will be presented to the Trust Board via the Workforce and Organisational Development Committee, detailing the work that has been carried out over the previous year, and identifying what actions the LSMS will employ to reduce security risks for the forthcoming year.

8.5 Staff members attending training will be asked to evaluate the effectiveness of the training in order that training can be reviewed to ensure it meet the needs of the staff.

9 Further Information

Equality Analysis (hyperlink)

References

Management of Health and Safety at Work Regulations, 1999

Health and Safety at Work Act 1974

A Professional Approach to Security Management in the NHS (Dec 2003 NHS (CFSMS)

NHSLA Risk Management Standards

Secretary of State for Health's Directions on NHS Security Management Measures (April 2003)

Secretary of State's Directions on work to tackle violence against staff and professionals who work to provide services for the NHS (2003)

'Not Alone'- A guide for better protection of lone workers in the NHS (CFSMS 2005)

Associated Documentation (see on DMS)

Security Policy - RM48
Risk Assessment Policy - RM4
Supporting Staff Policy - RM49
Transport Policy - M40
Mandatory Training - M31
Duty of Candour - RM47
Incident Reporting and Management Policy - RM2
CCTV Policy - RM52
Safe and Therapeutic Responses to Disturbed Behaviour Policy - MH2
Tier 4 Service – Guidance for Managing Violence and Aggression
Safeguarding Procedures - M3
Looked After Children Policy - M25
Child Abduction Policy - RM53
Complaints and Concerns Policy - RM6
Mobile Phone and Data Contracts Policy - M71
Bomb Threat Plan
Self Harm Reduction and Suicide Prevention Policy - RM40

Appendix A

Visitors and Relatives Charter

A healthier future for children and young people

openness

What you can do for us...	What we will do for you...
Tell us if any patient details change, such as address, contact number, GP or if you feel some of the information we hold about you is inaccurate.	**We will keep the records that we hold up to date** and record any changes you notify to us where appropriate.
Give us accurate information so we can choose the most appropriate treatment for our children and young people.	**We will listen to you and work with you** to achieve an excellent experience. **We will put our patient at the centre of their care, making sure any special needs are considered** when planning and providing care.
Recognise that the information we collect will be shared with those who have a direct involvement in the care of our patient.	**Our staff will share confidential information when it is needed for the safe and effective care of patients;** We have a leaflet called **"Looking after your records"** which tells you how we use the information we collect and who we may share it with.
Tell us if you wish for some of our patients' information not to be shared with other individuals/ organisations as stated in the **"Looking after your records"** leaflet.	**Where you ask for some information not to be shared with individuals/organisations** we will discuss the consequences of not sharing the information with you. We will record your request in the patient's notes and the outcome of the discussion.
Please tell us information about your family: • Language • Ethnicity • Religion and belief • If you have a long-term health condition • How you would prefer to be communicated with	**We will keep this information confidential** and use it to help us improve your experience when visiting us.

respect

What you can do for us...	What we will do for you...
Respect the needs of other patients and families.	**We will ensure that our treatment of patients does not impact on others as far as possible.**
Treat everyone, including staff, other patients, their families and visitors with dignity and respect.	**We will treat all individuals with dignity and respect.**
Recognise that violence and aggression towards staff, patients and families is not tolerated and may lead to our Violence and Aggression at Work Policy being invoked.	**We will seek to understand people's priorities, needs abilities and limits.** We will take your concerns seriously and ensure that the treatment of others does not impact on you as far as possible.

If you would like to talk to us about your child's care or stay the **Ward Manager** or **Matron** will be happy to help.

together

What you can do for us...	What we will do for you...
Respect the privacy of other patients, visitors and also our staff. You must consider others present and your environment before taking photographs or making recordings. **Recording devices, such as baby monitors, are not allowed.** If you wish others to be included ask if they are happy with this and respect their decision.	**Confidential information about our patients will be treated confidentially and respectfully.** Each and every patient will receive effective and appropriate monitoring according to their clinical needs. All staff are required to attend training on protecting the privacy of individuals on an annual basis.
Ask staff for their permission before recording or photographing any medical practices, consultations or anything that could be part of a medical consultation. Do not go ahead unless permission is given. Anything in relation to how we work is a public record and may be accessible if requested in writing.	**We will try to accommodate your request where practical to do so and where staff don't want to be recorded we will provide a copy of a patient's clinical records to those who have parental responsibility or the patient themselves.** This can be done by contacting our Access to Health records team.
When on our premises do not access or view, either on the Trust internet, or the internet via other means, anything which could be considered offensive or inappropriate.	**We will block access, by means of filtering systems on our network, as far as is practically possible, to any material considered offensive or inappropriate.**

excellence

What you can do for us...	What we will do for you...
Keep any and all hospital appointments, or if you have to cancel, doing so in good time so we can offer that appointment to another patient.	**We will keep any changes to your scheduled sessions to a minimum and accommodate you where we can.** We will always give as much notice as we can to changes in your appointments.
Recognise that we are a teaching hospital and understand that we may ask you if you are happy for students to be present during the care of our patients.	**We will always ask** if you are happy for students to be present during patient care and will respect your decision.

innovation

What you can do for us...	What we will do for you...
Please give feedback to us – both positive and negative. If your experience could have been better tell us.	**We will act on the information** you give us to constantly improve the services and care we offer children and their families.

Appendix B: Violence and Aggression Checklist

Violence and Aggression Checklist

Ward / Department:

Division:

Date:

Assessor:

Physical Environment – Inside Areas	Yes	No	Comment
Does the area look welcoming (especially if a public reception or waiting area)?			
Are all signs clear, simple and suitably visible to direct people to the appropriate location? Are V&A signage up in ward visible to members of the public?			
Have any furniture or other fixtures and fittings that are likely to be used as a weapon been removed or fixed in place?			
Are other items that can be used as weapons kept secure e.g. scissors, sharp instruments etc?			
Does all staff have unimpeded views of the area including all access points?			
Are all entrances/ exits controlled/ restricted e.g. swipe card access or manned?			
Is privacy for patients and staff provided?			
Are rooms provided with reinforced observation panels where appropriate e.g. assessment rooms			
Does layout enable staff to leave unimpeded e.g. are they nearer to the main door than the violent person?			
Are reception areas arranged so that members of the public do not have access to the clinical rooms without passing by?			
Are clinical and other sensitive or non public areas able to be locked?			
Is there safe storage for personal effects?			

Is access to the area restricted e.g. swipe card access, keypad, manned or other?			
Is there a CCTV system?			
Is there a panic alarm /Nurse call button?			
Physical Environment – external (NHS & Public premises)	**Yes**	**No**	**Comments**
Is there adequate external lighting of all footpaths, roads and car parks?			
Are all signs clear, simple and suitably visible to direct people to the appropriate location?			
Are there areas where intruders could hide e.g. poorly lit, undergrowth removed?			
Is access to external areas restricted or controlled e.g. swipe card, call button or manned access?			
Activities & Systems of Work	**Yes**	**No**	**Comments**
Identify which of the following activities are present, that are known to present a higher risk of Violence and Aggression either directly or indirectly:			
Clinical procedures that cause anxiety and /or pain e.g. giving injections, changing dressings			
Giving people unwelcome information such as bereavement or cancellation of an operation or appointment			
Working alone			
Driving on work business			
Working at night/ during darkness			
Visiting patients homes			
Visiting areas where there is a known higher risk of Violence &/or crime			
Carrying (either on person or in a vehicles) valuable items e.g. laptop, drugs and other items of value that could be a target			
Working in main or other reception areas where people are likely to have to wait for long periods			
In a role to bring into contact with violent and aggressive individuals			
Are there adequate systems for letting people know how long they may have to wait and why?			

Do all authorised persons wear identification at all times?			
Do staffs challenge all people without appropriate identification?			
Are all valuable items including all work equipment and vulnerable patients tagged or marked?			
Is there a communications system to warn others (within a department and between departments/agencies) of people who are known or suspected to be violent & aggressive?			
Do safe systems of work cover people not normally based in the area e.g. doctors, porters etc ?			
Are security personnel available to accompany staffs who feel at risk?			
Are all incidents of violence and aggression, including near misses, reported on Sentinel?			
Human Factors	**Yes**	**No**	**Comments**
Are the following likely to be present (these may be out in the community as well as on NHS premises):			
People known or suspected to be under the influence of alcohol or other substances?			
People with a known or suspected mental illness or other relevant clinical conditions			
People previously identified as being violent and aggressive towards others			
People making complaints (please note the complaint may be justified)			
Staff Issues	**Yes**	**No**	**Comments**
Are staff familiar with their work environment &/or activities employed in?			
Are staffs trained in the activities and systems of work operating in their areas?			
Has all staff received the appropriate level of awareness training in Conflict resolution?			
If Assessed as a need for their role, have all staff received restraint /breakaway training			

Are new staffs or those unfamiliar with an area adequately supervised?			
Are staffs familiar with control measures in place with dealing with violence and aggression e.g. phoning security, police?			
Have risk assessments been completed for any staff who may be particularly at risk from physical violence e.g. pregnant women?			
Management Issues	**Yes**	**No**	**Comments**
Has the ward/department violence and aggression risk assessment been carried out, and has all staff been made aware of the risks highlighted in the assessment?			
Are staffs aware of any assessments on patients/parents/family members that have been carried out? If they are the named nurse for that patient			
Do staffs check for the Child protection / security alerts on meditech? Are staffs aware of theses sections on meditech?			
Has a copy of the checklist been sent to the Security management specialist within risk management?			
Has an assessment been carried out if needed for extra staff to deal with complex needs patients?			

Appendix C: Risk Assessment for Lone Workers

See also: CAMHS Lone Worker Guidelines (on DMS)

1. Risk Assessors

All risk assessors must attend the Trust's risk assessors' training day to learn the theoretical and the practical techniques in carrying out an assessment, and to comply with the Trust policy on risk assessments.

2. Risk Assessment

The manager should already have ensured that the ward/department risk assessor has completed a risk assessment in order to identify the hazards of any work; they should ensure that any additional risks to lone workers (and other groups at risk, such as pregnant workers and young workers) are identified. They should devise and implement safe working arrangements to ensure that the risks are either eliminated or adequately controlled.

3. The assessment should consider the following factors:

i. Is it necessary for the individual to work alone?

Foreseeable emergencies.

ii. **It must be recognised that a lone worker is more vulnerable when the unexpected occurs, e.g. fire, equipment failure, illness, accidents and violence and aggression.**

iii. The fitness and suitability of the person to work alone. Will working alone require additional physical or mental stamina? Is there a medical condition that makes the individual unsuitable for working alone? Is that person competent? Has he or she received appropriate training?

iv. Can the work be done safely by a lone worker?

4. When considering the workplace the following questions should be considered:

i. Does the workplace present a special risk to the lone worker?

ii. Is there a safe means of entry and exit to the workplace?

iii. Can all equipment, substances and goods be safely handled by one person?

iv. Will cash or valuables be handled and will this increase the risk of violence?

v. Are there arrangements for food and drink and adequate welfare facilities?

vi. Is the worker vulnerable to sexual harassment or assault?

vii. Have they access to communications in the work area?

5. Ensure that:

i. Lone workers have full knowledge of the hazards and risks to which they are being exposed.

ii. The lone workers know what to do if something goes wrong and whom to contact.

iii. Someone else knows the whereabouts of the lone workers and what they are doing

6. The level of supervision for lone workers should be determined to ensure that it is consistent with the possible risks and that there is a system for maintaining contact.

7. The remoteness of the workplace should also be considered when assessing the risks to lone workers, for example:

i. Will the emergency services be able to approach close enough if necessary?

ii. Is the length of time to do the job defined?

iii. Is there adequate access to first aid?

8. Arrangements should be in place to protect or assist lone workers in the event of fire, accident, illness or an incident of violence.

9. Staff should appreciate their responsibility for their own safety.

10. Lone workers should receive training in the use of any necessary tools and equipment such as Identicom. The tools or equipment used should be safe and correct for the task, and any increased risk to a lone worker should be identified in the risk assessment.

11. The manager should define working limits of what can and what cannot be done while working alone. This may be difficult, but the overriding principle should be “if in doubt, ask a supervisor”. The lone worker should clearly understand when and under what circumstances to stop work, and should be fully supported by management if any such decisions are made.

12. The manager must develop procedures to control the risks and protect employees and other individuals. The employees should know and understand such procedures.

Appendix D: Lone Worker Control Measures

See also: **CAMHS Lone Worker Guidelines** (on DMS)

Consider the following practical guidelines:

1. Authorisation for lone working is required from a manager.

2. Lone workers, outside normal working hours, should telephone Security on 2004 for retained estates and 3181 for CHP giving their name, place of work (and if possible a room number) and expected duration of stay. They should telephone Security as they leave the building.

3. Keep exit doors locked. Managers should allocate to someone the job of checking these doors are locked.

4. Pregnant workers – should they work alone?

5. Ensure a working telephone is available. Staffs who work out in the community and who match the definition of a lone worker (section 5.5 of the policy) have access to a mobile telephone and have access to the "Identicom" System if this has been raised within the risk assessment.

    5.1 The "Identicom" system is a personal safety monitoring system for lone workers. When working alone, users record details of their visits and "Identicom" monitors their status. If after a pre-defined period they have not closed their visit and they cannot be contacted, appropriate supervisors will be alerted automatically. This gives the lone worker peace of mind, because they always know that if something happens they will not be forgotten.

    5.2 "Identicom" also allows a lone worker to summon assistance quickly if they feel threatened, by raising an alarm. This makes them feel more secure because they know help is just a phone call away.

6. Managers should ensure that "panic buttons" or personal alarms are working – check them at regular intervals (e.g. weekly, monthly or at the beginning of each work period).

7. A book (at a reception desk, for example) to register attendance should be completed and available for the Fire Brigade/Security staff.

8. Lone workers should not undertake dangerous work (e.g. using dangerous chemicals) – this should be indicated by a risk assessment.

9. Checks should be made by Security staff by telephone if they have not heard from an individual after a designated length of time.

10. Where substantial car travel is required (e.g. transplant /McMillan), the availability of a mobile phone may be necessary.

11. It is illegal to use hand held mobile phones whilst driving: staff must pull over to use the phone.

12. Home visits can produce particular risks (e.g. unsafe houses, potential for being attacked). A visit to a home may be necessary to aid the risk assessment. In particular, consider the points raised in the following checklist:

12.1 Are staff who visit:

i. Trained to deal with violence and aggression - conflict resolution training

ii. Briefed about the areas where they work (out in the community).

iii. Aware of attitudes, traits or mannerisms, which can annoy clients etc.

iv. Given all available information about the patient and their family from all relevant sources (e.g. colleagues, police, the patient's General Practitioner, social services).

12.2 Have staff:

i. Understood the importance of previewing cases.

ii. Left an itinerary.

iii. Made plans to keep in contact with colleagues.

iv. Got the means to contact a manager (i.e. mobile telephone) if assessed as necessary.

v. An understanding of the Trust's Policy on Managing of Violence and Aggression at work and Lone Workers Policy

vi Authority to arrange an accompanied visit, security escort, or use of a taxi.

12.3 Do staff:

i. Know how to control and defuse potentially violent situations

ii. Know how to complete the Trust Online Incident Report form if necessary (Sentinel).

12.4 Car users should:

i. Remove their hospital parking permit if appropriate (someone might think drugs are inside the car)

ii. Park in well-lit areas

iii. Ensure their car is in good condition

iv. Not use hand held mobile phones whilst driving. In an emergency they must pull over and turn the engine off (see Transport Policy).

Appendix E: Procedures for dealing with substance misuse

1.1 If confirmed substance abuser is aggressive or violent:

Dial 2222, request immediate assistance from security AND police.

Staff will take advice from the police but the abuser will usually be removed from the premises. If the person returns under the influence, or if advised by the police that the person should not return, call for immediate assistance from security and the police.

If the abuser is a parent, carer or another person who might influence the patient's safety, you must report the incident to the child's consultant and the Trust's Safeguarding nurses and seek their advice before the patient is discharged, if there is any concern for the current or future safety, care or wellbeing of the patient. The paediatric community team should be advised before discharge.

Report incident on the Ulysses system.

1.2 If confirmed substance abuser is not violent or aggressive but disruptive:

Dial 2222, request assistance from security who will escort abuser from premises.

Report incident on the Ulysses system.

Warn abuser:

- Drug abuse/alcohol use is not allowed on Trust premises.
- They must leave the premises.
- If they return under the influence they will be reported to the police and removed from the premises.
- The Trust's Safeguarding nurses may be advised of the incident and the police may be informed.
- If the abuser returns and is again disruptive, proceed as above (section 1.1) and call the police.

1.3 If abuser is not violent, aggressive or disruptive but is obviously and openly abusing substances:

- Request that a Security Officer attend the ward or department.
- Report incident on the Ulysses system.

In a non-confrontational manner advise the abuser that:

- Drug abuse/alcohol use is not allowed on Trust premises.
- They must leave the premises.
- If they return under the influence they will be reported to the police and removed from the premises.
- The Trust's Safeguarding nurses will be advised of the incident.

- If the abuser is a parent, carer or another person who might influence the patient's safety, you must report the incident to the child's consultant and the Trust's Safeguarding nurses and seek their advice before the patient is discharged, if there is any concern for the current or future safety, care or wellbeing of the patient. The paediatric community team should be advised before discharge.

1.4 If abuse is suspected but not confirmed and person is not obviously under the influence.

- Inform Security.
- If the suspected abuser is a parent, carer or another person who might influence the patient's safety:-
  a) Discuss your suspicions with a senior colleague.
  b) If your suspicions give any cause for concern for the current or future safety, care or wellbeing of the patient:
     i. Inform the patient's consultant and discuss.
     ii. In a non-confrontational manner discuss the concerns with the parent or carer and advise that in the best interests of the child the Trust's Safeguarding nurses may be informed if your concerns remain.
     iii. Report incident on the Ulysses system.
  c) Seek advice from the Safeguarding nurses before the patient is discharged. The paediatric community team should be advised before discharge.

  Note: The person who discusses concerns with the parent/carer must have appropriate training and support to deal with a situation that could provoke distrust, anger or even result in violence.

1.5 If substance abuse is suspected in non-patient care areas (e.g. restaurant, toilets, McDonald House):

- Inform Security.
- Continue to observe the situation.
- Do not challenge the suspects.
- Inform staff on the ward / department (if known where the patient is).

1.6 Reporting

All incidents to be reported on the Ulysses Incident Reporting System.

If a person is aggressive or violent the police should have been involved. If they have not or in the case of disruptive persons, a report should be submitted to the Service Manager/Lead Nurse by the Ward or Department Manager and the Local Security Management Specialist (LSMS) who will decide whether to inform the police.

The Clinical Risk Advisors and the LSMS will prepare a report of incidents and report to the Health and Safety Committee quarterly.

1.7 Prevention

Regular meetings will be held between the Local Security Management Specialist and the Police who will advise on prevention/disruption measures for 'public' areas of the Trust premises and will jointly review the handling of incidents and development of procedures.

Parents, carers or relatives of patients requiring advice on substance abuse will be supported by referral to the Health Promotion Team for information on abuse programmes.

1.8 Abusers under 16 years

Visitor: As above. Discuss with police any further action required. Make a referral to the Safeguarding Team.

Patient: Inform the relevant consultant and ward / department staff. Make a referral to the Safeguarding Team.

1.9 Alcohol and Drug Misuse Contact Information

Addaction

Addaction help transform the lives of people affected by Drug and Alcohol problems.

For FREE confidential information and support call 0151 706 7898 or call Young Addaction if your under 18 years 0151 706 9747 www.addaction.org.uk

Liverpool Community Alcohol Service

Liverpool Community Alcohol Service is a FREE, NHS care and treatment service with dedicated staff across the city that can help you or someone you know deal with an alcohol problem.

Call 0151 529 4504 for more information.

FRANK

FRANK offered confidential information on Drug misuse and support, FRANK is available in 120 languages, 24 hours a day, 7 days a week. Call 0800 77 66 00, Text Questions and Frank will text you back 82111 or visit www.talktofrank.com

Appendix F: Quick Reference Guide to identify relevant Zero Tolerance Procedure to invoke

Behaviour	Individual	Procedure	Stages Available
Non-physical / non-violent in Person	Parent	Appendix G	Stages 1-5
Non-physical / non-violent in Person	Other Visitor	Appendix H	
Violent in person	Any Parent or Visitor	Appendix I	Stage 5 only
Non-threatening by telephone	Parent	Appendix J	
Non-threatening by telephone	Other Individuals	Appendix K	
Violent or offensive by telephone	Any Parent or Individual	Appendix L	Stage 5 only
Offensive in writing	Any Parent or Individual	Appendix M	
Threatening in writing	Any Parent or Individual	Appendix N	Stage 5 only

Appendix G: Procedure to follow for non-physical / non-violent behaviour in person by parents / carers / legal guardians

Non-Physical / Non-Violent Behaviour	Stage of Trust response	Staff involved	Action	Outcome
A **first incident of non-physical** inappropriate or unacceptable behaviour occurs for example shouting, filming without consent, passive aggressive behaviour	**Stage 1: Local Resolution**	**Front line staff:** Based on your assessment of the situation, can the incident be resolved locally in person or by telephone by yourselves as staff directly involved in the child's care? Consider if you: • Feel safe to do so • Safety not compromised • No actual or attempted physical assault has occurred If you do not feel confident or safe to do so, escalate to the Nurse in Charge / your Line Manager / Night Matron. Consider involving the child's Consultant	a) Try to talk to the parent in a quiet area away from the patient's bedside to reduce any distress to the patient. b) Listen to the parent to establish if any issues that may have triggered the behaviour can be resolved. c) Try to clarify why the unacceptable behaviour occurred. d) If the behaviour has been triggered because the parent has a concern with the care being delivered to their child, apologise and reassure that the problem will be addressed (in line with the Trust **Complaints and Concerns Policy - RM6** - see on DMS) Important to note, any **parental concern does not make such behaviour acceptable**. e) Clearly separate unacceptable behaviour from any concerns about care delivered. Be clear with the parent the nature of the unacceptable behaviour that has been witnessed, as a parent may not appreciate that Trust staff find such behaviour unacceptable. Explain that the Trust has a duty to provide a safe and secure environment for all patients, staff and visitors and has a Visitor and Relatives Charter (Appendix A) to help visitors and staff do this together to ensure acceptable behaviour. Explain that such behaviour is unacceptable and why. Explain the actual or potential adverse consequences of inappropriate behaviour on the delivery of care – it is likely to make staff, other patients and other visitors feel anxious. **Tell the parent that the inappropriate behaviour must stop.** f) Allow the parent time to vent their frustrations. This may mean the parent continues to, or starts, shouting and / or swearing however this behaviour will usually subside more quickly if time is given to allow for emotional venting. If you not dot feel safe or comfortable with the parent	**Agreed verbal plan to go forward** (documented in health record)

			in this situation, escalate to the Nurse in Charge, Ward Manager, Matron, Line Manager. g) Acknowledge the emotion the parent is expressing. h) Offer the parent support and ensure they know who they can speak to regarding any concerns they have (Ward / Department Manager; Matron; PALS). Advise the parent that you will escalate the concern the parent has raised with your Manager and you will document the concern in the child's health record. i) Negotiate and agree a plan to go forward. j) Consider any wider familial and / or cultural support the parent has or needs which can be accessed, for example spiritual support; translation services. k) Fully document the conversation with the parent in the child's health record in line with section 6.3. l) Complete a Ulysses incident form. m) Seek advice from Matrons and LSMS as required.	
A **second incident of non-physical** unacceptable behaviour occurs / unacceptable behaviour continues	**Stage 2: Meeting**	Ward Manager / Operational Manager Lead Consultant	a) Formal face to face meeting with the parent where the child is in or attending the Trust, or formal telephone meeting where the unacceptable behaviour has been via telephone or written. b) Include the appropriate actions covered in Local Resolution process above. c) Listen to the parent to establish if any ongoing issues have not been resolved to try to clarify why the unacceptable behaviour has occurred again and reiterate that it will not be tolerated. d) Tell the parent that the inappropriate behaviour must stop and reiterate the Trust Visitor and Relatives Charter (Appendix A). e) Give the parent a verbal warning being clear that the Trust will not tolerate this behaviour	**Verbal warning given** **Written agreement**

			f) Agree a written plan to go forward (see template Appendix O). g) Complete a referral to the Safeguarding Team and inform the parent h) Fully document the meeting in the child's health record	
A **third incident of non-physical** unacceptable behaviour occurs / unacceptable behaviour continues	**Stage 3: Meeting**	Matron / Service Manager Lead Consultant	a) Conduct meeting as outlined in Stage 2. b) Reiterate that the behaviour is unacceptable and / or inappropriate and will not be tolerated. c) Inform the parent that they will now receive a formal written warning (see template letter Appendix P). Be clear that the Trust will not tolerate this behaviour and that further incidents may result in restrictions on visiting or exclusion. d) Escalate the behaviour to the Divisional Senior Leadership Team (Associate Medical Director; Associate Chief Operating Officer; Associate Chief Nurse) e) Fully document the meeting in the child's health record	**Formal written warning**
A **fourth incident of non-physical** unacceptable behaviour occurs / unacceptable behaviour continues	**Stage 4: Speak to parent**	Divisional Head of Nursing or Divisional Associate Chief Nurse / Associate Chief Operating Officer Clinical Director or Divisional Associate Medical Director	a) Final written warning issued (see template letter Appendix Q) with appropriate visiting restrictions (consider who can visit; appropriate adult accompanying parent; length of visit and requirement to take breaks; any child protection arrangements with Social Services; consider appropriate duration of visiting restrictions). b) Warn the parent that any further unacceptable behaviour may result in their exclusion from the hospital c) Escalate the situation to the Chief Nurse / Director of Nursing and Medical Director; Safeguarding Lead Nurse; LSMS d) Inform the out of hours operational and management team: Night Matron and on call managers. d) Fully document in the child's health record	**Final written warning with visiting restrictions**

A **fifth incident of non-physical** unacceptable behaviour occurs / unacceptable behaviour continues	**Stage 5: Excluded from the hospital**	**In hours:** Chief Nurse / Director of Nursing Medical Director LSMS / Security **Out of hours:** First On Call Manager Night Matron Security Registrar (if available) Inform the second on call manager	a) Parent asked to leave the hospital by the Chief Nurse / Director of Nursing and the Medical Director, or a member of the senior team on duty or on call out of hours. A member of the Security Team should be in close proximity though not necessarily in direct proximity. b) Ensure that safety is maintained at all times. If behaviour becomes violent or there is a threat of violence or safety is felt to be compromised call Security on 3181 main hospital, or 2004 Catkin, and call the Police on 999 c) Issue a letter of exclusion to the parent (see template letter Appendix R). d) If the parent refuses to leave the hospital, the Security Team will escort the parent from the hospital e) Escalate the situation to the Executive team / second on call manager f) The parent is not allowed to return to the hospital until an Emergency Planning Meeting has been held on the next working day in line with section 6.5 to devise an agreed plan. (If, for the patient's benefit, access is urgently required prior to the Emergency Planning Meeting being held, this must be agreed by the Executive Lead, LSMS and Security in hours, and the Site Co-ordinator, Second On Call Manager and Security out of hours)	**Excluded from the hospital** **Emergency Planning Meeting to be convened next day**

Appendix H: Procedure to follow for non-physical / non-violent behaviour by other visitors

Non-Physical / Non-Violent Behaviour	Stage of Trust response	Staff involved	Action	Outcome
A **first incident of non-physical** inappropriate or unacceptable behaviour occurs for example shouting, filming without consent, passive aggressive behaviour	**Stage 1: Local Resolution**	**Front line staff:** Based on your assessment of the situation, can the incident be resolved locally in person or by telephone by yourselves as staff directly involved in the child's care? Consider if you: • Feel safe to do so • Safety not compromised • No actual or attempted physical assault has occurred If you do not feel confident or safe to do so, escalate to the Nurse in Charge / your Line Manager / Night Matron. Consider involving the child's Consultant	a) Try to talk to the visitor in a quiet area away from the patient's bedside to reduce any distress to the patient. b) Listen to the visitor to establish if any issues that may have triggered the behaviour can be resolved. c) Try to clarify why the unacceptable behaviour occurred. d) If the behaviour has been triggered because the visitor has a concern with the care being delivered to their child, apologise and reassure that the problem will be addressed (in line with the Trust **Complaints and Concerns Policy - RM6 -** see on DMS). Important to note, any **concern does not make such behaviour acceptable**. e) Clearly separate unacceptable behaviour from any concerns about care delivered. Be clear with the visitor the nature of the unacceptable behaviour that has been witnessed, as a parent may not appreciate that Trust staff find such behaviour unacceptable. Explain that such behaviour is unacceptable and why. Explain the actual or potential adverse consequences of inappropriate behaviour on the delivery of care – it is likely to make staff, other patients and other visitors feel anxious. **Tell the visitor that the inappropriate behaviour must stop and failure to do so will result in their exclusion from the hospital.** f) Offer the visitor support and ensure they know who they can speak to regarding any concerns they have (Ward / Department Manager; Matron; PALS). Advise the visitor that you will escalate the concern with your Manager and you will document the concern in the child's health record. g) Inform the child's parent of the incident and that the visitor will be excluded from visiting if there are any further incidents	**Agreed verbal plan to go forward** (documented in health record)

			h) Fully document the conversation with the visitor in the child's health record in line with section 6.3. i) Complete a Ulysses incident form. j) Seek advice from Matrons and LSMS as required.	
A **further incident of non-physical** unacceptable behaviour occurs / unacceptable behaviour continues	**Stage 5: Excluded from the hospital**	**In hours:** Associate Chief Nurse / Head of Nursing Associate Medical Director LSMS / Security **Out of hours:** First On Call Manager Night Matron Security Registrar (if available) Inform the second on call manager	a) Visitor asked to leave the hospital by the Associate Chief Nurse and the Associate Medical Director or Associate Chief Operating Officer, or a member of the senior team on duty or on call out of hours. A member of the Security Team should be in close proximity though not necessarily in direct proximity. b) Ensure that safety is maintained at all times. If behaviour becomes violent or there is a threat of violence or safety is felt to be compromised call Security on 3181 main hospital, or 2004 Catkin, and call the Police on 999 c) Send a letter of exclusion to the individual (see template letter Appendix R) d) If the visitor refuses to leave the hospital, the Security Team will escort the visitor from the hospital e) Escalate the situation to the Executive team / second on call manager f) The visitor is not allowed to return to the hospital until an Emergency Planning Meeting has been held on the next working day in line with section 6.5 to devise an agreed plan. (If, for the patient's benefit, access is urgently required prior to the Emergency Planning Meeting being held, this must be agreed by the Executive Lead, LSMS and Security in hours, and the Site Co-ordinator, Second On Call Manager and Security out of hours)	**Excluded from the hospital** **Emergency Planning Meeting to be convened next day**

Appendix I: Procedure to follow for violent behaviour by any visitor including parents

Violent Behaviour	Stage of Trust response	Staff involved	Action	Outcome
An incident of violent behaviour occurs	**Stage 5: Excluded from the hospital**	**In hours:** Chief Nurse / Director of Nursing Medical Director LSMS / Security **Out of hours:** First On Call Manager Night Matron Security Registrar (if available) Inform the second on call manager	a) Parent / visitor asked to leave the hospital by the Chief Nurse / Director of Nursing and the Medical Director, or a member of the senior team on duty or on call out of hours. A member of the Security Team should be in direct proximity. b) Ensure that safety is maintained at all times. If behaviour becomes violent again or there is a threat of violence or safety is felt to be compromised call for additional Security assistance on 3181 main hospital, or 2004 Catkin, and call the Police on 999 c) Send a letter of exclusion to the individual (see template letter Appendix S) d) If the parent / visitor refuses to leave the hospital, the Security Team will escort the parent / visitor from the hospital e) Escalate the situation to the Executive team / second on call manager f) The parent / visitor is not allowed to return to the hospital until an Emergency Planning Meeting has been held on the next working day in line with section 6.5 to devise an agreed plan. (If, for the patient's benefit, access is urgently required prior to the Emergency Planning Meeting being held, this must be agreed by the Executive Lead, LSMS and Security in hours, and the Site Co-ordinator, Second On Call Manager and Security out of hours)	**Excluded from the hospital** **Emergency Planning Meeting to be convened next day**

Appendix J: Procedure to follow for inappropriate / non-threatening behaviour over the telephone by parents / carers / legal guardians

Non-Physical / Non-Violent Behaviour	Stage of Trust response	Staff involved	Action	Outcome
An **incident of non-threatening** inappropriate or unacceptable behaviour occurs for example shouting down the telephone	**Stage 1: Local Resolution**	**Front line staff:** Based on your assessment of the situation, can the incident be resolved locally on the telephone by yourselves as staff directly involved in the child's care? Consider if you: • Feel safe to do so • Safety not compromised • No threat of violence has occurred If you do not feel confident or safe to do so, escalate to the Nurse in Charge / your Line Manager / Night Matron / Service Manager. Consider involving the child's Consultant	a) Listen to the parent to establish if any issues that may have triggered the behaviour can be resolved. A parent may shout and / or swear down the telephone out of frustration if they feel they have been passed between multiple departments with no effective resolution. If the behaviour has been triggered because the parent has a concern with the care / service being delivered to their child, apologise and reassure that the problem will be addressed (in line with the Trust **Complaints and Concerns Policy - RM6** - see on DMS) Important to note, any **concern does not make such behaviour acceptable**. b) Be clear that you want to help and try to diffuse the situation. Be clear with the parent / visitor that they are shouting / swearing and politely ask them to stop c) If the shouting / swearing continues, advise that you are going to end the call. Important to note, **if you do end or intend to end the telephone call ensure that the safety of the child will not be compromised (for example regarding an appointment, admission, need to attend ED) and ensure appropriate arrangements are made (for example senior staff to telephone back with management plan; management plan sent in writing)** d) Offer the parent support and ensure they know who they can speak to regarding any concerns they have (Ward / Department Manager; Matron; PALS). Advise the parent that you will escalate the concern the parent has raised with your Manager and you will document the concern in the child's health record. e) Negotiate and agree a plan to go forward.	**Agreed verbal plan to go forward** (documented in health record)

			f) Consider whether translation services need to be accessed g) Fully document the conversation with the parent in the child's health record in line with section 6.3. h) Complete a Ulysses incident form. i) Escalate to your Line Manager and LSMS as required.	
Unacceptable behaviour **continues**	**Stage 2: Transfer the call**	Line Manager / Operational Manager	a) Transfer the call to your Line Manager b) Include the appropriate actions covered in Local Resolution process above. c) Listen to the parent to establish if any ongoing issues have not been resolved to try to clarify why the unacceptable behaviour has occurred again and reiterate that it will not be tolerated. d) Tell the parent that the shouting / swearing must stop. e) Give the parent a verbal warning being clear that the Trust will not tolerate this behaviour f) Agree a plan going forward, for example an appropriate single point of contact in the Trust g) Complete a referral to the Safeguarding Team and inform the parent h) Fully document the discussion in the child's health record	**Verbal warning given**
Unacceptable behaviour **continues**	**Stage 3: Meeting (face to face or telephone)**	Matron / Service Manager / Lead Consultant	a) Invite the parent to attend a meeting. If the parent is going to be attending the hospital this may be a viable option to meet in person otherwise likely to be a telephone meeting b) Reiterate that the behaviour will not be tolerated. Inform the parent that they will now receive a formal written warning (see template letter Appendix P). c) Escalate the behaviour to the Divisional Senior Leadership Team (Associate Medical Director; Associate Chief Operating Officer;	**Formal written warning**

			Associate Chief Nurse). Plan made in the event of continued aggressive telephone calls regarding safe treatment of the child d) Fully document the meeting in the child's health record	
Unacceptable behaviour **continues**	**Stage 4: Meeting (face to face or telephone)**	Divisional Head of Nursing or Divisional Associate Chief Nurse / Clinical Director or Divisional Associate Medical Director / Associate Chief Operating Officer	a) Final written warning issued (see template letter Appendix Q) b) Escalate the situation to the Chief Nurse / Director of Nursing and Medical Director; Safeguarding Lead Nurse; LSMS. Plan made for the safe treatment of the child c) Fully document in the child's health record	**Final written warning**

Appendix K: Procedure to follow for inappropriate / non-threatening behaviour over the telephone by any other individual

Non-Physical / Non-Violent Behaviour	Stage of Trust response	Staff involved	Action	Outcome
An **incident of non-threatening** inappropriate or unacceptable behaviour occurs for example shouting down the telephone	**Stage 1: Local Resolution**	**Front line staff:** Based on your assessment of the situation, can the incident be resolved locally on the telephone by yourselves as staff directly involved in the child's care? Consider if you: • Feel safe to do so • Safety not compromised • No threat of violence has occurred If you do not feel confident or safe to do so, escalate to the Nurse in Charge / your Line Manager / Night Matron / Service Manager. Consider involving the child's Consultant	a) Listen to the caller to establish if any issues that may have triggered the behaviour can be resolved. A caller may shout and / or swear down the telephone out of frustration if they feel they have been passed between multiple departments with no effective resolution however in most circumstances you will only be able to discuss with those with parental responsibility and not other family members / friends. Important to note, any **concern does not make such behaviour acceptable**. b) Be clear that you want to help and try to diffuse the situation. Be clear with the caller that they are shouting / swearing and politely ask them to stop c) If the shouting / swearing continues, advise that you are going to end the call and ask that the parent makes contact with the hospital to discuss any issues. d) Fully document the conversation with the caller in the child's health record in line with section 6.3. e) Complete a Ulysses incident form. f) Escalate to your Line Manager and LSMS as required.	**Agreed verbal plan to go forward** (documented in health record)
Unacceptable behaviour **continues**	**Stage 5: Inform parents / Exclude**	Line Manager / Operational Manager	a) Transfer the call to your Line Manager b) Inform the caller that you are going to end the call and that the Trust will only speak with the parent. c) Inform the parent that the individual must not make any further calls and is effectively excluded from making contact with the Trust about their child	**Exclude from contacting the hospital**

Appendix L: Procedure to follow for threatening or offensive language over the telephone by any individual including parents

Violent Behaviour	Stage of Trust response	Staff involved	Action	Outcome
An incident of threatening or offensive language occurs for example a threat of violence; discriminatory, malicious or prejudiced language	**Stage 5: Inform the Police** **Excluded from the hospital**	Chief Nurse / Director of Nursing / Medical Director / Chief Operating Officer	a) Tell the parent / caller you are going to terminate the telephone call and do so immediately. b) Inform your line manager immediately who will escalate to the Divisional Management Team, the Safeguarding Team, LSMS and the Police to report the incident c) Call the Police on 999 to report the incident d) Send a letter of exclusion to the individual. This will advise that in the event that their child needs to attend the hospital for a planned appointment during the period of exclusion, another responsible adult should accompany the child. Where a child needs to attend the Emergency Department (ED), and the individual excluded is the adult responsible for the child at that time, then in the interests of patient safety the individual is allowed on the premises to escort the child to ED (see template letter Appendix S) e) Escalate the situation to the Executive team / second on call manager f) Invoke an Emergency Planning Meeting for the next working day in line with section 6.5 to devise an agreed plan.	**Excluded from the hospital** **Emergency Planning Meeting to be convened next day**

Appendix M: Procedure to follow for Offensive or Abusive Language in writing (letter; email; social media; text) by Any Individual including Parents

Non-Violent Behaviour	Stage of Trust response	Staff involved	Action	Outcome
An incident of offensive written communication occurs	**Stage 4: Final written warning**	Divisional Head of Nursing or Divisional Associate Chief Nurse / Clinical Director or Divisional Associate Medical Director / Associate Chief Operating Officer	a) Inform your line manager immediately who will escalate to the Divisional Management Team, the Safeguarding Team, and LSMS b) Consider whether you / the Trust want to report the incident to Police c) Final written warning issued (see template letter Appendix Q) b) Escalate the situation to the Chief Nurse / Director of Nursing and Medical Director; Safeguarding Lead Nurse; LSMS. Plan made for the safe treatment of the child c) Fully document in the child's health record	**Final written warning**

Appendix N: Procedure to follow for threatening behaviour in writing (letter; email; social media; text) by any individual including parents

Any members of staff who receive a bomb threat must act in line with the Trust Bomb Threat and Suspicious Packages / Persons Incident Plan.

Violent Behaviour	Stage of Trust response	Staff involved	Action	Outcome
An incident of threatening written communication occurs	**Stage 5: Inform the Police** **Excluded from the hospital**	Chief Nurse / Director of Nursing / Medical Director / Chief Operating Officer	a) Do not respond. Inform your line manager immediately who will escalate to the Divisional Management Team, the Safeguarding Team, LSMS and the Police to report the incident b) Send a letter of exclusion to the individual. This will advise that in the event that their child needs to attend the hospital for a planned appointment during the period of exclusion, another responsible adult should accompany the child. Where a child needs to attend the Emergency Department (ED), and the individual excluded is the adult responsible for the child at that time, then in the interests of patient safety the individual is allowed on the premises to escort the child to ED (see template letter Appendix S) c) Escalate the situation to the Executive team / second on call manager d) Invoke an Emergency Planning Meeting in line with section 6.5 on the next working day to devise an agreed plan.	**Excluded from the hospital** **Emergency Planning Meeting to be convened next day**

Appendix O: Stage 2 Zero Tolerance Process template letter (agreed plan and verbal warning)

This letter is intended to provide a template to assist in writing to a parent at Stage 2 of the Zero Tolerance Process. The template should be amended to reflect the nature of the meeting with the parent. Two copies of the letter should be issued to the parent: one letter for the parent to retain; and one letter for the parent to sign and return confirming they will abide with the agreed plan. The final letter must be appropriately letter headed.

<Parent's name>

<Parent's address>

<Date>

Dear <Parent's name>,

Stage 2 of the Zero Tolerance Policy: Agreement Plan

Alder Hey Children's Hospital has a duty to provide a safe and secure environment for our patients, staff and visitors. The Trust has a Zero Tolerance Policy to manage inappropriate or unacceptable behaviour from parents/carers or visitors as such behaviour is not safe and will not be tolerated.

I am writing to you further to our formal meeting on *(enter date and ward / department).* Also present at the meeting was / were (*enter name / relationship of other visitors if known; name and role of staff*).

I explained to you that the Trust has a duty to provide a safe and secure environment for all of our patients, staff and visitors, and that the Trust has devised the Visitors and Relatives Charter to help visitors and staff to do this together, to ensure acceptable behaviour towards all our patients, staff and visitors within the Trust.

I explained my significant concerns about your behaviour on *(enter date).* It is alleged that *(describe the behaviour).* Behaviour such as this hinders our ability to provide safe care to our patients, is unacceptable and will not be tolerated. The Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse.

I am aware this is not the first incident of unacceptable behaviour, and that your behaviour has been discussed with you previously on *(enter date)* on *(ward / department).* At that time, you agreed *(summarise the actions agreed at Stage 1).* Therefore, I again advised you that the inappropriate behaviour must stop, and on this occasion, regretfully I had to give you a Verbal Warning.

You told me that *(describe any ongoing issues that the parent raises to clarify why the unacceptable behaviour has occurred again).*

All of the staff are mindful of the stress that families may experience when children are *(in hospital / attending clinic)* for care and treatment.

Therefore we agreed the following plan going forward:

- (enter as agreed. This might include parent directing any concerns to the Ward Manager / Nurse in Charge; agreeing a regular day / time to catch up; putting in place actions to resolve any issues that have occurred
- x
- x

I advised you that a referral to the Safeguarding Team has / would be made to provide further support, advice and guidance to yourself and the staff.

I am confident that going forward there will be no further concerns raised regarding your behaviour, and we are keen to continue to work with you to prevent the need for us to further escalate the Zero Tolerance Policy.

I trust that you will comply with the actions that we have deemed necessary and appropriate in the best interests of your child, and all of our children, families and staff. As such, please can you sign a copy of this letter and return to myself to indicate that you have read and understood the above warning and agree to abide by the plan that we agreed. If you do not reply within fourteen days I shall assume tacit agreement.

Yours sincerely,

Ward Manager

Cc Lead Consultant

Matron

Operational Manager

File copy in patient health record

Signed by senior staff member…………………………… Date: / /20

I, ……………………….. accept the conditions listed above and agree to abide by them accordingly.

Signed……………………………………… Date: / /20

Appendix P: Stage 3 Zero Tolerance Process template letter (written warning)

This letter is intended to provide a template to assist in writing to a parent at Stage 3 of the Zero Tolerance Process. The template should be amended to reflect the nature of the meeting with the parent. The final letter must be appropriately letter headed.

<Parent's name>

<Parent's address>

<Date>

Dear <Parent's name>,

Stage 3 of the Zero Tolerance Policy: Written Warning

Alder Hey Children's Hospital has a duty to provide a safe and secure environment for our patients, staff and visitors. The Trust has a Zero Tolerance Policy to manage inappropriate or unacceptable behaviour from parents/carers or visitors as such behaviour is not safe and will not be tolerated.

I am writing to you further to our formal meeting on *(enter date and ward / department).* Also present at the meeting was / were (*enter name / relationship of other visitors if known; name and role of staff*).

X *(enter staff name and role from Stage 2 letter)* wrote to you previously on *(insert date)* following a meeting on *(insert date)* regarding concerns about an incident on *(inset date and ward / department)* in the context of our Zero Tolerance Policy, and your behaviour towards our staff, and outlined actions needed to move towards the resolution of this.

I met with you again due to your continued inappropriate behaviour on *(enter date).* It is alleged that *(outline of further incident or continued occurrences)*. X *(enter staff name from Stage 2 meeting)* informed you at the meeting that your behaviour continues to affect your child, other patients, families and our staff. This behaviour hinders our ability to provide a safe and secure environment, is unacceptable, will not be tolerated and must stop. The Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse. This was made clear to you at the meeting you attended with *(enter staff name from Stage 2 meeting)*.

You told me that *(describe any ongoing issues that the parent raises to clarify why the unacceptable behaviour has occurred again).* As a result we agreed that *(outline or list actions agreed).*

I informed you that a referral to the Safeguarding Team has been made to provide further support, advice and guidance to yourself and the staff.

I urge you to consider your behaviour when attending *(enter ward / department / or 'the Trust').* If you fail to act in accordance with these conditions, and do not modify your behaviour and continue to demonstrate what we consider to be unacceptable behaviour, I will have no choice but to take further action in line with the Trust Zero Tolerance Policy which could include restrictions on visiting arrangements to the hospital or exclusion. In line with our Zero Tolerance Policy, this letter acts as a Written Warning.

All of the staff are mindful of the stress that families may experience when children are *(in hospital / attending clinic)* for care and treatment, and we remain keen to continue to work with you and confident that we will not need to further escalate the Zero Tolerance Policy.

Yours sincerely

Matron

Cc Lead Consultant

Ward / Department Manager

Service Manager

Divisional Associate Chief Nurse

Clinical Director

File copy in patient health record

Appendix Q: Stage 4 Zero Tolerance Process template letter (final written warning and visiting restrictions)

This letter is intended to provide a template to assist in writing to a parent at Stage 4 of the Zero Tolerance Process. The template should be amended to reflect the nature of the meeting with the parent. The final letter must be appropriately letter headed.

<Parent's name>

<Parent's address>

<Date>

Dear <Parent's name>,

Stage 4 of the Zero Tolerance Policy: Final Written Warning with Visiting Restrictions

Alder Hey Children's Hospital has a duty to provide a safe and secure environment for our patients, staff and visitors. The Trust has a Zero Tolerance Policy to manage inappropriate or unacceptable behaviour from parents/carers or visitors as such behaviour is not safe and will not be tolerated.

I am writing to you to inform that despite two previous meetings held with yourself, followed up in writing to you, you have continued to behave in a way the Trust does not consider to be acceptable or appropriate.

You have received the following formal correspondence in relation to this matter:

1. Stage 2 Zero Tolerance Procedure: Agreement Plan letter dated *(enter date)* from *(enter staff name and role)*
2. Stage 3 Zero Tolerance Procedure: Written Warning letter dated *(enter date)* from *(enter staff name and role)*

I spoke with you today regarding your continued inappropriate behaviour on *(enter date).* It is alleged that *(outline of further incident or continued occurrences)*. You have repeatedly been asked to stop behaving in a manner that is unacceptable and not tolerated as it seriously impacts on the Trust's ability to provide a safe and secure environment for your child, patients, families and staff. The Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse.

You have raised concerns about (*outline).* In response to your concerns we have *(list actions taken).*

We have concerns significant concerns about aspects of your behaviour which are *(outline or list the behaviours which are considered unacceptable).*

As a result of your continued inappropriate behaviour, regrettably this letter acts as a Final Written Warning. It is also necessary, in line with the Trust Zero Tolerance Policy, to restrict your current visiting arrangements.

As a result, I informed you today that visiting access will be restricted to the following:

- List the visiting restrictions. This might include:
    1. Time of day parent permitted to visit
    2. Limit the duration of the parent's visit
    3. No overnight stay on the Ward / Department
    4. Visit to be supervised / supported (agree by whom)
    5. Restriction to the number of other visitors to the patient

I informed you that further contact with the Safeguarding Team has been made to provide further support, advice and guidance to yourself and the staff.

If you fail to act in accordance with these conditions, and do not stop behaving in a manner that the Trust considers to be unacceptable, I will have no choice but to take further action in line with the Trust Zero Tolerance Policy which will result in you being excluded from the Trust. Clearly this is not an action that we want to take, therefore I urge you to consider your actions in the interest of safety for your child, patients, families and the staff.

Yours sincerely

Associate Chief Nurse

Cc Lead Consultant

Ward / Department Manager

Matron

Associate Medical Director

Associate Chief Operating Officer

Director of Nursing

File copy in patient health record

Appendix R: Stage 5 Zero Tolerance Process template letter: exclusion following escalation through other Stages of the process

This letter is intended to provide a template to assist in writing to a parent at Stage 5 of the Zero Tolerance Process where there has been repeated incidents of unacceptable behaviour managed through the Stages of the Zero Tolerance Process. The template should be amended to reflect the nature of the meeting with the parent. The final letter must be appropriately letter headed.

<Parent's name>

<Parent's address>

<Date>

Dear <Parent's name>,

Stage 5 of the Zero Tolerance Policy: Exclusion from the Trust

Alder Hey Children's Hospital has a duty to provide a safe and secure environment for our patients, staff and visitors. The Trust has a Zero Tolerance Policy to manage inappropriate or unacceptable behaviour from parents/carers or visitors as such behaviour is not safe and will not be tolerated.

I am writing to you to inform that despite three previous meetings held with yourself, followed up in writing to you and resulting in a Final Written Warning, you have continued to behave in a way the Trust does not consider to be acceptable or appropriate.

You have previously received the following formal correspondence in relation to this matter:

1. Stage 2 Zero Tolerance Procedure: Agreement Plan letter dated *(enter date)* from *(enter staff name and role)*
2. Stage 3 Zero Tolerance Procedure: Written Warning letter dated *(enter date)* from *(enter staff name and role)*
3. Stage 4 Zero Tolerance Procedure: Final Written Warning and Visiting Restrictions letter *(enter date)* from *(enter staff name and role)*

I spoke with you today regarding your continued unacceptable behaviour concerning an incident that occurred on (*enter date and ward / department*). It is alleged that you *(outline of further incident or continued occurrences).*

Despite the Trust making every effort to assist you to modify your behaviour by *(list actions taken),* you have continued to behave in a way that is seriously affecting the

ability of the Trust to provide a safe environment for our patients, families and staff. This is unacceptable and will no longer be tolerated.

Therefore I have no alternative but to exclude you from the Trust premises in line with Stage 5 of the Trust Zero Tolerance Policy. This means that you must leave the hospital immediately. *I have informed the House Manager of Ronald McDonald House, where you have been resident, of this decision and the Manager will discuss ongoing accommodation arrangements with you (amend as appropriate based on residency)*.

I must inform you that until you agree to an action plan to improve these aspects of your behaviour, you will be refused entry to the hospital and associated buildings. If you attempt to return, you will be escorted from the hospital by the Security Team. The Trust will draw up an action plan at an Emergency Planning Meeting to be held *(enter date: this should be the next working day)*, which will review the duration of the exclusion, and review arrangements for future visits or for enforcing ongoing exclusion from the Trust. X *(enter staff name and role)* will contact you as soon as possible after the Emergency Planning Meeting to discuss this action plan with you.

(Where the child is not an in-patient, include terms of the exclusion as follows). Where a child that you are the responsible adult for needs to attend the Emergency Department (ED), you are allowed on the premises to escort the child. However you should inform the ED staff of the terms of the current exclusion.

At the Emergency Planning Meeting, the Trust will also consider *(amend as appropriate):*

- That the matter will be reported to the Police with a view to the Trust supporting a criminal prosecution by the Crown Prosecution Service.
- That the matter will be reported to the NHS Protect Legal Protection Unit with a view to the Trust supporting criminal or civil proceedings or other sanctions. Any legal costs incurred will be sought from yourself.
- Obtaining a civil injunction in the appropriate terms, with any legal costs incurred to be sought from yourself.

I informed you that a referral to the Safeguarding Team has been made to provide further support, advice and guidance to yourself and the staff.

I sincerely regret that the Trust has been forced to take this action, however we have done so to ensure the safety of your child, patients, families and our staff. I trust that you will reflect on the behaviour that has led to such action and agree to the action plan in the hope that your visiting access can be positively reviewed.

Yours sincerely

Chief Nurse / Director of Nursing / Medical Director / Chief Operating Officer

Cc Lead Consultant

Ward / Department Manager

Matron
Clinical Director
Associate Medical Director
Associate Chief Operating Officer
Chief Nurse
Director of Nursing
Medical Director
Chief Operating Officer
File copy in patient health record

Appendix S: Stage 5 Zero Tolerance Process template letter: exclusion following a violent incident

This letter is intended to provide a template to assist in writing to a parent at Stage 5 of the Zero Tolerance Process where there has been an incident of a violent nature. The template should be amended to reflect the nature of the discussion with the parent. Where the letter is regarding the violent behaviour of a visitor, the letter should be sent to the visitor and a copy sent to the parent of the patient. Where the name of the visitor is not known, the letter should be sent to the parent and make clear that the behaviour has been displayed by one of their visitors. The final letter must be appropriately letter headed.

<Parent's name>

<Parent's address>

<Date>

Dear <Parent's name>,

Stage 5 of the Zero Tolerance Policy: Exclusion from the Trust

Alder Hey Children's Hospital has a duty to provide a safe and secure environment for our patients, staff and visitors. The Trust has a Zero Tolerance Policy to manage inappropriate or unacceptable behaviour from parents/carers or visitors as such behaviour is not safe and will not be tolerated.

I am writing to you regarding an incident that occurred on (*enter date and ward / department*). It is alleged that you *(outline incident of violent / aggressive / threatening behaviour. Outline the action taken such as calling Security and / or the Police).* Behaviour such as this hinders our ability to provide safe care to our patients, is unacceptable and will not be tolerated. The Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence or abuse.

Given the serious nature of the alleged incident, I have no alternative but to exclude you from the Trust premises in line with Stage 5 of the Trust Zero Tolerance Policy. This means that you must leave the hospital immediately. *I have informed the House Manager of Ronald McDonald House, where you have been resident, of this decision and the Manager will discuss ongoing accommodation arrangements with you (amend as appropriate based on residency).*

I must inform you that until you agree to an action plan to improve these aspects of your behaviour, you will be refused entry to the hospital and associated buildings. If you attempt to return, you will be escorted from the hospital by the Security Team. The Trust will draw up an action plan at an Emergency Planning Meeting to be held *(enter date: this should be the next working day)*, which will review the duration of the

exclusion, and review arrangements for future visits or for enforcing ongoing exclusion from the Trust. X *(enter staff name and role)* will contact you as soon as possible after the Emergency Planning Meeting to discuss this action plan with you.

(Where the child is not an in-patient, include terms of the exclusion as follows). Where a child that you are the responsible adult for needs to attend the Emergency Department (ED), you are allowed on the premises to escort the child. However you should inform the ED staff of the terms of the current exclusion.

At the Emergency Planning Meeting, the Trust will also consider *(amend as appropriate):*

- That the matter will be reported to the Police with a view to the Trust supporting a criminal prosecution by the Crown Prosecution Service.
- That the matter will be reported to the NHS Protect Legal Protection Unit with a view to the Trust supporting criminal or civil proceedings or other sanctions. Any legal costs incurred will be sought from yourself.
- Obtaining a civil injunction in the appropriate terms, with any legal costs incurred to be sought from yourself.

I informed you that a referral to the Safeguarding Team has been made to provide further support, advice and guidance to yourself and the staff.

I sincerely regret that the Trust has been forced to take this action, however we have done so to ensure the safety of your child, patients, families and our staff. I trust that you will reflect on the behaviour that has led to such action and agree to the action plan in the hope that your visiting access can be positively reviewed.

Yours sincerely

Chief Nurse / Director of Nursing / Medical Director / Chief Operating Officer

Cc Lead Consultant

Ward / Department Manager

Matron

Clinical Director

Associate Medical Director

Associate Chief Operating Officer

Chief Nurse

Director of Nursing

Medical Director

Chief Operating Officer

File copy in patient health record

Appendix T: Stage 5 Zero Tolerance Process template letter: exclusion lifted

This letter is intended to provide a template to assist in writing to a parent at Stage 5 of the Zero Tolerance Process following the Emergency Planning Meeting once the exclusion has been lifted. The final letter must be appropriately letter headed.

<Parent's name>

<Parent's address>

<Date>

Dear <Parent's name>,

Stage 5 of the Zero Tolerance Policy: Outcome of Emergency Planning Meeting

I am writing to you following an Emergency Planning Meeting that was held on *(enter date)* following the decision to exclude you from attending the Trust due to significant concerns regarding your behaviour, as outlined in the letter dated *(enter date).*

It was agreed at the Emergency Planning Meeting that the exclusion *can be lifted / will remain in place until* (*enter date).*

An action plan has been drawn up and will be discussed with you. It is imperative that you comply with the actions. Failure to do so may result in a further period of exclusion. The actions include:

- List the actions and visiting restrictions. This might include:
    1. Time of day parent permitted to visit
    2. Limit the duration of the parent's visit
    3. No overnight stay on the Ward / Department
    4. Visit to be supervised / supported (agree by whom)
    5. Restriction to the number of other visitors to the patient

However I am confident that you will have reflected on your recent behaviours as a result of the action the Trust had to take, and I am optimistic that moving forward you will consistently modify your behaviour in order to ensure the safety of your child, patients, families and our staff.

Yours sincerely

Chief Nurse / Director of Nursing / Medical Director / Chief Operating Officer

Cc Lead Consultant

Ward / Department Manager

Matron

Clinical Director

Associate Medical Director

Associate Chief Operating Officer

Chief Nurse

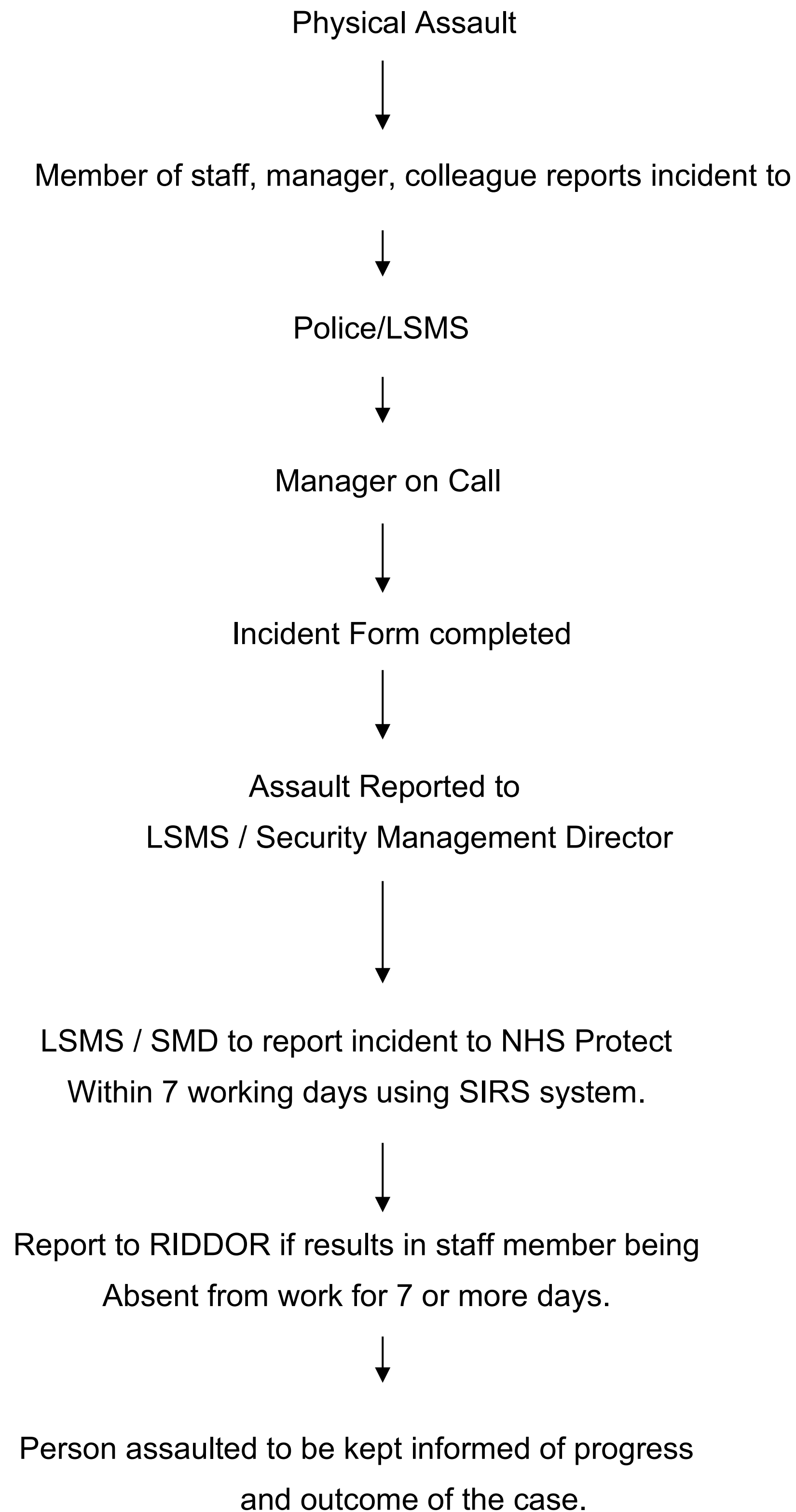
Director of Nursing

Medical Director

Chief Operating Officer

File copy in patient health record

Appendix U: Procedure for reporting violent incidents against employees



Appendix V: Guidance regarding legal action for staff and managers

1. Non-physical assault:

1.1 Where necessary the police should be contacted, as soon as is practicable, by the person subject to the non-physical assault or by their manager or a relevant colleague. The seriousness of the incident should be taken into account when deciding whether the police should be involved.

1.2 The LSMS will arrange:

- To liaise with, co-operate with and monitor cases of non-physical assault that have been referred to and are being handled by the police.
- To consider whether the Trust should initiate private prosecution and/or civil proceedings where the matter has been reported to the police and the police have decided not to pursue the matter.
- To ensure that the details of the incident have been recorded on the Trust's incident reporting system to comply with Trust Policy.
- To ensure that an acknowledgment of the report is sent to the injured party and ensure that any necessary support arrangements, such as counselling or occupational health are offered. The acknowledgement should state that the matter will be dealt with, that action will be taken and that the particular member of staff will be kept informed of progress and outcome.
- To inform the person subject to the non-physical assault of the outcome of any action taken.

1.3 There are a range of sanctions that can be considered against those who carry out non- physical assaults against employees. These include:

Civil proceedings

- Proceedings based on the tort of assault.
- Anti-social behaviour orders: these are civil orders but may also be obtained in the Magistrates' Court (applied for by the police or the local authority).

Criminal Prosecution (Public or Private)

- Any use of threatening, abusive or insulting words or behaviour with intent to cause someone to believe that immediate unlawful violence will be used against him or another person contrary to the Public Order Act 1986, s.4.A.
- Intentionally using threatening, abusive or insulting words or behaviour or disorderly behaviour, with intent to cause a person harassment, alarm or distress contrary to the Public Order Act 1986, s.4.A.
- Using threatening, abusive or insulting words or behaviour or disorderly behaviour, which is likely to cause a person harassment alarm or distress contrary to the Public Order Act 1986, s.5.

- Carrying out a course of conduct leading to intentional harassment contrary to the Protection from harassment Act 1997, ss.1 & 2.

The Crime and Disorder Act 1998, ss. 31 & 31 have created a racially or religiously aggravated form of all the above criminal offences.

***2.* Physical assault:**

2.1 The police are to be contacted immediately (where appropriate) by the person assaulted, their manager or a relevant colleague. Staff should be aware that failure to report an assault to the police could adversely affect any claim for compensation under the Criminal Injuries Compensation Authority Scheme.

2.2 The Security Management Director and the Local Security Management Specialist must also be contacted as soon as is practicable by the person assaulted, their manager or a relevant colleague.

2.3 The Security Management Director (SMD) or LSMS will arrange:

- To contact the relevant NHS Protect, with specific information about the physical and non physical assault (within 7 working days). The report can be made electronically on SIRS.
- That full co-operation is given to the police investigation and any subsequent action, into a case of physical assault, including access to personnel, premises and records (electronic or otherwise) considered relevant to the investigation.
- That details of the incident are recorded on the Trust's incident reporting system to comply with Trust Policy.
- That all possible preventative action is taken to minimise the risk of a similar incident reoccurring.
- That an acknowledgement of the report is sent to the injured party and ensure that any necessary support arrangements, such as counselling or occupational health are offered. The acknowledgment should state that the matter would be dealt with, that action will be taken and that the particular member of staff will be kept informed of progress and outcome.

2.4 The Crown Prosecution Services (CPS) should undertake a criminal prosecution, if the police are handling the case. If the police are not handling the case or the CPS is unwilling to undertake a criminal prosecution, then the NHS Protect Legal Protection Unit, (LPU) will consider a private prosecution. Civil proceedings will be considered by NHS Protect LPU in consultation with the Trust and the person/persons subjected to the assault.

2.5 There are a range of sanctions that can be considered when dealing with those who physically assault NHS staff. These include:

Civil proceedings

- Proceedings based on the tort of Battery.
- Anti-social behaviour orders: these are civil orders but may also be obtained from the Magistrates' Court (applied for by the police or local authority).

Criminal Prosecution (Public or Private)

- Common assault contrary to the Criminal Justice Act 1988, s39.
- Actual bodily harm contrary to the Offences Against the Person Act 1861,s.47
- Wounding or inflicting grievous bodily harm contrary to the Offences Against the Person Act 1861, s.20.

In relation to the above, the Crime and Disorder Act 1998, s29 creates a racially or religiously aggravated form of these offences and increases the maximum penalties.

- Wounding or causing grievous bodily harm with intent contrary to the Offences against the Person Act 1861, s.18.

Appendix W: Trust Risk Assessment Proforma: Comparative risk assessment of accommodation at Alder Hey

The comparative risk assessment of accommodation at Alder Hey (wards / departments) for patients with challenging behaviour can be used as a basis for individual patients. It is not an exhaustive list and must be individualised, amended and added to based on the risk review.

Date of assessment....................................

Date of last assessment.................................

Department/Division.. Location..

Assessor.. Designation...

Nº	**Identifiable Hazards**	**Persons at Risk**				**Impact**					**Likelihood**					**Risk Category**				**Existing Controls**	**Adequate? Yes / No**
		EM	PT	VI	CO	5	4	3	2	1	5	4	3	2	1	1-3 (Very low)	4-6 (Low)	8-12 (Moderate)	15-25 (High / Extreme)		
1	Patient (*patient initials*) is known to abscond:		Y																		
	136 room locked						Y								Y		4			Room locked	
	136 room unlocked						Y						Y					12			
	DJU						Y							Y				8		Locked Unit, security	
	A ward						Y				Y								20	Swipe access, additional security	

2	Patient (*patient initials*) is at risk of self harm:		Y																		
	136 room locked						Y								Y		4			No access to harmful objects / situations	
	136 room unlocked						Y							Y				8		Limited access to harmful objects / situations.	
	DJU						Y							Y				8		Limited access to harmful objects / situations.	
	A ground / 1st floor ward						Y					Y							16	Bay / cubicle would need to be made ligature free / freed from harmful objects	
	A 3rd / 4th floor ward					Y							Y						20	Balcony on floor – risk if absconds	
3	Patient is at risk of social deprivation and lack of basic facilities		Y																		
	136 room locked						Y				Y								20	No ensuite facilities (toilet / bathroom) Dark small room, no window.	
	136 room unlocked						Y					Y							16	No ensuite facilities (toilet / bathroom) Dark small room, no window.	
	Tier 4 Inpatient Unit						Y								Y		5			Natural light, wider spaces, access to bathroom facilities	
	A ward						Y								Y		5			Natural light, wider spaces, access to ensuite bathroom facilities	

4	Patient is a risk to the safety of other CYP, staff and visitors due to known violence and aggression	Y		Y																	
	136 room locked						Y							Y				8		No access to CYP,	
	136 room unlocked						Y						Y					12		No access to CYP,	
	DJU						Y						Y					12			
	A ward						Y				Y								20		
5	The accessibility of care for other CYP is at risk of being compromised:																				
	136 room in ED: No access for other CYP; need to divert these CYP				Y	Y					Y								25		
	Wards with no non commissioned beds available: Bed closures to maintain a safe environment				Y	Y					Y								25		
	Wards with non commissioned beds available				Y	Y									Y		5				

	Ward	No	Reason	Yes (in principle)	Risks
6	SDC MDC EDU 1CN 1CC HDU PICU Burns 3A 3B 3C 4A 4B 4C CRF DJU				

EM = Employee, PT (PATIENT INITIALS) = Patient, VI = Visitor, CYP = Children and Young People

Date of this assessment....................................

Next assessment before...

Alder Hey NHS Foundation Trust

Risk Assessment - Action Plan

Department/Division ……..
Location...

Assessor...
Designation...

Nº	Action Required	Action By	Target Date	Completion Date

NHS
Alder Hey Children's
NHS Foundation Trust

Management Toolkit & Guidance Supporting Documentation Version 3

In conjunction with Alder Hey's E4 – SUPPORTING SICKNESS AND ATTENDANCE POLICY

Document Control Sheet

Supporting Sickness and Attendance Policy Toolkit	
Version:	3.3
Date approved:	March 2020
Name of originator/author:	Christine Cain, HR Adviser
Name of responsible committee:	Employment Policy Review Group
Date issued:	April 2024 (Extension)
Review date:	September 2027

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
3.3	April 2024	Katie Jones	Current	Extension until September 2024 agreed by Staff Side.
3.2	August 2023	Christine Cain	Archived	6 month extension in line with sickness policy
3.1	February 2023	Christine Cain	Archived	6 month extension in line with sickness policy
3	March 2020	Christine Cain	Archived	Supports updated policy
2.1	April 2019	Christine Cain	Archived	Interim extension
2	April 2016	Christine Cain	Archived	Amended to match changes in policy, introduced checklists and guidance notes
1	April 2014	Taffy Chisango	Archived	Review due 2016

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APPENDIX 1 NOTIFICATION OF ABSENCE FORM

This form is used to open the absence record and is to be completed on the first day of absence by the manager/supervisor or person receiving notification of absence from the member of staff.

Member of Staff Details					
Name:					
Department/Section					
Manager/Supervisor					
Notification given by: In all but exceptional circumstances this should be the member of staff					
Person receiving notification: In all but exceptional circumstances this should be the manager/supervisor					
Date and time of notification	Date:		Time:		
First date of absence	Date:		**Contact during absence:**		
Reason given for this absence: i.e. sickness, carers, domestic, other					
Type of Absence: Work Injury ☐ Work Related Sickness ☐ Pregnancy Related Absence ☐ Other Sickness ☐ Accident Outside of Work ☐ Did this accident cause you to consult a medical practitioner or attend hospital? ☐ Was your injury due to an accident involving a third party, e.g. road traffic accident ☐ **NB:** *If the answer is 'yes' and damages are received from third party you will not be entitled to occupational sick pay and would be expected to return the net pay to the Trust.*					
How notified: (Tick appropriate box)	Telephone ☐	In Person ☐	Email ☐	Text ☐	
Expected date of return (if known)	Date:		**GP Consultation:** Has the member of staff visited their GP? If not, will they be contacting their GP regarding their illness?		
Give details of work commitments e.g. meetings scheduled; deadline for processing work in progress etc.:					
Annual Leave Does the employee have any leave planned in the near future? If so provide details					
Did the member of staff leave during the day/shift?			YES/NO*		
If **YES**	What was the scheduled start and finish time?		Actual Start time:	Actual Finish time:	
Reiterate the importance to the employee the importance of keeping in touch with their manager during this period of absence. Advise the employee that a Return to Work Interview will be held with their manager on their return to work					
Further information (if applicable)					

APPENDIX2 RETURN TO WORK INTERVIEW FORM (For management use only)

Return to work meetings should be supportive and the opportunity to identify and review the overall sickness/durations. They are crucial in effectively managing absences allowing both the manager and the employee to discuss the period of sickness and to see if any specific assistance is required and to make the employee aware of the number of absences/days in relation to the short term sickness triggers. The return to work interview form should be mutually discussed and signed detailing all supported offered whether accepted or not. Managers are required to enter onto the MSS system the date of RTW no later than 7 working days.

This is to be an informal *interview and the form is to be completed for every occasion of sickness absence*, by the line manager (or equivalent) within 48hrs (or as soon as possible) of the return to work. On completion, the line manager must enter the date of this interview on the MSS system and retain a copy on their file securely. By completing this form, you are confirming that the employee has fully completed and returned to you the Trust Self Certificate held in Appendix D of the Supporting Sickness & Attendance policy.

Name:	Ward:	Division:	Hrs of Work:
RTW Interview		Telephone	
Nature of Illness:			
Date Absence Commenced		Date absence finished		Total Calendar Days	
Total Absence during last 12 months	/State number of Days on? Occasions?		
Has the employee completed and signed the Trust Self Certificate to your complete satisfaction? (If No, refer to Appendix D of the policy to ensure that this is done)	Yes❑ No❑	On the Trust Self Certificate has the employee declared that they have worked during their absence?	Yes❑(refer to HR) No❑
Ensure that the absence triggers are explained to the employee so they are fully aware of policy implications. Has this been done**?**			
Has the employee hit a trigger as stated in the policy?	Yes❑ = *confirm possible formal meeting but do not discuss this in detail and refer arrange separate appropriate meeting liaising with HR for advice where required.* No❑= *confirm any previous absence and ensure they are of triggers*		
Explain that any confidential information made known will be not be disclosed other than to the employee's line management and HR/ Occupational Health			
If you are a clinician, explain that you are seeing the employee in your role as their manager not their clinician.			

Did employee:

Comply with the departmental reporting arrangements?	Yes❑	No❑
Give details/reason for the absence?	Yes❑	No❑
Give expected duration of absence/date of expected return?	Yes❑	No❑
If you have answered 'no' to any of the above please note any reasons/explanations and any follow-up action taken:		
Does the employee consider themselves to have a disability under the Equality Act? *If yes detail what support has been implemented in consideration of this (Contact HR if required)*	Yes❑	No
What stage of the Supporting Sickness and Attendance Policy and Procedure is the employee at after this period of absence?		

None❑	Stage 1First Formal❑	Stage 2 Final Notification❑	Stage 3 Formal Hearing❑

Is the absence covered by:	Self certificate❑	Medical statement❑

Give brief details of the reason for the absence (if relating to accident/incident at work give details & attach any relevant forms):

Is the member of staff fully recovered?	Yes❑	No❑

If 'no' please explain health condition and any factors associated with resumption arrangements:

Does the employee consider it likely that they will have further absences due to their medical condition? **If yes detail below, discuss with HR & obtain advice from the Occupational Health Service.**	Yes ❑	No ❑	
Has a phased return to work or adjustments been advised by Occupational Health?	Yes❑	No❑	N/A❑

If 'yes' please give details of hours/days/patterns of hours agreed and period after which this will be reviewed: (Take into consideration the recommendations from Occupational Health)

Are reasonable adjustments necessary e.g. to the workplace/duties	Yes❑	No❑	N/A❑

If 'yes' please give details:

Additional comments or details of further action:

E.g. appointment with occupational health, follow-up meeting to discuss progress, arrangements of formal interview to discuss sickness absence levels as per Trusts procedure, review of work arrangements etc.

Date for review (if appropriate)	Date of Return to Work Interview

INFORM OF NEXT STAGE & DETAIL ADDITIONAL NOTES OR COMMENTS (INCLUDING AGREED ACTION POINTS FROM ABOVE EMPLOYEE BELOW AND SIGN AS CONFIRMATION.

NB: Failure to declare accurate and truthful information on this form may lead to disciplinary action and result in matters being referred to the Trust's Local Counter Fraud Specialist to investigate.

I am signing to confirm that the information that I have provided during my return to work interview is correct to the best of my knowledge and that during this period of sickness absence I have not undertaken any paid or unpaid employment (without prior agreement) whilst also claiming sick pay from the Trust.

Name & Signature of Manager:	Name & Signature of Employee:

Managers Comments:

SECTION A

SHORT TERM SICKNESS ABSENCE

APPENDIX3 SHORT TERM SICKNESS ABSENCE

1 INVITE TO STAGE 1 - SHORT TERM FIRST FORMAL ABSENCE REVIEW MEETING LETTERHEADED PAPER

DATE:

Strictly Private & Confidential
ADDRESS:

Dear NAME

Re: Stage 1: First Formal Meeting Invite

Further to your recent absence, I am writing to invite you to attend a Stage 1 First Formal Absence meeting in accordance with the Trust's Supporting Sickness and Attendance Policy. The purpose of the meeting is to enable us to review your absences and identify any support we can offer to help you to improve your attendance at work.

Arrangements have been made to meet with you on DATE at TIME in ROOM/Venue. Also present at this meeting will be NAME, HR as a representative from the Human Resources Department. *(Only if requested by manager/agreed but not compulsory at stage 1 of policy delete as appropriate)* You have the right to be accompanied to this review meeting by a recognised trade union representative or work based colleague. If this is the case you are required to contact me in advance so that the necessary arrangements can be made. You should be aware that it is your responsibility to arrange your representative's availability.

In the event you are unable to attend on the date specified you are required to notify me on STATE NUMBER or email: STATE EMAIL ADDRESS no later than 2 working dates before the date arranged stating the reasons where re-arrangements will be made within five days of the original date, or as soon as practically possible.

I would advise that you read the Trust's Supporting Sickness and Attendance policy which is available on the Trust's intranet, so that you are aware of this process. If you cannot gain access to the intranet please contact myself for a copy of this policy.

If you have any queries in advance of the meeting please do not hesitate to contact me.

Yours sincerely

LINE MANAGER
TITLE

APPENDIX 4 STAGE 1 & STAGE 2 MANAGEMENT CHECKLIST & NOTES

This form is provided for guidance and/or part of the note taking if required. The outcome should be followed up as a letter using the template letter in appendix *

PRIVATE & CONFIDENTIAL

<table>
<tr><td>

<u>**To be Completed Prior to Formal Meeting**</u>

Name of Employee: .... Stage Number: .... Ward:........... Division:................

Detail number and frequency of sickness absence(s) over the last 12 months including trigger point hit:

....

Any Medical Assessment's by Occupational Health?

....
....

Any Assistance/adjustments discussed and made to date:

....
....

</td></tr>
<tr><td>

<u>**During Meeting Script and Prompts**</u>

1. **Introduce** all, REP NAME ..../
2. **State Purpose** of Meeting: Confirm absence unacceptable, aim to reduce the risk of further absence requirement to help by
3. identify and provide any further support where identified and for staff member to ensure they apply own self help where necessary.
4. Refer to the flow chart in the policy to demonstrate to the staff member where they are on the policy
5. **Confirm this is Stage 1 /Stage 2** *of policy(**delete as appropriate*) with Review Date due ....STATE...
6. Dates& nature of absences since previous stage:
....
7. Detail **employee's comments**...
....
....
8. **Detail other support** offered prior to this meeting:
....
9. Are there any reoccurring sicknesses and/or themes?...
10. What **further support** does the employee require?
………………………………………………………………………….
11. Are there **any factors** affecting the absence levels?...
12. Can the employee envisage any potential issues which may lead to further absence?
....
....

</td></tr>
</table>

13. Are there any **further adjustments** or considerations?

- If Yes - Agreed / Not Agreed **(delete as appropriate)*
- If Not Agreed state rationale: ………………………………………………………………………………….

14. Has the employee raised any **significant mitigating circumstances**?..
....
....

15. Confirm a **referral OH for an update** if not already or refer to OH should the employee go off sick following this meeting.(Managers Note *before any procedure to a Stage 3 of the policy will an up to date OH report will be required).*
16. Confirm **the outcome** (Stage: 1 or 2 *)(*delete as appropriate) with a **12 month review**.
17. Refer to the flow chart to demonstrate **where they are in the policy**, **unacceptable levels** and **further absences** as stated in policy **will result in stage 2 meeting /stage 3 hearing** (*if stage 3 confirm that this is a hearing and potential outcome could result in termination of contract*)
18. **State the impacts** the absence is having on the service/department.
19. Confirm a letter will be issued in writing summarising the content – not verbatim

<u>**After the meeting**</u>

- **Confirm the outcome** of your meeting **in writing** to the staff member using the templates below
- **Retain copies** securely in your file

APPENIDIX 6 SHORT TERM: INVITE TO STAGE 2: LETTERHEADED PAPER

Date*

Strictly Private & Confidential
Employees Full Name
Home Address
Post Code

Dear First Name

RE: Stage 2 Final Formal Notification Invite

Following your Stage 1 First Formal Absence Review Meeting held on DATE, you have now been absent during the 12 month review period as follows:-

STATE DATES IN BULLET FORM AS PER TRIGGERS DEFINED IN POLICY

In light of the above, you are invited to attend a Stage 2 Final Formal Absence Review Meeting in accordance with the Trust's Supporting Sickness and Attendance Policy.

The purpose of this meeting is to review your absence record since your Stage 1 meeting and where possible, identify any further support we can provide to help you to improve your attendance at work.

Arrangements have been made to meet with you on DATE at TIME in ROOM/Venue. Also present at this meeting will be NAME, HR as a representative from the Human Resources Department **(in exceptional circumstances).* You have the right to be accompanied to this review meeting by a recognised trade union representative or work based colleague, if this is the case please advise me accordingly. You should be aware that it is your responsibility to arrange your representative's availability.

In the event you are unable to attend on the date specified you are required to notify me on STATE NUMBER or email: STATE EMAIL ADDRESS no later than 2 working dates before the date arranged stating the reasons where re-arrangements will be made within five days of the original date, or as soon as practically possible.

I would advise that you read the Trust's Supporting Sickness and Attendance policy which is available on the Trust's intranet, so that you are aware of this process. If you cannot gain access to the intranet please contact myself for a copy of this policy.

If you have any queries in advance of the meeting please do not hesitate to contact me.

LINE MANAGER
JOB TITLE

Cc: Human Resources Department

APPENDIX 7 STAGE 2 SHORT TERM OUTCOME LETTERHEADED PAPER

Date

Strictly Private & Confidential
Employees Full Name
Home Address Line 1
Home Address Line 2
Home Address Line 3
Postcode

Dear First Name,

RE: Stage 2 – Outcome of Final Formal Notification Meeting

I am writing to confirm the outcome of your Stage 2 Final Formal Absence Meeting which was conducted in line with the Trust's Supporting Sickness and Attendance Policy. The meeting was held on **DATE**, **Name** *attended as a representative from the Human Resources (dependant)* Department and I note that you were/ were *not* accompanied at this meeting *by **NAME***.

At this meeting I considered your absence record during your review period in that you have been further absent as follows:-

DETAIL ALL RELEVANT ABSENCES & REASONS DISCUSSED HERE

I can confirm that further to reviewing your absence(s) you have reached the trigger point of having had STATE EITHER (3x 12 rolling/ 10 days plus or any pattern detail) and therefore confirmed you are at Stage 2 Final formal notification of the policy for a further 12 month review period until STATEDATE(is taken from last date of absence).

During the meeting we discussed additional support that may help you to improve your attendance and we agreed that DETAIL ANY SUPPORT HERE IF APPROPRIATE. We also discussed a referral to occupational health and agreed this was necessary / not necessary if No explain why.

I reiterated to you that your current level of attendance is unacceptable and that any further episodes of absence will result in a move to Stage 3 – Dismissal Formal Hearing. You should be aware one potential outcome of such a meeting may result in termination of your contract of employment. I referred to my letter of DATE in which I reminded you of the way in which significant sickness absence can adversely affect the work of your Department and place an additional burden on your colleagues.

You were asked to notify me of any difficulties or changes in your circumstances, which could adversely affect your attendance.

With the support proposed as agreed, I am hopeful that you are able to achieve and sustain an acceptable level of attendance. Again, should you at any time feel that I might be of assistance to you in any matter relating to your employment then please do not hesitate to contact me.

If you have any queries in relation to any of the above please do not hesitate to contact me.

LINE MANAGER
TITLE

APPENDIX 8 REQUEST TO ATTEND MEETING UNDER STAGE 3 SHORT TERM FINAL HEARING

Private and Confidential

Name
Address

Date

Dear xxx

Stage 3 Dismissal – Final Formal Hearing Invite

I am writing further to our discussion on (dates of stage 2 discussions and any subsequent reviews) regarding your unsatisfactory attendance. As this has not satisfactorily improved you are required to attend a stage 3 meeting with myself and ………. (any other manager who will chair the meeting – NB HR Manager must also be involved at this stage)**,** on ………… (date), at ……… (time). This meeting will be held in ………. (venue).

I wish to discuss the ongoing attendance issues previously identified to you at previous meetings on (list dates) held under the Trust's Supporting Sickness and Attendance policy**.**

You should be aware, that one potential outcome may result in your contract of employment being terminated as such you are advised to be accompanied by a trade union representative or work colleague.

A copy of the Trust's Supporting Sickness and Attendance policy has previously been provided to you. However, if you require a further copy, please let me know. Please find attached a copy of the management report which will be presented on the date *(please refer to appendix 20 and contact your HR rep delete*)*

Please contact me as soon as possible if you are unable to attend in order that I may arrange an alternative date and time, within 5 working days after (**date of this suggested meeting**), for this meeting.

Yours sincerely,

c.c. Personal File

APPENDIX 9: NOTIFICATION OF DISMISSAL DUE TO UNSATISFACTORY ATTENDANCE UNDER STAGE 3

Private and Confidential

Xxx

Date

Dear xxx

Re: Stage 3 Hearing Outcome

I am writing further to our meeting on xxx, in accordance with the Trust's xxx policy, at which we discussed your attendance. Present at the meeting were myself and xxx, and xxx as Human Resources Manager, with xxxxx (line manager) and xxxx (HR Advisor). For the record, you were accompanied by/chose not to be accompanied.

At the meeting you were informed that, despite previous warnings, your attendance had continued to remain at an unsatisfactory level [outline specific failure]. You have been formally advised of this on previous occasions and have been given adequate time and support [define support provided e.g OH] to improve your attendance. You were warned at a Stage 2 meeting on xxx that any further absences during the three month review period may lead to a Stage 3 hearing, which could result in the termination of your employment.

This letter is to confirm the outcome of the Stage 3 meeting which was held on xxx. It is with regret, therefore, that I give you formal notice of termination of your employment on the grounds of your continued poor attendance record despite previous warnings.

(If termination is the outcome): In accordance with your contract of employment you will receive x weeks pay in lieu of notice and will also receive any outstanding annual leave. You are not required to work your notice period, and will not be required to attend for duty after xxx.

You have the right to appeal against this decision in accordance with the Trust's Appeals Procedure. Any appeal must be made in writing, and should be addressed to the Director of Human Resources. It should be submitted within 10 working days of the date of this letter. (Send copy to HR for files and complete leavers form and send to employment.services@alderhey.nhs.uk)

If contract to continue state rationale and confirm further extension and 12 month review. & send copy to HR for files.

Yours sincerely,

c.c. Personal File

SECTION B

LONG TERM SICKNESS ABSENCE

(4 WEEKS +)

APPENDIX 10 GUIDANCE FOR MANAGING LONG TERM SICKNESS

Managers can refer to a guidance checklist in appendix 13 for reference and should confirm the outcome of all meetings discussed using the templates designed for long term sickness provided in appendices 12 & 14.

The purpose of "level" meetings is to support the staff member and explore any assistance they may require to facilitate a return to work. At these meetings the following issues may be considered:

- Occupational Health advice and any other medical advice available.
- Potential return to work and any adjustments that may be required either temporary or permanent and if
  this should be on a phased basis. This must always be fully considered if the staff member has a disability.
- Potential for re-deployment if advised by Occupational Health
- Any re-training, mentorship or additional support needed.
- Ill Health Retirement, if applicable.

Managers are required to observe the minimum timeframes in accordance with the level of the meetings in order to manage long term sickness absence and liaise with OH and HR for advice.

Level 1 – Welfare Review (> 4 Weeks < 8 Weeks)

Long term absences is sickness for four weeks or more or were a foreseeable return to work is not envisaged:-

Throughout the period of long term sickness, regular contact will be maintained between both the staff member and the immediate manager/supervisor, at least when submitting each fit note. Initial contact from the staff member to the manager should be made via telephone where possible.

Staff members should ensure regular timely medical updates to the manager for the duration of absence where this is possible. Text is not considered appropriate except in exceptional circumstances.

Where absence extends or is expected to extend beyond 4 weeks the manager will contact the staff member, as mentioned above, and will normally refer the staff member to Occupational Health. Referrals should be made using the appropriate Occupational Health form located on the intranet. If the sickness was as a result of stress/musculoskeletal or planned surgery, then referrals should be made on first date of the absence.

The staff member should be informed that a referral to occupational health will be made and explain their entitlements to see any subsequent report produced by the OH Physician or Nurse Advisor.

Where a staff member has indicated an imminent return to work after the 4-week period and the manager decides that a referral to Occupational Health would not be beneficial to the staff member, it is not necessary to make such a referral. However, it might be necessary to deal with the absence under the Short-Term Absence part of this policy and advice should be sought from the Human Resources Department.

Level 2 Welfare Review (>8 Weeks < 12 Weeks)

The purpose of this meeting is to provide support to the staff member and the meeting should be conducted sensitively. A copy of the Supporting Sickness and Attendance Policy should be made available to the staff member as soon as possible prior to this meeting.

Following receipt of the Occupational Health report the staff member should be invited, in writing to attend a Level 2 Welfare Meeting. The purpose is to provide any further support with the aim of facilitating an earlier return to work where medically recommended. Management should discuss any reports produced by Occupational Health and the advice regarding such a return to work.

Managers are expected to exercise judgement in respect of the appropriate timing of Occupational Health referral and the scheduling of meetings with the staff member based on the individual circumstances (e.g.it may not be appropriate to make these arrangements if the staff member is very seriously ill at that time and could not reasonably be expected to attend in either case management should refer to a Human Resources Representative).

Potential outcomes of this meeting may include one or more of the following:

- If not already done, the staff member should be referred to the Occupational Health Department for assessment and a further review meeting arranged if there is no return to work advised.
- Discuss and Review with the staff member all the information available, including Occupational Health advice if available.
- Discuss and agree a facilitated return to work to ease the staff member back in to their normal working pattern. Taking into account any advice from Occupational Health a structured plan involving reduced hours and/or duties may be formulated over an agreed time period, normally no more than four weeks, during which the staff member will be paid their normal contractual hours.
- If there is no return to work, as advised by Occupational Health, inform staff member that a review of their medical situation will occur at a Level 3: Final Review Hearing. This will be arranged by the Manager within 4 weeks.

A standard letter should be produced outlining the details of this meeting and any actions taken. A copy of the letter should be sent to the staff member, the relevant HR Advisor and Trade Union representative if requested by the staff member.

Where the absence continues and/or Occupational Health indicates a requirement fora periodic review, careful monitoring should take place. Managers and staff members should maintain regular contact during periods of absence by means of both telephone and further welfare meetings. Where absence extends beyond a 3 month period then further advice should be sought from Occupational Health regarding future actions. Please refer to the Occupational Health referral form found here.

Underlying Health Conditions

If the Occupational Health Service advises of a significant underlying health condition, the manager should discuss the implications with Occupational Health. In some cases a staff member’s condition may be managed with suitable accommodations allowing the possibility of a return to work (refer to appendix 15 - Planning adjustments/accommodations)

Outcomes may include the following:

- Consider/complete an application for ill health retirement if appropriate.
- Consider adjustments to the staff member's current post, including a change of hours, job restructuring, adapting equipment, or retraining. These options should be considered on either a temporary or substantive basis according to individual circumstances, with advice from Occupational Health and HR.
- Consider a graduated return over a planned and monitored period of 4 weeks.
- Consider redeployment into another post if the individual is able to return to the Trust but not within their current post. These options should be considered on either a temporary or substantive basis according to circumstance with advice from Occupational Health if required.
- Request further information from the Occupational Health Department.
- Review all the information available and decide that no further action other than a letter on the staff member's personnel file is required.
- Consider whether the service is able to sustain the sickness absence until the return date or if no there is still no imminent return to work date considers options to move the next level of the procedure.

A standard letter (as indicated in appendix 12 & 14 of this toolkit) should be produced outlining the details of this meeting and any actions taken. A copy of the letter should be sent to the staff member, the relevant HR Advisor and Trade Union representative if requested by staff member.

A level 3 final review hearing will take place in the following circumstances:

- The staff member remains unable to return to work.
- Medical opinion or clarification has been received in relation to the staff member's health.
- Unable to plan a return to work with adjustments or to consider redeployment.
- The Occupational Health Department has advised that due to the staff member's health condition, a return to work is unlikely in the foreseeable future.

Level 3 Final Review Hearing (>12 Weeks)

Where Occupational Health advises that the individual is unlikely to return to work in the foreseeable future then a decision may be made to fairly dismiss the staff member on the grounds of ill health. This is on the basis that there is likely to be continued absences from work on a regular basis, the service/department is unable to sustain this level of sickness absence and no suitable alternative employment has been found.

The manager should arrange to meet the staff member at the earliest opportunity to discuss the likelihood of this decision and their entitlements. The staff member will have the right to be accompanied by a Trade Union representative or workplace colleague.

The Manager will need to consider whether the individual's condition is covered by The Equality Act 2010 (see appendix 15 of the toolkit) and the eligibility to apply for ill health retirement benefit at Tier 1 or Tier 2 following advice from Occupational Health (refer to section 17 of the policy NHS Ill Health Pension for further details)

APPENDIX 11 COMMUNICATIONS LOG

Name of Employee:	
Department:	
Job Title:	

Date Absence Began:	
Diagnosis:	

Date & Time of Communication	Form of Communication	Details

Notes:

Date of Formal Meeting	Outcome

Date of Occ Health Appt	Outcome

Date Returned to Work:	

Details of Any Phased Return and/or Reasonable Adjustments:

APPENDIX 12: NOTIFICATION TO ATTEND MEETING REGARDING LONG TERM (SEE IMPORTANT FOOTNOTE)

Example Letter

Private and Confidential

Xxx

Date

Dear xx

Level STATE Welfare Meeting

I am contacting you further to my *letter dated/phone conversation* on (**insert date**) in respect of your current absence from work due to (**insert reason**) since (**insert date**).

I hope that you are making good progress back to full fitness and as outlined within our previous letter/as discussed during my last phone call* delete as appropriate I would like to make arrangements to meet with you to understand how we can continue to provide you with assistance and help. Therefore in line with the Trust's Supporting Sickness and Attendance Policy I wish to arrange a welfare meeting with you to discuss your current situation, provide any necessary support and explore how we can assist your return to work once you are fit to do so.

I would like to meet with you on **DATE** at **TIME** in **VENUE**. Alternatively, if you are medically unable to come in to see us we can arrange to visit you at home. Upon receipt of this letter I would be grateful if you could contact me on **NUMBER** to confirm your attendance or agree alternative arrangements as may be appropriate.

At the meeting you may wish to be accompanied by a trade union representative or workplace colleague. You should be aware that it is your responsibility to arrange your representative's availability.

I look forward to meeting you on (insert date) however in the meantime should you require any further information then please do not hesitate to contact me.

If you require any further information then please do not hesitate to contact me.

Yours sincerely,

c.c. Personal File

IMPORTANT

If, having been following the Trust's Procedure the meeting being arranged is at a formal stage where dismissal could be a possible outcome of that meeting then the employee must be advised of this possibility in the formal invitation to attend letter. This is a legal obligation. In all such cases advice must be sought from the Human Resources Department on the additional information/wording of the letter based on the individual circumstances of the case.

APPENDIX 13: CHECKLIST FOR LONG TERM SICKNESS MEETING

PRIVATE AND CONFIDENTIAL

Please use the below checklist to obtain the following information while remembering that any disclosure must be on a voluntary basis.

Having completed the form please retain a copy on your file ensuring information kept is private and confidential.

Employee Name		**Meeting Date**	
Level of Meeting		**Fit Note Expiry Date:**	*(NB If expired classed as unauthorised absence and are required to issue new without delay)*
Ward/Dept.		**Manager Name**	
Date OH Report:		**Representative Name:**	

Inform the Employee about the purpose of the meeting – the meeting is conducted in accordance with the Sickness Absence and Management Policy. If no representation present – obtain confirmation that the employee is happy to continue unrepresented?
Review with Employee: What is the length of current absence, reason for absence, submission of Fit Notes *(have they been timely? If no reiterate reporting procedures)* What is the estimated length of absence? *If employee has not been referred to OH to date, please advise that a referral is require and reiterate the importance of attendance at appointments*
Has the Employee any Medical problems/disability that may affect their future attendance at work, inclusive of this absen reason?
Is the employee in receipt of any Treatment/Support and could referral to OH provide additional support? *If yes please detail. Is the Employee continuing to take any medication?*
Is the Employee aware of any treatment planned for the future *(e.g. Specialist appointments, Wellbeing reviews etc if Yes please detail i.e. Dates)*
What is the Employees own assessment of likely return to work date*(please ensure that you ascertain the Employee's own opinion; if they cannot envisage an imminent return please detail this).*

What is their GP/Specialist's assessment of likely date for return
Employee's own thoughts about his/her suitability to return to their training programme *Can the following be considered: i.e. Phased return to work, employment break?*
Can the Employee anticipate any problems on return to work and would they require any adjustments or restrictions? Would a phased return be an option? (*If yes please detail and also detail any support that may be offered).*
Any other comments Inform Employee of next steps including any further review meetings, expected contact dates for telephone updates and ensure that they are aware that HR may be present at future meetings if absence continues to look at alternative support and further options

Agree a date for next welfare			
Agree timescale for continued telephone contact i.e. every 2 weeks			
Advise that a copy of the welfare meeting will be forwarded to the HR Management team and a copy will be maintained on their personal file			
Reviewing Officer Signature		**Date**	
Employee Declaration			
I confirm that the above information is accurate and that (tick as appropriate)			
I have not done any work, paid or unpaid during the period of time I have been absent from work through illness. **Or**			
I have undertaken work during the time I have been absent from work through illness. Please provide details			
Employee Signature		Date	

APPENDIX 14 LONG TERM SICKNESS WELFARE OUTCOME LETTER

Strictly Private & Confidential

Full Name
Home Address Line 1
Home Address Line 2
Home Address Line 3
Postcode

Date:

Dear First Name,

Re: Level 1/2/3 (delete as appropriate) Welfare Review Outcome

I am writing to confirm the outcome of our recent Level 1 Welfare Review Meeting which was conducted in line with the Trust's Supporting Sickness and Attendance Policy. The meeting took place on **DATE** and I note that you were/ were *not* accompanied at this meeting *by* ***NAME***. Also in attendance was **Name, Job Title,** from Human Resources (delete as appropriate).

The purpose of this meeting was to review your long term absence that commenced on DATE, and to decide the next steps in line with the Policy. You updated me on your current medical situation confirming the following:-

DETAIL HERE A SUMMARY OF THE DISCUSSIONS WHAT WAS SUGGUESTED AND AGREED ETC

We reviewed the Occupation Health report dated DETAIL SUMMARY OF DISCUSSIONS AND PROPOSALS
From the information provided and discussed, we agreed DETAIL HERE AGREED ACTIONS AND NEXT STEPS & CONFIRM NEXT LEVEL OF MEETING AS DEFINED IN THE TIMELAND STATED IN THE POLICY CONTACTING HR BEFORE PROCEEDING WITH A LEVEL 3.

Yours sincerely

NAME
TITLE

Cc: Personnel File (issue a copy to your HR Rep)
Staff Side (if applicable)

APPENDIX 15: GUIDANCE FOR MANAGING DISABILITIES PLANNING/ADJUSTMENTS/ACCOMODATION

Managing Disabilities

i. The Equality Act 2010 (2010) defines disability as follows:

The person's ability to carry out normal day-to-day activities can be adversely affected in one or more of the following ways:

- Mobility
- Manual dexterity
- Physical co-ordination
- Ability to lift or otherwise move everyday objects
- Speech, hearing or eyesight
- Memory or ability to concentrate, learn or understand
- Understanding the risk of physical danger

ii. However, some conditions are identified as coming under the Equality Act with or without symptoms e.g. depression where medication is used.

iii. Where an employee has a disability, advice may be sought from Occupational Health and/or Equality & Diversity Manager and a risk assessment carried out to identify if any reasonable adjustments need to be made to support the individual in work. Employees and Managers should also refer to the Trust Access to Work process on the equality and diversity intranet site here and if relevant, advise staff to contact the Access to Work Scheme.

iv. It is important to encourage employees to disclose a health-related or other impairment at the start of employment, during employment or during the absence period, for example to enable reasonable adjustments to be identified.

2 Disclosing Disabilities

i. There are many reasons why disabled people may not disclose a health related or other impairment (such as fear of negative misconceptions, prejudicial treatment, wanting to fit-in etc.). Many people who fall under the Equality Act definitions may not choose to use 'disabled' as a label to describe themselves.

ii. The extent to which an employer knows of any impairment can also be determined by an employee's request for confidentiality. If an employee has disclosed an impairment in confidence to any individual in the organisation (such as Occupational Health) then the Trust can argue that it did not know about the disability, as long as 'reasonable' steps have been taken to find out.

iii. ‘Reasonable’ steps to find out about employees’ health condition or impairment might include assuring staff that harassment and victimisation will not be tolerated, that disclosure is only requested so that the employer can support staff in carrying out duties, and that every effort will be made to retain staff if they are disabled or have acquired a disability whilst in employment.

iv. If failure to disclose a disability would adversely affect Health and Safety then Occupational Health would advise the individual of the need to inform the employer.

Managing Attendance and Disability

i. Where it becomes apparent that an employee’s attendance is being affected by their disability (e.g. at an informal meeting with the employee to discuss concerns regarding attendance) there should be a referral to Occupational Health for support and advice.

ii. Reasonable adjustments should be considered and outcomes agreed to support the employees improved attendance or to reduce the need for absence and allow for occasional planned absences

iii. A time frame should be identified for review of any reasonable adjustments. It may be necessary to continue with the review process over an agreed period to continue to support the employees improved attendance.

iv. Where reasonable adjustments are used, care must be taken to ensure that the employee has the support of managers and colleagues. With the approval of the individual concerned, they may need to be made aware of the nature and purpose of the adjustments. This will help raise awareness of Equality Act requirements and reduce the risk of discrimination, victimisation and harassment.

v. The disabled employee is reasonably expected under the Equality Act 2010 to modify their behaviour to prevent and reduce the effects of impairments on normal day-to day activities to fulfil their role.

Planning and undertaking workplace accommodations or adjustments

I. Where the staff member is considered unfit for their present duties but fit for modified duties or a different type of job, every effort will be made to find suitable alternative employment or make suitable reasonable adjustments where this has been identified by occupational health, within a reasonable period of time.

II. In considering potential alternative employment a period of three months will normally be used during which potential alternatives will be explored. Records must be maintained of actions taken by Managers and Occupational Health (using the re-deployment form in this toolkit/below) with regard to this and any potential alternatives which are explored. Managers are required to e-mail the re-deployment form to their HR representative so that

the employee can be entered on the redeployment risk register which is held within the HR Department.

III. At the end of the three month period if no suitable roles have been identified or completed or if the staff member has refused suitable alternative offers of employment, then managers should refer to a Level 3 Final Hearing as detailed in the policy.

Examples of Workplace Adjustments

I. Trust has specific legal responsibilities and, in the case of staff members who have a disability within the meaning of the Equality Act (2010) to make reasonable adjustments. However, there is no onus on the Trust to create a job or to protect pay. Therefore, this financial consideration must be borne in mind by both parties in making an offer or accepting an offer of what may be 'suitable' alternative employment.

II. Workplace adjustments can be made on either a temporary or permanent basis.

III. Examples of adjustments to working arrangements include:

Examples of reasonable adjustments that may be appropriate include:

- providing specialised equipment; e.g. IT equipment
- reallocating work
- Phased return using accrued annual leave
- Changing an individual's working hours/shift pattern etc.
- Providing help with transport to and from work
- Arranging home working, providing a safe environment can be maintained
- Allowing an employee to be absent from work for rehabilitation treatment

Examples of adjustment to premises include:

- Moving tasks to more accessible areas
- Making alterations to premises / work station / work area

Examples of adjustments to a job include:

- Providing new or modifying equipment and tools
- Job share/part time working
- Flexible working choices such as buying back annual leave, career breaks
- Modifying work furniture
- Providing additional training
- Modifying instructions or reference manuals
- Modifying work patterns and management systems
- Arranging telephone conferences to reduce travel
- Providing a buddy, mentor or supervision:
- Providing training
- Reallocating work within the employee's team
- Providing alternative work through redeployment, secondments etc.

IV. Any adjustments should be documented clearly and certified in writing to employee clearly stating whether temporary or permanent in nature.

V. Reasonable adjustments should be implemented and tested to evaluate their effectiveness for the individual in that particular job. There may be a number of meetings with the individual to review the effectiveness of the reasonable adjustments making further adjustments if necessary.

VI. Reasonable adjustments should be supported by information, instruction, training and supervision; and allowances should be made for adapting to new and equipment when performance is assessed.

VII. Any temporary adjustments must specify the agreed timeframe in which a return to fill "normal" duties is required. If after the agreed timeframe the employee is or feels unable to return to their contacted role, then a further referral to Occupational Health should be made along with notification to your HR representative.

Access to Work Scheme

i. To support disabled people in the workplace the government has developed the Access to Work Scheme. The scheme is run by the Department of Work and Pensions and encourages employers to recruit and retain disabled people by offering practical help for employers and staff that can be tailored to suit the needs of an individual in a particular job. Access to Work also provides funding towards any extra employment costs resulting from a person's disability to ensure that disabled staff can work on an equal basis with their non-disabled colleagues.

ii. Details of the Access to Work Scheme and further advice and information can be found on the Access to Work web pages at www.gov.uk[1] together with Trust guidance on the E&D intranet pages found here.

iii. Employees are required to contact Access to Work and make the arrangements notifying their manager of the outcome and any correspondence/timeframes that is associated with this.

Absence from Work due to Disability

i. Disabled employees may have cause to be absent from work for disability-related reasons. These include absences for consultant's appointments, physiotherapy, hearing and adjustments/replacements which are considered as reasonable adjustments (as stated above). In addition to treatment or medical consultation and/or recuperation, disability-related absence can also include rehabilitation (if the impact of impairment deteriorates or if an employee acquires impairment) and training for specialist equipment.

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[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/184941/Access_to_work_eligibility_letter.pdf;

ii. Certain disabilities (such as Cystic Fibrosis or conditions that require immune-suppressant prescribed medication) may make employees more susceptible to infection. Guidance may be sought from Occupational Health regarding whether any reasonable adjustments can be made. Advice and support is available to Managers in this area from the Human Resources and Equality and Diversity departments.

iii. Absences related to a disability will be managed through this policy, with consideration for the appropriateness of trigger levels. It may be considered appropriate; following the advice given from Occupational Health, not to advance the employee through the stages of the sickness absence policy, for example if the sickness absence is deemed entirely attributable to their disability.

Redeployment

The redeployment process should involve an examination of the individual's skills, experiences and training needs and the template should be used within this policy (appendix 16) and you should issue a copy to your HR representative.

Wherever possible:

- these should be matched to current and future vacancies over a period not exceeding three months
- the individual should be redeployed at least at the same level and salary and should ideally be a substantive post where possible.
- If the individual meets the person specification for the vacant position he or she should not be subject to competitive interviews

Management of Staff Being Treated For Life Threatening Illnesses

i. A person with a diagnosis of Cancer[2], HIV and MS are deemed disabled and offered protection under the Equality Act 2010 from the point of diagnosis.

ii. The absence management of a member of staff with these illnesses or any other life threatening illness or progressive condition should be handled sensitively. If a member of staff is off work with a long term absence, and they are unable to resume work in the near future, potentially their contract of employment may be terminated on the grounds of ill health. For the purposes of managing staff with life threatening illnesses, the Trust may look at extending their period of leave, (for example if their condition is terminal); or may support alternatives such as a career breaks or other various pensions' options. In any case, management are required to contact a representative from the HR department.

2 http://www.macmillan.org.uk/

APPENDIX 16: SICKNESS ABSENCE PERMENANT RE-DEPOLYMENT FORM

Name (In Full)		Contact Details	

	CURRENT EMPLOYMENT							PROSPECTIVE EMPLOYMENT						
Job Title/Band/Dept														
Salary p.a														
Hours worked p.w														
Days worked (x)	*M*	*T*	*W*	*T*	*F*	*S*	*S*	*M*	*T*	*W*	*T*	*F*	*S*	*S*
Hours on each day if different														
Shift Pattern (Give Details)														
Line Manager														
Limitations:								All Qualifications/Skills						

POSSIBLE SUITABLE ALTERNATIVE EMPLOYMENT:			
Types of Post (*Please List)*		Protection *(If applicable*)	
Alternative Hours (*Please specify)*		Date placed on "At Risk" register (contact HR & explain process) and Expiry Date	Start: Expiry:

WHERE SUITABLE ALTERNATIVE POST(S) IDENTIFIED (*To be completed by Prospective Manager & in conjunction with HR*)	
Details of Potential Post (post title, hours, base)	
Notes of Discussion:	

FOUR WEEK TRIAL PERIOD:			
Start Date:		End date:	
Training Needs Identified			
Feedback from Trial Period *(if not suitable reasons of why not?)*			
Suitable Alternative Transfer Agreed		Date:	
Change of circumstances Form completed & remove from "at risk" register		Date:	
Variation to Contract Completed		Date:	
Signed by:	Employee:	Manager:	Date:

Please e-mail to your HR Representative

APPENDIX 17: GENERIC RISK ASSESSMENT

Job Demands	How might the employee's condition affect their ability to manage the job demands	What is already in place to support the employee?	What further action is necessary?	Action by who?	Action by when?	Completed
Physical (e.g. lifting, walking, sitting for long periods)						
Emotional (e.g. exposure to distressing events, requirement to support others)						
Environmental (e.g. working in small spaces, exposure to gases, heat, light)						
Working Pattern (e.g. length of shift, shift working)						
Accessibility (e.g. access to place of work, other places of work outside of hospital)						
Equipment (e.g. requirement to use drills, hammers, fine tools)						
Other						

NB: For the stress risk assessment, please refer to the stress policy on the intranet

APPENDIX 18: PERSONAL FILE CHECKLIST FOR ANY FINAL STAGES/LEVEL MEETINGS

Document Required	Return to Work Interview.	Trust Self Cert Form	Present in File?	Date Actioned
Stages				
Stage 1 Invite letter				
Stage 1 Checklist				
Stage 1 Confirmation Letter				
Stage 2 Invite letter				
Stage 2 Checklist				
Stage 2 Confirmation Letter				
Stage 3 Invite letter				
Stage 3 Checklist				
Stage 3 Confirmation Letter				
Levels				
Level 1 Invite letter				
Level 1 Checklist				
Level 1 Confirmation Letter				
Level 2 Invite letter				
Level 2 Checklist				
Level 2 Confirmation Letter				
Level 3 Invite letter				
Level 3 Checklist				
Level 3 Confirmation Letter				

NB: *The above matrix is to assist you with the management of Stage and Level meetings for all employees employed at Alder Hey. Please refer to the Trust's Supporting Sickness and Attendance Policy for further information*

APPENDIX 19: STAGE 3/LEVEL 3 – POTENTIAL DISMISSAL WHAT TO EXPECT

Please ensure you liaise with your HR representative prior to any Stage or Level 3:-

i. The Line Manager will present the evidence of unsatisfactory attendance to the appropriate Senior Manager using the Statement of case in the template on page 36. The Line Manager should have liaised with their HR representative when preparing their management case.

ii. Managers must consider all of the information available, including Occupational Health advice and the possibility of any improvement before considering the possibility of terminating the staff member's contract of employment.

iii. When neither a reasonable adjustment nor redeployment can be found, there may be no alternative but to consider dismissal. If so, Managers must manage the process of potential termination of employment in accordance with Trust policy

APPENDIX 20: STAGE 3/LEVEL 3 MANAGEMENT CASE TEMPLATE

Alder Hey Children's
NHS Foundation Trust

Private & Confidential

NAME
TITLE
DEPARTMENT
LONG TERM/SHORT TERM (DELETE AS APPR)
MANAGEMENT OF CASE

Policy referred to:

Line Manager: NAME
HR Support: NAME

INDEX

1.0 Introduction Page *

2.0 Timeline Page *

3.0 Management of Case Page *

4.0 Conclusion Page *

5.0 Recommendation Page *

6.0 Appendices Page *

1.0 Introduction & Background

NAME/TITLE within the X DEPARTMENT has been absent from duties since DATE due to DETAILS.

NAME was appointed to the Trust on DATE and is on CONTRACT DETAILS INCLUDING BAND AND SALARY.

DETAILS OF HALF PAY/NO PAY.

HAD HAD ATOTAL NUMBER OF DAYS/OCCURECES ABSENCE (REFERING TO SICK REPORT AS AN APPENDICES) OVER STATE PERIOD.

2.0 Timeline

Below is NAME's Sickness Record and copies of documentation relating to specific events or planned events are included in the appendices section

ENSURE THE INFORMATION YOU PROVIDE BELOW IS IN CHRONOLOGICAL ORDER

Date	Reason/Topic	Action	Outcome
e.g 1/2/16 – 5/2/16	*Sickness Absence – Cough/cold*	*Return to Work Interview*	*Arrange flu jab - No support identified.*
e.g 3/4/16 – 19/5/16	*Sickness Absence – Back pain*	*Referred to OH*	*Agreed phased return and temp light duties confirmed trigger identified sep meeting*
Eg. 22/5/16	*Stage 1 First Formal Notification*	*Support already provided, Name aware to notify manager of any further concerns*	*Stage 1 with 12 month review date 22/5/17.*

3.0 Management of NAME Sickness Case

DETAIL TO PRESENT DAY OF HOW CASE WAS MANAGED INCLUDING MEETINGS AND OCCUPATIONAL HEALTH REPORTS (NEED TO APPENDICE THESE).

AlSO LIST HERE WHAT SUPPORT HAS BEEN OFFERRED, TAKEN UP IF IT WORKED, IF NOT WHY NOT AND ANY DISCUSSIONS ABOUT ALTERNATIVE ROLES ETC / IF CANNOT REFER TO OH REPORTS .

4.0 Conclusion

NAME has been absent from their role as since DATE due REASON.

ENTER DETAILS AROUND LATEST WELFARE AND OCCUPATIONAL HEALTH MEETINGS AND WHAT THE OUTCOME WAS AND PROVIDE A SUMMARY AND JUSTIFCATION OF PROCEEDING TO LEVEL 3 / STAGE 3 FOR MANAGEMENT CONSIDERATION

5.0 Impacts to Service

DETAILS HERE WHAT THE IMPACTS ARE TO SERVICES, HOW AND WHO IS COVERING FOR THIS

6.0 Recommendation

Taking into consideration all the above factors, I propose to refer NAME case to the panel for review and to consider an outcome in accordance with the Trust Supporting Sickness and Attendance Policy.

NAME
TITLE

Supported by: **NAME**
TITLE

6.0 Appendices

All appendices to be attached including absence policy/occ health reports/any risk assessments/welfare meeting letters/copy sick notes/return to work documents.

NHS
Alder Hey Children's
NHS Foundation Trust

E4 – SUPPORTING SICKNESS AND ATTENDANCE POLICY

Version:	11.3
Name of Ratifying Committee:	Workforce & Organisational Development Committee
Date ratified:	02/03/2020
Name of originator/author:	Zoe Connor (HRBP) Health and Wellbeing Steering Group
Name of approval committee:	Employment Policy Review Group
Date Approved:	11/02/2020
Executive Sponsor:	Director of Human Resources and Organisational Development
Key search words:	Attendance, sickness, absence, E4
Date issued:	April 2024 (Extension)
Review date:	September 2024

Short Term Absence Flow Chart

Employee notifies Manager, or appropriate individual within department, of their absence prior to start of shift

Employee Returns and **submits medical certification** (available on the intranet & Appendix D) (self-certificate for 7 days or less, or GP certificate for absences of more than 7 days)

Manager to **record** on the MSS ESR system within 7 days

Early Intervention referral to OH to be made for absences related to;

- Stress
- Work related Injury
- Musculoskeletal
- Surgery

If Employee does not notify manager of absence, manager to make contact with individual/ next of kin

On return to work Manager to conduct **Return to Work Interview** within 48 hrs (working days) and update MSS system. During interview absences / triggers to be reviewed and proceed to stage 1 review if appropriate

Stage 1 First Formal Review
Line Manager to arrange meeting and send Invite letter, allowing representation. Manager to summarise meeting in writing and issue copy to individual and to HR for recording purposes.

12 Month Review Period – Have there been any further absences as per triggers in section 9.2 of policy during review period?

Yes → Stage 2

No → Continue to support employee's health and wellbeing and ensure support / adjustments in place, as appropriate

Stage 2 - First Formal Meeting
Line Manager to arrange meeting and send Invite letter, allowing representation. HR Adviser may be present to provide support. Manager to summarise meeting in writing and issue copy to individual and HR for recording purposes (refer to Toolkit)

12 Month Review Period – Have there been any further absences resulting in a trigger in line with section 9.2 of policy during review period?

Yes → Stage 3

No → Please see section 14

Stage 3 – Final Formal Meeting
Manager to escalate sickness management process to **Divisional Senior Manager.** Final formal review meeting to be arranged with HR present (Section 15). Manager to send invite letter, allowing representation. Previous Line Manager, with support from HR, to provide a summary of support put in place to date with relevant documentation, and copy to be sent to all parties prior to review meeting.

Summary and outcome of meeting to be issued in writing to all parties present, including details of right to appeal if applicable

If dismissal on grounds of Ill Health Capability - line manager to inform payroll

No dismissal - return to Stage 2

Long Term Absence Flow Chart

Early Intervention referral to OH to be made for absences related to;

- Stress
- Work related Injury
- Musculoskeletal
- Surgery

Absence of 4 weeks or more = Long Term

Manager to inform employee that they will be referred **to Occupationa Health (OH)**

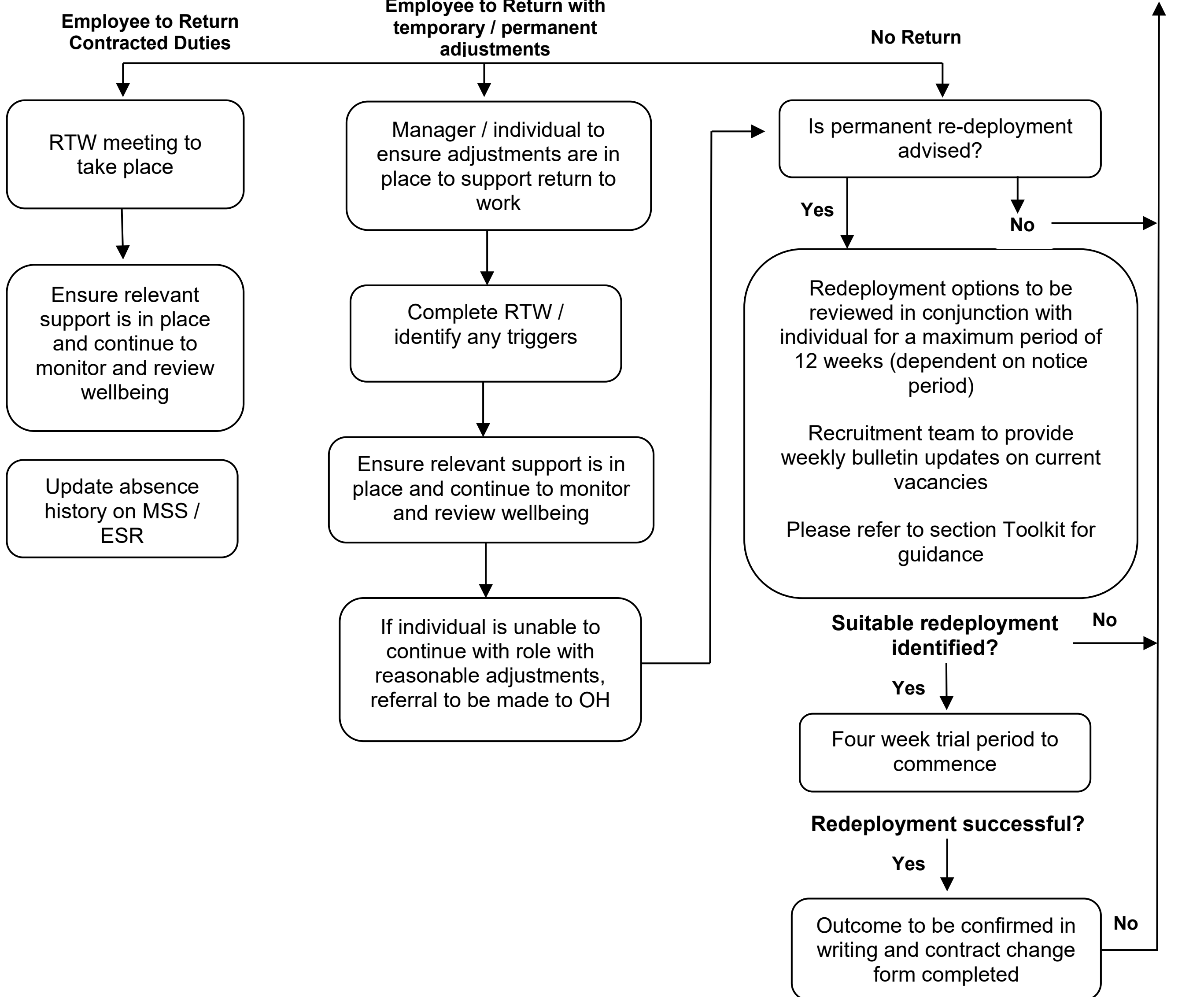
On receipt of OH report, manager to arrange **a Welfare meeting** or Home Visit (if more appropriate). Please refer section 17.

Regular contact should be maintained with an employee to support them during any period of absence. Arrangements for communication should be agreed between the line manager and individual and should be two-way. Welfare meetings should take place at the following stages of absence.

Level 1 Welfare Meeting - >4 weeks <8 weeks

Level 2 Welfare Meeting - >8 weeks<12 weeks

Level 3 Welfare Meeting - >12 weeks



Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
11.3	April 2024	Zoe Connor (Senior HR Business Partner), Health & Wellbeing Steering Group	Current	Extension given until September 2024 by Staff Side to enable approval and review
11.2	August 2023	Zoe Connor (Senior HR Business Partner), Health & Wellbeing Steering Group	Archived	Extension
11.1	February 2023	Zoe Connor (Senior HR Business Partner), Health & Wellbeing Steering Group	Archived	Extension
11	March 2020	Zoe Connor (Senior HR Business Partner), Health & Wellbeing Steering Group	Archived	
E4 - Sickness Absence & Management of Attendance Policy				
10.3	October 2019	Maria Salcedo, Neil Davies, Sharon Owen, HR Business Partners, Christine Cain, HR Adviser	Archived	Interim extension
10.2	April 2019	Maria Salcedo, Neil Davies, Sharon Owen, HR Business Partners, Christine Cain, HR Adviser	Archived	Interim extension
10.1	January 2017	Maria Salcedo, Neil Davies, Sharon Owen, HR Business Partners, Christine Cain, HR Adviser	Archived	
10	April 2016	Maria Salcedo, Neil Davies, Sharon Owen, HR Business Partners, Christine Cain, HR Adviser	Archived	
E4 – Promoting and Supporting Attendance at Work Policy				
9	April 2014	Taffy Chisango, HR Adviser	Archived	Employment Policy Review Group
E4 - Sickness and Attendance Management Policy				
8	December 2013	J Brannon - HR Manager, M Mander - CSP Rep, James Quinn -UNISON Rep; M Salcedo - HR Manager	Archived	Policy updated including management reference guide
E4 - Sickness Absence Policy				
7	February 2012	Jackie Waring	Archived	New Occupational Health Referral Form Appendix C
6	June 2010	Linda Guatella	Archived	Policy updated to include the new medical statement and a new Occupational Health Referral Form Appendix C
5	May 2009	Linda Guatella	Archived	
4	October 2006	Greg Thompson	Archived	
3	August 2006	Hannah Ainsworth	Archived	
2	August 2005	Greg Thompson	Archived	

1	August 2003	Jayne Shaw	Archived	
0	March 1995	Unknown	Archived	

Record of changes made to Supporting Sickness and Attendance Policy – Version 11.2			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Dates updated	6 month extension

Record of changes made to Supporting Sickness and Attendance Policy – Version 11.1			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Dates updated	6 month extension

Record of changes made to Supporting Sickness and Attendance Policy – Version 11			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
Various	Various	Title updated. Further reference and information on reasonable adjustments. Signposting and support included on IVF / Gender Reassignment / Menopause etc. Clarity on sickness stages for short term sickness. Clarity of reasonable adjustments and manager discretion for managing absences. Clarity on Equality Act and managing long term conditions.	Updated throughout

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1 Introduction

1.1 The Trust is committed to creating an environment which supports employee's health and wellbeing and to promoting good attendance at work.

1.2 The Trust regards its employees as their key asset in providing the best health care to patients and regular attendance at work is vital in assisting the Trust to deliver the highest possible standard of patient care.

1.3 This policy is aimed at supporting an employee's wellbeing, to promote a culture of attendance amongst employees, and to provide managers with a clear framework on how to consistently and fairly support and manage absence.

1.4 This policy aims to ensure that employees are treated according to their personal circumstances and need.

1.5 This policy applies to all employees of the Trust, including those employed on fixed term and honorary contracts

1.6 This policy covers:

- The responsibilities of those involved in attendance management
- The procedure for the management of short-term sickness absence
- The procedure for the management of long term sickness absence

2 Health and Wellbeing

2.1 The Trust is committed to providing individuals with the support and guidance to promote their wellbeing in work

2.2 Health and wellbeing incorporates a number of factors, which include physical, psychological, social, economic and environmental factors. If any of these are out of balance, then this can have a negative impact on wellbeing.

2.3 As part of the Trust's Health and Wellbeing offering, there are a number of benefits and supporting activities including fast track physiotherapy, physical activities, counselling, holistic therapies, chiropody, signposting and guidance and Health and Wellbeing services provided by Team Prevent (**www.teampreventwellbeing.co.uk)**. The pin code needed to register is 2007.

3 Definitions

3.1 A list of definitions can be found in Appendix A.

4 Sick Pay

4.1 The scales on NHS sick pay allowance are outlined in Section 14 of the NHS Agenda for Change Terms and Conditions.

4.2 There may be instances where Sick Pay is to be withheld, in cases where employees have not issued timely medical certification or a back dated medical certificate, and the period of absence is considered unauthorised. Repeat occurrences may result in formal action under the Trust's Disciplinary policy as a potential breach of the employee's responsibility within this policy.

4.3 Whilst in receipt of sick pay during a period of sickness absence, employees are not permitted to undertake paid employment (in the NHS or external) without written consent from Divisional Senior management. In circumstances where it is requested

4.4

4.5

4.6

4.7

4.8 to undertake work elsewhere, the line manager should escalate to Divisional Associate Chief Operating Officer or Nurse who, in line with HR advice, confirm in writing if this is agreed.

5 Duties & Responsibilities

5.1 A list of individual and departmental duties can be found within Appendix B of this policy.

6 Occupational Health (OH)

6.1 Occupational Health provides expert advice and guidance to managers and the Trust on the needs of an individual, and identifies a range of resources and options available to support and maintain health and wellbeing.

6.2 In addition to the medical care provided by their dentist, GP or other health professionals, an employee may be required to attend an assessment with Occupational Health when asked to do so.

6.3 Management can make an Occupational Health referral by registering for the portal on the Alder Hey intranet and then accessing the portal: https://eopas.teamprevent.co.uk/GenohsisPortal/Genohsis_Portal.aspx

6.4 In all cases, it is advised that before an employee can be referred by their line manager to Occupational Health, the referral must be discussed with the employee, where possible.

6.5 A referral to Occupational Health can be done at any stage; however an Early Intervention referral should always be undertaken without delay in the following circumstances:

- Immediately where the absence relates to *musculoskeletal problems*, *stress at work* and *any planned surgery*.
- Before any stage of the Short Term Sickness Procedure and after 4 weeks absence in line with the Long Term Sickness Procedure, unless absence relates to one of the three reasons as detailed above, where an immediate referral must be completed.

6.6 An employee can self-refer to Occupational Health at any time. At the time of the consultation it will discussed if it felt to be appropriate for a report to shared with their manager and whether they give their consent for this.

6.7 Employees who fail to attend Occupational Health, or fail to notify both their manger and Occupational Health within 48 hours that they are unable to attend, the cost of the missed appointment will be subject to a charge.

6.8 In situations where there is conflicting advice from Occupational Health and from an employee's GP or specialist, the Trust will normally be guided by the advice of Occupational Health.

7 Notification of Sickness Absence

7.1 On the first day an employee is unable to attend work due to sickness, it is their responsibility to report their sickness absence by telephone (or by text phone for employees with a hearing impairment) to their manager or designated deputy (as per their local procedure), as soon as they become aware that they will not be able to attend work. Early notification is particularly important when alternative cover needs to be arranged. This will normally be no later than the normal time of commencement of duty and within first hour, wherever practical.

8 Pregnancy / Maternity Related Absences

8.1 Where absences are related to pregnancy, individuals should be supported in line with this policy to facilitate a return to work as soon as possible, with any necessary support or adjustment to duties during the pregnancy. However any absences will not be factored into short term triggers of this policy. In addition, referral to Occupational Health may be required for advice and support.

8.2 If an employee is off sick due to pregnancy related illness on or after the fourth week before the expected week of confinement, their ordinary maternity leave will commence the day after their first completed day of sickness absence. For further information, also see Trust's Maternity, Paternity and Adoption leave Policy - E22).

8.3 Where a pregnant employee suffers from non-pregnancy related sickness absence, these absences will count towards the management of sickness absence as usual.

9 Planned Absence for Surgery or Ongoing Treatment

9.1 Sickness absence can be planned where it is known that the employee will be undertaking a programme of clinical treatment that will mean they are absent from work for a recognised period of time. As an organisation, the Trust will ensure that all staff undergoing planned or ongoing treatment are supported and provided with reasonable adjustments.

9.2 Where an employee provides notice of surgery or ongoing treatment, Line Managers will make a referral to Occupational Health immediately, via Early Intervention, prior to the employee's surgery. This will provide an opportunity for the employee to discuss any concerns and to seek advice on adjustments to their job, which may be incorporated into their return to work plan.

9.3 The manager and employee will meet prior to the absence and discuss the following:

- The likely period of time the employee will be absent;
- Agreed dates and times for maintaining regular contact, to update each other on work and progress of recovery;
- Agreed date and time for a formal meeting to start to plan a return to work;
- Any other issue of concern for either party;
- A mutually agreed plan must be drawn up and a copy kept by both parties;
- Support in the drawing up this plan can be obtained from the Occupational Health Department.

9.4 In cases of gender reassignment surgery, the manager should discuss with the member of staff how best to support them with this process and the basis of a return to work. Occupational health and professional medical advice should be sought to ensure that individuals have the relevant support and adjustments in place. To support and facilitate appointments, sick leave will be utilised as appropriate, and mixtures of annual leave and unpaid leave also utilised. An employee would not be progressed through the short term policy due to absences connected with this treatment.

9.5 In cases of In Vitro Fertilisation (IVF), the manager should discuss with the member of staff how best to support them. This will be individual to the member of staff and will be dependent on personal circumstances. Occupational health and professional medical advice should be sought to ensure that individuals have the relevant support and adjustments in place. To support and facilitate appointments, sick leave will be utilised, as appropriate, and mixtures of annual leave and unpaid leave also utilised. An employee would not be progressed through the short term policy due to absences connected with this treatment.

10 Cosmetic Surgery

10.1 Unless for a medical reason confirmed in a medical report, any absence taken for the purposes of cosmetic surgery cannot be taken as sickness absence and should be covered by annual or unpaid leave (if agreed by the manager). This time off must be agreed in advance with the line manager.

11 Supporting Women's Health

11.1 It is advised that managers undertake informal conversations with staff which will enable discussions if there are any changes in health, including symptoms relating to the menopause. It may be valuable simply to acknowledge that this is a normal stage of life and that adjustments can easily be made. Such conversations can identify support at work that can help women remain fully productive and encourage them to discuss any relevant health concerns with their GP and occupational health. Further support can be found here.

12 Returning to Work

12.1 The return to work meeting is an important element in the management of sickness absence and it is important that it is undertaken consistently and appropriately after every period of absence.

12.2 Return to work (RTW) meetings are required to be carried out by a manager following any period of sickness absence (whether short or long term – i.e. more than 4 weeks) no later than 48 hours of the employees return, or as soon as practicably possible. (RTW form can be found the management toolkit).

12.3 The return to work meeting should be a supportive meeting. It should be carried out in a sensitive and considerate manner, where the primary focus is ensuring that the employee is fit and well to carry out their duties required.

12.4 Return to work meetings should:

- be conducted in private, with sensitivity where any issues can be explored in a caring and concerned manner

- be approached with an open mind, and give the employee the opportunity to discuss reason behind their absence
- not be judgmental, and assumptions about the absence should not be made
- an opportunity to discuss any occupational health advise and identify adjustments that may be supportive
- an opportunity for signposting to relevant support services
- an opportunity to discuss absence history and consider whether any formal review meetings are required

12.5 Management are required to enter the date of the return to work meeting on the MSS ESR system within 7 days following the employee return and retain copies of those discussions securely in their local personnel file. Guidelines and a template of return to work forms can be found in the Toolkit.

12.6 Overtime and bank work will not be permitted, either within the organisation or elsewhere until an employee has resumed their agreed contractual hours with ongoing review where deemed necessary. Mangers also have the discretion to withhold any overtime or bank work, if appropriate, and will need to notify NHSP of any such restrictions.

13 Reasonable Adjustments

13.1 Employers have a duty to make reasonable adjustments to ensure workers with disabilities, or physical or mental health impairments, are not disadvantaged when doing their jobs and formal risk assessments may be required to support an employee in work.

13.2 In many cases, simple and cost-effective workplace adjustments can make a big difference and enable people with health conditions and disabilities to remain in work. The adjustment needed could be a change in practice or workload.

13.3 The aim of the adjustment is to minimise or reduce the impact of the health condition for the employee and enable them to carry out their job / duties.

14 Sickness Absence Triggers

- 3 episodes of absence in a 12 months rolling period and/or
- 10 days or more absence in a 12 month rolling period (pro rata for part time staff see Appendix E) and/or
- Any trend or pattern of absence causing concern.

Staff who work long days or longer than the standard hours (i.e. 7.5) in the day will have triggers based on hours recorded as sick, rather than days. See Appendix E for chart / formula to calculate.

14.1 It is important to be able to distinguish, and act appropriately, between both short term and long term absences and to deal with them separately as set out in the policy. Nevertheless, there can be occasions where the pattern of absence of an individual staff member is both short term and long term, and in these instances both elements of the procedure may be involved.

14.2 Where an employee gives the reason for absence as an underlying health issue that could amount to a disability under the Equality Act 2010, the manager must refer the employee to the occupational health department. This includes where the employee states that they are suffering from stress.

15 Short Term Absence - The Procedure

15.1 A brief overview of the short term sickness procedure is shown in a flow chart at the start of this policy.

15.2 For sickness absence as a result of bereavement, long term or chronic medical conditions or ongoing medical treatment which could amount to a disability under the Equality Act 2010, managers should be aware of the organisations responsibility to make reasonable adjustments. It should be considered when the absence is wholly or partly for a disability-related or long term reason, that the trigger points referred to in this policy are appropriately modified to take this into account. Other adjustments and modifications to the procedures set out in this policy may also need to be made and should be considered as part of welfare and return to work conversations. Advice should be sought from Human Resources department and Occupational Health, as appropriate.

15.3 Management are required to submit to staff all invite letters and outcome letters (templates can be found in the management toolkit) for each formal stage of the policy. The employee has the right to be accompanied by a trade union representative or work colleague in all the formal stage meetings**.**

Formal Stage 1: First Formal Review

a) Where staff have triggered as a result of sickness absence (section 14) the line manager may be required to arrange a Formal Stage 1: First Welfare Review Meeting. The aim of this meeting is to identify any support the employee may require in order to improve their attendance. Invites to this meeting should be done in writing at least 5 days prior to the proposed meeting date. At this meeting a potential outcome may be confirming that the employee will be at Formal Stage 1 of the procedure with a review period of 12 months from the date of the meeting.

b) Further Managers Guidance can be located in the management toolkit. It is not necessary, unless in exceptional circumstances, that HR be present at this meeting.

c) An Occupational Health referral should be discussed and, if deemed necessary, should be completed before the meeting to clarify any support, identification of the basis of the employee's sickness absence and any underlying conditions.

d) If during the 12 month review period, the employee either has no further absence or if the absence is less than the trigger points (see section 14), the employee will be automatically be removed from Formal Stage 1. If the employee has future episodes of absence after being taken off the stage, their overall absence rate will be considered over the last 12 months, and if the triggers are met, the employee may be invited to attend a further Formal Stage 1: First Formal Review.

e) At any time within the 12 month review period, if the staff member has sickness absence at the level of the triggers as detailed in section 9.2, the manager should review the sickness absence to date, the circumstances of the sickness absence,

the needs of the individual and the support in place. If appropriate, the manager should proceed to Formal Stage 2 – First Formal Meeting.

Formal Stage 2: First Formal Meeting

a) In the event of further / repeat absences during the 12 month review period, as outlined in the triggers in section 14, it may be necessary to convene a Stage 2 Final Formal Meeting. Consideration should be given to the reasons for further sickness absence prior to proceeding, to ensure the necessary support is in place to support an individual's attendance at work.

b) It is recommended that prior to a Formal Stage 2 meeting taking place that an up to date Occupational Health report is obtained to establish any additional support or adjustments.

c) Following a Formal Stage 2 meeting, the manager will send a letter to the individual to confirm the outcome and any agreed actions or next steps. Following this, if there are no further absences during the next 12 month review period, the sickness management process will be ended. If there are absences but they are less than the trigger points (see section 14), then the employee will return to Formal Stage 1 of the policy, with a 12 month review period from the date the Formal Stage 2 ended.

d) For individuals with chronic or long term conditions which may be recognised within the Equality Act (2010), managers are advised to consider the circumstances relating to the episodes of sickness absence and review the support in place for an individual before progressing to the next stage of this Policy. It may be considered a reasonable adjustment to **not** progress an individual to the next stage of Policy, given individual circumstances and needs. Managers should seek advice and guidance from occupational health and a Human Resources representative as appropriate. It may also be beneficial to also seek advice from other relevant specialists.

e) At any time within the 12 month review period, if the staff member has sickness absence at the level of the triggers as detailed in section 14, the manager should review the sickness absence to date, the circumstances of the sickness absence, the needs of the individual and the support in place. If appropriate, the manager should proceed to Formal Stage 3 – Final Welfare Review Meeting.

Stage 3: Final Formal Meeting - Procedure

a) In the event of further / repeat absences during the 12 month review period, as outlined in the triggers in section 14, it may be necessary to convene a Stage 3 Final Formal Meeting. Consideration should be given to the reasons for further sickness absence prior to proceeding, to ensure the necessary support is in place to support an individual's attendance at work.

b) Prior to progressing to a Final Formal Meeting, redeployment options should be given due consideration, and managers should seek advice and guidance on redeployment from Occupational Health and a HR Representative as appropriate. Further guidance can be found in the toolkit.

c) If it is considered appropriate to progress to a Final Formal meeting, the manager responsible for managing and supporting the welfare and sickness absence of the member of staff will be required to compile a summary of the sickness absence

and support in place, with all accompanying documentation, to demonstrate the support offered and adjustments in place.

d) The Final Formal Meeting will be chaired by a Trust senior manager, in line with the Scheme of Delegation as detailed in the Trust's Disciplinary Policy - E5, and should be supported by a Senior Human Resources Representative. The individual can be accompanied by either a Trade Union representative or workplace colleague.

e) The manager supporting the member of staff will provide a summary of the support and adjustments in place to date. The meeting will provide the opportunity to review absence history to date, the support in place and the options available moving forward.

f) A manager must have an up to date report from Occupational Health prior to this meeting being arranged, to ensure medical advice is taken into account when considering the potential outcomes, including termination of contract employment due to Ill Health Capability.

g) There are two potential outcomes of the Stage 3 meeting:-

- Termination of the employee's contract of employment due to Ill Health Capability
- Further support and adjustments- the employee will be placed back on Stage 2 for a further review period of 12 months.

h) The meeting Chair should inform the employee verbally of the outcome of the meeting on the day of the hearing. In exceptional circumstances, the outcome should be in writing no later than 5 working days after the date of the meeting. If the decision is to terminate their contract of employment, the employee should also be advised of details of their entitlements, such as the right of appeal, and this should be confirmed in writing.

i) Further advice should be taken with the Human Resources Department regarding whether it is appropriate to contact the relevant Regulatory Professional Body (where applicable).

16 Long Term Sickness Absence

16.1 The triggers defined under long term absence are referred to as levels. They commence where employee's absence is for four weeks or more (or known at an earlier stage to be more than 4 weeks)

16.2 Long term sickness absence should be treated separately to the short term triggers. Levels are to provide guidance only on a time frame for support, where this is medically appropriate to do so. In some situations, it may be necessary to proceed straight to a Final Welfare Meeting if there is no immediate or foreseeable return to duties of the same nature or adjusted basis (including re-deployment), which has been confirmed through medical advice and guidance. In such instances, management are required to contact a representative from the Human Resources Department.

- Level 1: Welfare Review (> 4 Weeks < 8 Weeks)
- Level 2: Welfare Review (>8 Weeks < 12 Weeks)
- Level 3: Final Review (>12 Weeks), including referral to Final Review Meeting

17 Long Term Sickness Absence Procedure

17.1 This type of sickness absence relates to episodes of four weeks or more.

17.2 The Long Term Sickness Absence Flow Chart is on page 3.

17.3 The manager should look at options and practical ways to support absent employees to return to work, giving due consideration to both the wellbeing of the employee and the requirements of the role, to ensure the necessary support and adjustments are in place.

17.4 Employees absent due to long term sickness, will need help and support during their recovery and their return to work. An understanding and sensitive approach should be taken by the manager in all cases.

17.5 Managers should at the earliest opportunity proactively and positively manage long term sickness, with the primary aim of supporting the employee and facilitating a return to work as soon as possible.

17.6 Following four weeks of absence (or immediately on awareness that the absence is to extend beyond 4 weeks), the manager should refer the employee to Occupational Health, if they have not already done so.

17.7 The manager will arrange to meet with the employee after the fourth week of absence (ideally when the Occupational Health outcome is available) and then on a regular basis thereafter. The frequency and format of these regular catch-ups will be dependent on the nature of the absence, and should be agreed with the employee. Arrangements for such contact should be agreed when the sickness is first reported and kept under review. The employee will have the right to be accompanied by their staff side representative or work colleague, and it may be appropriate for a representative from HR Department to also be attendance. The employee will receive a record of the meeting in writing.

17.8 The employee must keep in contact with their manager on a regular basis throughout their absence, and update on any developments and availability for review meetings and catch-ups. This contact allows the manager to keep track of the employee's recovery and progress in order to facilitate return to work, when appropriate

17.9 The purpose of the meetings is to support the employee and explore any support and adjustments they may require to facilitate a return to work. At these meetings the following issues may be considered;

- Occupational Health advice and any other medical advice available.
- Potential return to work and any adjustments that may be required, either temporary or permanent, and if this should be on a phased basis, as advised by Occupational Health, particularly where the employee has a disability as defined by the Equality Act (2010). Potential for re-deployment if advised by Occupational Health.
- Any re-training, mentorship or additional support needed.
- Redeployment - temporary or permanent
- Ill Health Retirement, if applicable.

17.10 If the employee is unable to return to their current post, as advised by Occupational Health, and no suitable alternative employment can be found within a reasonable

timeframe, a Final Review Meeting will be undertaken where termination of the employee's contract of employment due to Ill Health Capability will be considered, as one option. The manager responsible for managing and supporting the welfare and sickness absence of the member of staff will be required to compile a summary of the sickness absence to date, support in place and the options explored to facilitate a return to work, with accompanying documentation to demonstrate the support offered and adjustments in place

17.11 This meeting will be chaired by a senior manager, in line with the Scheme of Delegation as detailed in the Trust's Disciplinary Policy. The panel chair must have a recent report from occupational health prior to this meeting being arranged, to ensure medical advice is taken into account when considering the options available.

17.12 Sick Pay entitlement does not have to be exhausted before a Final Review can be considered.

18 Postponement of Formal Meeting for the Purpose of Securing Representation

18.1 It must be recognised that in cases of long term ill health in particular, there will be occasions when the employee may be too unwell to attend a proposed meeting. Any such request for postponement will therefore be dealt with sympathetically based on the individual circumstances.

18.2 Employees are responsible for identifying their Trade Union representation. Where an employee requests the postponement of a formal sickness meeting due to difficulties in organising representation, the employee or his representative must suggest an alternative time within 5 working days of the original meeting. Where the request is judged to be unreasonable, the manager may, in conjunction with HR, decide to proceed with the meeting as arranged and, if necessary, in the absence of the employee.

19 Annual Leave & Sickness Absence

19.1 The use of annual leave / lieu days to cover periods of sickness is not permitted but can be used to facilitate a return to work. This may follow a phased return to work in agreement with the Manager.

19.2 For sickness absence as a result of bereavement, long term or chronic medical conditions or ongoing medical treatment, managers should give due consideration, based on individual circumstances, to the use of annual leave to facilitate the attendance at appointments.

19.3 If an employee is on long term sickness they may wish to take a holiday to facilitate their recovery. This must be discussed and agreed with their line manager before any holiday is taken, as they will not be available for meetings during that time.

19.4 Any annual leave taken during a period of sickness will continue to be recorded as sickness absence on ESR. The sickness absence episode **should not** be ended. Annual leave taken will be deducted from an individual's annual leave entitlement but will not be recorded on ESR. Managers are required to keep an offline record in these circumstances. If the employee has gone onto half or no pay, a manager should request payment to be made in lieu via an ETAD.

19.5 To comply with the European Working Time Regulations[1] sickness absence that bridges two annual leave years, or where there is insufficient time for the leave to be taken during the leave year, the employee is entitled to either;

- Carry over the shortfall, for a retrospective period of no more than eighteen months from initial date of sickness
- Be paid as part of final salary payment from the Trust if not resuming for a retrospective period of no more than 18 months

19.6 For the purpose of calculating carryover of annual leave as a result of sickness absence, employees annual leave entitlement is a capped at a maximum of 20 days per annual leave year less any holidays already taken within a maximum 18 month retrospective period from initial start date of sickness. The calculation will be pro-rata'd for staff employed on a part time basis.

20 Conduct while on Sick Leave

20.1 It is expected that the employee will do their utmost to facilitate a speedy return to fitness and to work. The Trust would not normally expect anyone who is absent from work due to sickness or injury to:

- Participate in any sports, hobbies, social or other activities which are in any way inconsistent with their illness or injuries, or which could aggravate the illness or injury or delay recovery.
- Undertake any other employment, whether paid or unpaid, when off sick and claiming Occupational Sick Pay.
- Engage in any activity, which is inconsistent with the nature of the illness or injuries.
- Engage in any activity which is unlikely to be conducive to their recovery.

20.2 A breach of any of the above may be deemed as gross misconduct and subject to the Trust Disciplinary Policy.

20.3 If fraudulent activity is suspected, for example working elsewhere whilst in receipt of sick pay or falsification of sickness absence documentation, the Trust's Local Counter Fraud Department must be notified. In the first instance, managers who have such a concern should contact Human Resources Department. All information provided via any of these reporting lines will be treated in strictest confidence and may be provided completely anonymously. The Trust's 'Raising Concerns at Work' policy will be enforced to ensure that no employee should suffer as a result of reporting reasonably held suspicions.

21 Compensation / Damages

21.1 If an employee is absent as a result of a non-work related accident and receives damages from a third party, they will not be entitled to Sick Pay. If Sick Pay has been paid and damages are received, the employee will be expected to repay the Sick Pay to the Trust.

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[1] http://www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/EWTD/Pages/EWTD.aspx;

21.2 Contractual sick pay is not normally payable for an absence caused by an accident due to active participation in sport as a profession, or where contributable negligence is proved, unless the Trust agrees otherwise.

22 Planning and Facilitating Return to Work Plans

22.1 When injury or ill health necessitates a lengthy period of sickness absence a phased return to work may support an individual to return back into the workplace. A phased return to work is, by definition, intended to be short term and will gradually increase to normal duties / hours over an agreed period, based on occupational health advice, and not normally exceeding a period of four weeks, or in exceptional cases to a maximum of 6 weeks.

22.2 Employees will be paid at their full contractual pay during an agreed period of phased return, up to 4 weeks, including any contractual enhancements. If an extended phased return is required for a period of longer than four weeks, the manager and the individual should discuss options for facilitating this including annual leave, temporary or permanent flexible working options.

22.3 If the employee's fitness does not enable them to return to their full duties, and reasonable adjustment/s that aim support and facilitate the member of staff to undertake their role cannot be accommodated, or are unsuccessful, then other options may need to be considered, such as ill health retirement. Advice should be sought from Occupational Health, Equality & Diversity Manager and HR.

22.4 If, despite all efforts, the phased return is unsuccessful, a further period of absence may be required. A referral to Occupational Health should be considered with a view to obtaining further guidance on the likelihood of a successful return in future, with or without reasonable / tailored adjustments and / or consideration to permanent or temporary redeployment.

23 Redeployment - Temporary and Permanent

23.1 Temporary redeployment -

If the employee is fit to attend work but not to their substantive post, or a phased return is attempted but is not successful, the manager may also consider temporary redeployment to facilitate a return to work for up to a period of up to 3 months. If redeployment is to a lower banded post, the individual will not suffer a detriment in pay.

23.2 Permanent redeployment -

In circumstances were an individual cannot return to the substantive position with reasonable adjustments and support within the foreseeable future, permanent redeployment should be considered in line with Occupational Health guidance. Individuals will be placed on the redeployment register for a period of up to 12 weeks, dependent on notice period. Further guidance can be found here.

24 NHS Ill Health Pension

24.1 An employee, who is a member of the NHS Pension Scheme, may indicate his/her wish to retire on the grounds of ill health. In order to qualify the employee will need to have been paying into the NHS pension scheme for at least two years. Although individuals have the right to make an application of their own volition, it is normally expected that any application for ill health retirement would need the support of Occupational Health.

24.2 The necessary forms will be initiated by Human Resources Department and after completion by Occupational Health and the employee, the application forms will be sent to the NHS Pensions Agency for a decision. This action will be taken in parallel with consideration of a Formal Review (Level 3) by the Trust on the grounds of ill health, and will not be dependent upon the outcome of a decision by the Pensions Agency. The decision to award ill health retirement benefits lies solely with the NHS Pensions Agency.

24.3 Further information on NHS Pension Scheme can be found on the website.[2]

25 Terminal Illness

25.1 There may be circumstances were a member of staff's health may deteriorate or they cannot be cured or adequately treated, and the possibility that the member of staff has limited life expectancy.

25.2 It may be appropriate in these circumstances for communication to be with a family member or next of kin. Managers are advised to seek advice, guidance and support from the HR department in these circumstances.

25.3 In these circumstances an employee who is a member of the NHS Pension scheme, who is terminally ill with limited life expectancy, may be eligible for adjusted benefits under the Pension scheme. Further information and advice can be obtained from the NHS pension's website.

25.4 Terminal illness of a member of staff can have an impact on the manager, the friends and colleagues. Support is available through the HR team and Occupational Psychology. Further information can be found on the intranet, or through the HR team.

26 Termination of Contract

26.1 Managers authorised to terminate employment under this procedure will be those set out in the Trust's Levels of Authority section, contained within Appendix E of the Disciplinary Policy and Procedure - E5, where the outcome of action taken in accordance with this procedure is termination of employment with notice. There is no entitlement to exhaust contractual sick pay before termination of employment. The Trust may terminate the contract and make payment of notice in lieu, plus any other outstanding payments.

27 Appeal Process

27.1 Employees who are dismissed on the grounds of their capability due to ill health or due to poor attendance are entitled to appeal to the Director of Human Resources and Organisational Development within 10 working days from the date of the letter confirming the outcome, stating details of the reasons for their appeal. In summary the individual will have the opportunity to present their case for appeal to an Executive Panel consisting of Executive and non-Executive Directors. The outcome of the Appeal Panel is final and exhausts all internal appeal processes.

28 Monitoring

28.1 Monitoring will include monthly HR dashboard reporting contained within Board and Corporate reporting processes. This includes equality monitoring.

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[2] http://www.nhsbsa.nhs.uk/Pensions.aspx;

28.2 The Trust will evaluate this data on an on-going basis to ensure that it continues to meet its legal obligations under The Equality Act 2010[2], and to assist in developing policies, processes and procedures that take a pro-active and supportive approach to disabled employees and potential employees.

29 Further Information

Equality Analysis (hyperlink)

References

- Data Protection Act 1998
- Disability Discrimination Act 2005
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)
- The Equality Act 2010

Associated Documentation

http://www.dwp.gov.uk/docs/fitnote-employer-guide.pdf

This policy should be read in conjunction with the following HR policies:

- Management Toolkit
- Flexible Working Policy
- Special Leave Policy
- Flexible Retirement Policy
- Stress Policy
- Drug and Alcohol Policy
- Capability and Performance Policy
- Disciplinary Procedure
- Grievance Procedure
- Infection Control Policy

Appendix A - Definitions

i. Management Toolkit – This policy works in conjunction with a management toolkit provided by Human Resources and available on the Intranet. The toolkit provides guidelines, template letters and examples to assist managers in the day to day management of sickness absence.

ii. Return to Work Interview (RTW) – Supportive interview between management and staff following any absence due to sickness completing a form and identifying if any, support and/or temp adjustments.

iii. Electronic Staff Record – (ESR) refers to the NHS HR and payroll system which is used by managers in entering timely information relating to any employee's absence.

iv. Manager's Self-Serve (MSS) – refers to management entry when recording sickness absence onto the ESR systems.

v. Statement of Fitness to Work ("Fit Note") - This is normally provided by the employee's medical practitioner (e.g. GP) as evidence of why they cannot work due to an illness or injury after the 7th day of sickness. The employee's doctor can also advise that they 'may be fit for work' or provide information on functional effects of the condition and/or any treatment planned and possible adjustments which could be made to aid a return to work.

vi. The Equality Act 2010 (2010) – A person with a disability for the purposes of the Act is if he or she has a physical or mental impairment and the impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. i.e. a substantial and/or long-term adverse effect on the employee's ability to carry out normal day-to-day activities'

'Long-term' means that the impairment must last, or be likely to last, for more than 12 months, or which is likely to last for the rest of the life of the person affected.

vii. RIDDOR - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations Act 1995.

viii. ELFS- East Lancashire Finance Services, Alder Hey's Payroll & Pension Provider.

ix. UA - unauthorised absence - occurs when an absence is not supported by current self-certification, medical fit note or by prior approval of your manager.

x. E.I – Early Intervention - This is a supportive and preventative Health and Wellbeing approach for Employees to enable Early Access and Intervention to evidence based professional advice, support and treatment (if required) relating to their health, their role and the workplace.

Appendix B - Individual Duties & Responsibilities

Line Manager Responsibilities;

i. Promote a positive attendance culture in the workplace through effective people management and promotion of health and wellbeing.

ii. Ensure all employees, including new employees during local induction, are aware of and understand this policy and the absence reporting procedure.

iii. Maintain appropriate contact with the employee during periods of absence(s), facilitate their return to work and adhere to **all** elements of the policy in ensuring that their employees are fully supported with reasonable adjustments in place

iv. Seek advice from Occupational Health in line with timeframes outlined in this policy and take steps to implement specified recommendations where reasonable.

v. Liaise and seek advice from Human Resources prior to taking each formal stage of the process including when managers may have to act outside of the provisions of this policy and procedure.

vi. Take direct responsibility for managing attendance consistently in line with this policy and providing appropriate and reasonable support and adjustments to staff

vii. Conduct return to work interviews with employees after **all** period of sickness absence and within 48 hours of an employee's return to work, ensuring they are fit to return. Identify any work related issues which can be addressed and implement support and adjustments where appropriate.

viii. Enter accurate sickness absence information onto manager self-service of ESR system in an accurate and timely manner

ix. Repeated failure to implement the policy, undertake return to work interviews and provide reasonable support and adjustments may result in formal action in line with Trust policy and procedures

x. Give appropriate consideration to the personal circumstances of employees who are absent for reasons relating to long term conditions, disability, pregnancy or work related injury when applying the policy and procedure.

xi. Signpost staff to the Access to Work scheme if they require reasonable adjustments to be made as a result of their disability or long term condition https://www.gov.uk/access-to-work (refer to management toolkit).

xii. Inform the Risk Management Department when an accident at work results in an employee being off sick for more than seven days, so that the Health & Safety Executive can be notified as required by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)

xiii. Retain electronic copies of all RTW's forms, formal letters, risk assessments and OH reports securely for audit purposes and ensure handover file during internal movement in the event of a transfer.

xiv. Review and implement support plans and reasonable adjustments

xv. Should comply with the General Data Protection Regulations (2018) when dealing with sickness absence. All those who have access to personal information relating to sickness absence have a legal responsibility to ensure that this information is treated in

a confidential manner in accordance with the Act. Breaches of confidentiality will be dealt with under the terms of the Trust's Disciplinary Policy and Procedure..

General Managers / Heads of Department responsibilities;

i. Responsible for ensuring that improvements are made within their areas/departments to meet the Trust's sickness absence targets

ii. Ensure management teams report sickness absence and return to work interviews timely and monitor performance as part of divisional performance

iii. To ensure that management teams adhere to the requirements of the Sickness Absence and Management of Attendance Policy.

Human Resources Department responsibilities;

i. To promote the fair and consistent application of the Sickness Absence and Management of Attendance Policy and to monitor the implementation of this policy to ensure procedures are managed fairly across the Trust and compliant with the Equality Act 2010[4].

ii. To support managers and staff and attend welfare meetings as required.

iii. To provide assistance, advice and support to managers and employees in the management of sickness absence and maintaining attendance at work

iv. To collect, analyse and publish departmental and organisational absence statistics

v. To review the continued relevance/appropriateness of policy and procedure on a regular basis.

vi. To provide Divisional Management with sickness absence summary reports highlighting any areas requiring support and focus.

Occupational Health Department responsibilities;

i. Provide line managers with timely and competent medical advice to inform decisions regarding the management of individual cases of sickness absence in order to promote health and wellbeing and support attendance at work.

ii. To promote and advise staff and managers about health and wellbeing in the workplace and the prevention of ill-health.

iii. Inform the line manager and HR of any non-attendance at a booked consultation and of circumstances were records have been closed as a result of non-attendance.

iv. Work with line managers in facilitating an employee's return to full duty as early as possible. This may include providing a medical opinion regarding the risks associated with any rehabilitation plan.

v. Accompany Line Managers at case conferences and advising employees and their managers of the appropriate measures of support, (including rehabilitation, redeployment, advice where disability discrimination legislation may apply and highlighting where medical conditions are reportable under RIDDOR (1995).

Payroll Department responsibilities;

i. ELFS is the Trust's payroll provider. In relation to sickness absence ELFS will:

- Ensure correspondence has been issued to employees in relation to changes to sickness entitlements.
- Send SSP1 to employees
- Inform employees when they are approaching half pay or nil pay.

Staff Side responsibilities;

i. All employees who are members of an accredited Trade Union have the right to be accompanied at all formal meetings by an accredited Trade Union representative. Employees who are not Trade Union members may be accompanied by a workplace colleague.

ii. Staff side representatives must therefore:

- Familiarise themselves with this policy and procedure.
- Advise members in accordance with this policy and procedure.
- Work in partnership with the Trust to promote a culture of health and wellbeing
- Work in partnership with the Trust to ensure policy and procedure is implemented fairly and equitably
- Support effective attendance management across the Trust

Employee responsibilities;

i. Meet the obligations of their contract of employment regarding regular attendance at work and compliance with Trust policies and procedures.

ii. Have an awareness of the impact of ill health on their teams' and service delivery and ensure they are seeking support and managing their health and wellbeing appropriately

iii. Bring any health issues/disabilities to the attention of their manager at the earliest opportunity and make suggestions as to any reasonable adjustments required.

iv. Should be aware, understand and adhere to this policy and procedure, which includes reporting any absence from work on the first day to the appropriate manager in accordance with this policy.

v. Maintain regular contact with their manager, advising of their progress and likely return to work date.

vi. Submit the appropriate self-certification and / or continuous medical statements timely and for the duration of the absence.

vii. Participate in return to work interviews after any period of sickness absence

viii. Required to attend arranged appointments to see Occupational Health

ix. Notify both their manager and Occupational Health directly, no later than 48hours prior to an OH appointment in the event they are unable to attend and to rearrange a new date as soon as possible

x. Notify their manager without delay or at the first opportunity in the event they have an accident at work.

xi. Attend regular Welfare Meetings/Sickness Reviews.

xii. If repeatedly unable to attend sickness absence reviews or attend Occupational Health appointments employees may be subject to formal action under the relevant Trust Policy and Procedures. Employees should ensure they are in regular communication with their manger and provide up to date information on their health status and ability to attend meetings so reasonable adjustments can be put into place to facilitate

xiii. Are to refrain from additional shifts (bank, overtime etc.) or unpaid work until a return to work interview has been undertaken and a sustained level of attendance is maintained (post any phased return to work arrangements).

xiv. Should refrain from activities that will delay their return to work

xv. Should refrain from undertaking any activities whilst off sick which are inconsistent with the reason for their absence or may delay their recovery.

xvi. Contact 'Access to Work', where required, and the employee should liaise with their manager to discuss those recommendations.

xvii. Should comply with the General Data Protection Regulations (2018) when dealing with sickness absence. All those who have access to personal information relating to sickness absence have a legal responsibility to ensure that this information is treated in a confidential manner in accordance with the Act. Breaches of confidentiality will be dealt with under the terms of the Trust's Disciplinary Policy and Procedure.

xviii. Only report sickness absence for personal sickness and not for other reasons. The Trust has policies for other types of leave such as Special Leave, Carers Leave and Career break policies. These policies must be used where appropriate. Inappropriate reporting of sickness may result in disciplinary action being taken.

Appendix C - Notification Procedure & Maintaining Contact with Employees

Notification Process:

The Trust's standard notification procedure is as follows:

i. Employees are required to notify their line manager (or alternative nominated person) in line with local department notification procedures by telephone. Failure to contact within local reporting requirement may result in withholding of sick pay for that day. Other forms of communication such a text message should not be used unless in exceptional circumstances or if otherwise agreed

ii. Calls from other people, texts and emails are unacceptable except in very exceptional circumstances as is reporting sickness absence via colleagues. In the exceptional circumstance that the employee is too sick to personally contact their line manager/suitable identified person a close relative or friend may contact the Trust on their behalf.

iii. All employees need to be aware who they should contact in the event that they need to take sick leave. In most circumstances this will be the manager, however, some notification procedures may identify another suitable individual as the point of contact. It is insufficient to simply leave a message with whoever answers the telephone or to leave a text message. In the event that you have been unable to speak directly to your manager to notify them of your sickness absence, your manager (or in their absence a person with designated responsibility) will return your call.

iv. Employees should inform their manager:-
   - Of the reason for absence
   - Action taken (e.g. GP appointment)
   - Of an estimated return to work date and any work commitments which require cover.

v. In the event this is not possible then employees should personally notify the next Senior Manager of their absence.

vi. Where an employee is unable to return to work on their expected date of return they are required to inform their manager/suitable identified person before the start of the working day/shift on which they are expected to resume so that appropriate resources can be put in place to meet the needs of the service.

vii. On returning from sickness the employee should contact their line manager/suitable identified person to inform them when they are returning to work before the next working day/shift starts.

viii. The employee should ensure that during a period of long term sick leave that they maintain regular contact with their line manager/suitable identified person. The reasonableness of the regularity of contact should be discussed by the manager and member of staff and is dependent on service needs and the individual circumstances of the sick leave. If the employee does not initiate and maintain contact, the manager will do so.

ix. Employees should complete a self-certification form on the first day that they return to work up to the first 7 days of absence (Appendix B). This may not be necessary if the employee has obtained a doctor's medical statement that provides cover from the first day of absence.

x. A doctor's statement is required from day 8 to cover the remainder of the duration of sickness absence and must be received by the ward/ department.

xi. Where the employee's absence continues past the expiry date of the medical statement the manager should receive a new medical statement immediately to ensure continuous certificated absence.

xii. Employees whose sickness period includes Saturday, Sunday and bank holiday will automatically be regarded as being sick on these days unless the employee has contacted the ward/department and informed them that they are fit to return to work and where applicable resumed work.

xiii. Employees who do not undertake standard 7.5 hours days will have sickness calculated based on hours of absence during the period concerned

xiv. Failure to comply with the notification procedure where there is not good reason to do so could result in disciplinary action. In addition, the HR Shared Service will be notified of the unauthorised absence which will result in an appropriate deduction in pay for those days absent without authorisation.

Maintaining Contact with Absent Employees

i. Where an employee reports in for work and during their shift falls sick, which results in the employee leaving the workplace, it should not be recorded as sick absence for that day.

ii. Line managers are required to keep a record of all such occasions as stated above, to identify any repeat patterns of absence or misuse of the policy and will recognise the patterns of absence and action as part of the short term triggers, stated within this policy.

Appendix D - Self Certification of Absence

This certificate is to be completed by the employee to cover:-

1. Absences lasting less than 7 calendar days.
2. The first 7 days of any absence lasting 8 or more days (This form must be returned with your Certificate of Fitness).
3. A second certificate must also be completed on return to work.
4. Failure to complete and submit this form to your line manager could result in the loss of sick pay and statutory sick pay and formal action in line with Trust policy and procedure

First Name: Surname

Assignment No: Band: Department:

National Insurance No: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Commencement of Illness		**Time:**
First Working Day of Absence **(if different to the above)**		**Time:**
Last Day of sickness		
Last Working Day of Absence **(if different to the above)**		
Actual Date of Return to Work		**Start Time:**
Total	**Working Days:**	**Working Hours:**

Absence Reason:

Back Condition ☐ Skin Disorders ☐ Other (Mental Health) ☐

Injury/ Fracture ☐ Arms/Shoulders Condition ☐

Headache/Migraine ☐ Stress/Anxiety/Depression ☐

Other musculoskeletal ☐ Cold/Flu ☐ Gastrointestinal problems ☐

Respiratory Condition ☐ ENT ☐ Long term condition ☐

Pregnancy Related Absence ☐ Skin disorders ☐

Benign & malignant tumour/ cancers ☐ Dental/oral ☐ Gynaecological ☐

Other ☐ **Please specify what other**: .

Type of Absence:

Work Injury ☐ Work Related Sickness ☐ Pregnancy Related Absence ☐

Other Sickness ☐ Personal circumstances ☐ Accident Outside of Work ☐

Did this accident cause you to consult a medical practitioner or attend hospital? ☐

Was your injury due to an accident involving a third party, e.g. road traffic accident? ☐

I am signing to confirm that the information that I have provided during my sickness absence is correct to the best of my knowledge and that during this period of sickness absence I have not undertaken any paid or unpaid employment (without prior agreement) whilst also claiming sick pay from the Trust. ☐

or

I have undertaken work during the time I have been absent from work through illness ☐

Please provide details

………
……….

Signed: ____________________ **Print**: **Date**:

NB: *Failure to declare accurate and truthful information on this form may lead to disciplinary action and result in matters being referred to the Trust's Local Counter Fraud Specialist to investigate.*

THIS FORM SHOULD BE COMPLETED WITH YOUR LINE MANAGER AS PART OF THE INFORMAL PROCESS.

NOTE FOR LINE MANAGER

A copy of this page should be placed on the employee's personal file. Where appropriate action is required, an e-mail copy may be forwarded to your relevant HR representative.

Appendix E- Sickness triggers for part time workers

The table below shows in hours those who will trigger following the 10 days in a rolling 12 month as stated in the short term sickness of the policy.

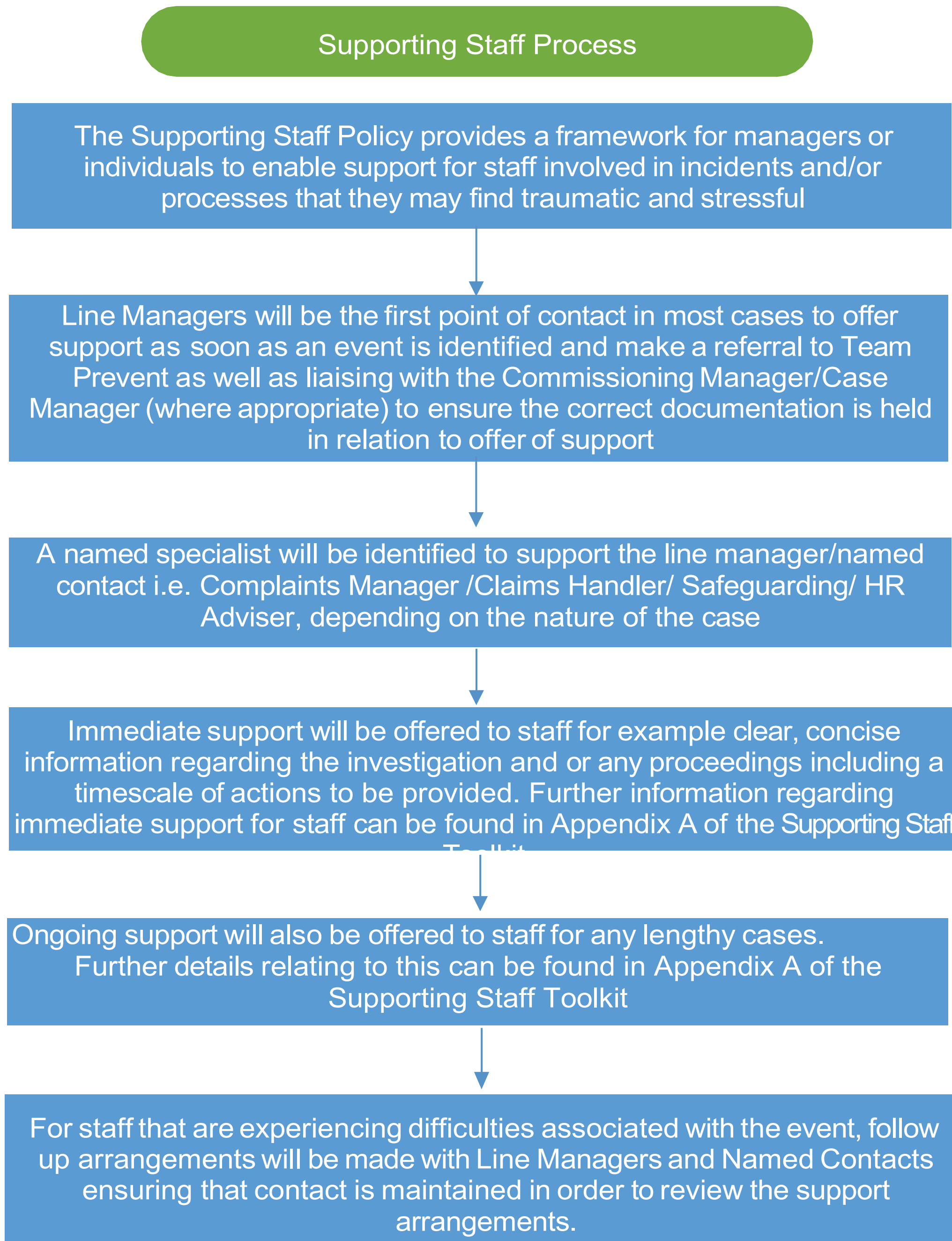
Weekly Working Hours	Trigger Hours (10)	Weekly Working Hours	Trigger Hours (10)	Weekly Working Hours	Trigger Hours (10)
7.5	15	18	36	28.5	57
8	16	18.5	37	29	58
8.5	17	19	38	29.5	59
9	18	19.5	39	30	60
9.5	19	20	40	30.5	61
10	20	20.5	41	31	62
10.5	21	21	42	31.5	63
11	22	21.5	43	32	64
11.5	23	22	44	32.5	65
12	24	22.5	45	33	66
12.5	25	23	46	33.5	67
13	26	23.5	47	34	68
13.5	27	24	48	34.5	69
14	28	24.5	49	35	70
14.5	29	25	50	35.5	71
15	30	25.5	51	36	72
15.5	31	26	52	36.5	73
16	32	26.5	53	37	74
16.5	33	27	54	37.5	75
17	34	27.5	55		
17.5	35	28	56		

Formula: - (Weekly working hours x 2)

Alder Hey Children's
NHS Foundation Trust

E31 - SUPPORTING STAFF POLICY

Version:	5.1
Name of ratifying committee:	People and Wellbeing Committee
Date ratified:	23/03/2021
Name of originator/author:	Zoe Connor
Name of approval committee:	Employment Policy Review Group
Date approved:	09/02/2021
Executive Sponsor:	Director of Human Resources
Key search words:	Support, witness, traumatic, stress, E31
Date issued:	February 2024 (Extension)
Review date:	May 2024


Supporting Staff Process
The Supporting Staff Policy provides a framework for managers or individuals to enable support for staff involved in incidents and/or processes that they may find traumatic and stressful
Line Managers will be the first point of contact in most cases to offer support as soon as an event is identified and make a referral to Team Prevent as well as liaising with the Commissioning Manager/Case Manager (where appropriate) to ensure the correct documentation is held in relation to offer of support
A named specialist will be identified to support the line manager/named contact i.e. Complaints Manager /Claims Handler/ Safeguarding/ HR Adviser, depending on the nature of the case
Immediate support will be offered to staff for example clear, concise information regarding the investigation and or any proceedings including a timescale of actions to be provided. Further information regarding immediate support for staff can be found in Appendix A of the Supporting Staff
Ongoing support will also be offered to staff for any lengthy cases. Further details relating to this can be found in Appendix A of the Supporting Staff Toolkit
For staff that are experiencing difficulties associated with the event, follow up arrangements will be made with Line Managers and Named Contacts ensuring that contact is maintained in order to review the support arrangements.

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
5.1	February 2024	Zoe Connor	Current	Extension until May 2024
5	March 2021	Zoe Connor	Archived	Policy renamed
Supporting Staff Involved in Traumatic or Stressful Incidents, Complaints or Claims Policy – E31				
4.1	December 2020	Katie Toner	Archived	3 month extension
4	November 2017	Katie Toner	Archived	Rewrite of out of date policy
3	February 2011	Rachel Patterson	Archived	Minor revisions to reflect CBU structure
2	November 2009	Linda Guatella	Archived	Policy number has changed (from RM49 to E31)
1	January 2007	Risk Manager	Archived	Policy number RM49

Record of changes made to Supporting Staff Policy – Version 5.1			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	All	Version and date changes	Extension
Various	Various	Updated support available to staff and managers	More resources available

Record of changes made to Supporting Staff Policy – Version 5			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
All	1	Policy renamed	To shorten title and ensure that it is clear the policy is applicable to all staff and managers requiring support
Various	Various	Updated support available to staff and managers	More resources available

Contents

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1 Introduction

1.1 The Trust recognises that during the course of working practice, members of staff may occasionally become involved in incidents and/or processes that they may find traumatic and stressful.

1.2 Examples of some of the investigative and procedural scenarios whereby staff may require support, either because they are the focus of the investigations or they are individuals giving evidence in the investigations, are set out as follows:

- Investigations in line with Trust Disciplinary policy
- Serious Untoward Incident
- Allegations of negligence
- Serious complaints or claims
- Inquest
- Police investigation
- Professional Conduct Hearing (i.e. General Medical Council/Nursing and Midwifery Council)
- Court Proceedings (i.e. Child Protection/Care Order)
- Fraud, Bribery or Corruption Investigation

Staff may experience events outside of work that could be stressful and traumatic and may require support from the organisation during times of difficulty

1.3 Objectives

- To provide a framework for managers or individuals to enable support for staff involved in incidents and/or processes that they may find traumatic and stressful
- To value, support and protect staff involved in incidents and/or processes that they may find traumatic and stressful
- To provide ongoing support in the 'best interests' of the individuals concerned

2 Definitions

RCN - Royal College of Nursing

GMC - General Medical Council

3 Duties

3.1 The Trust Board

i. To ensure that there is an approved process to adequately support staff involved in traumatic or stressful incidents.

ii. To ensure a fair and consistent approach to individuals involved in traumatic or stressful incidents.

3.2 Associate COO / Clinical Director

i. To ensure that support is offered to all staff in appropriate cases and that the support is consistently offered during the full course of any investigation or other process.
ii. To review support offered in individual cases to ascertain whether there are any learning points for future cases.

3.3 Line Managers / Named Contact

i. Line managers will in most cases be the first point of contact (the named contact) for an individual requiring support. In certain circumstances (i.e. where there may be a conflict of interest) it may be appropriate for the individual to seek assistance from Human Resources and/or Risk Management Department who will agree a named contact with the member of staff seeking support. Alternatively, staff may nominate a named contact which would be agreed by HR to ensure there is no conflict of interest.

ii. The Line Manager/named contact will in all cases offer support to staff as soon as the event is identified. The support offered should be immediate and proportionate to the event. Support will normally be arranged internally within the organisation; however provision of external support will be made available according to individual need. The Line Manager/named contact will also ensure staff are aware of counselling and support services available.

iii. The Line Manager/named contact should ensure that the Commissioning Manager/Case Manager (e.g. for Bullying & Harassment/Disciplinary Investigations) is made aware and that appropriate documentation is held and preserved in relation to offers of support.

iv. To ensure that support is offered to all staff in appropriate cases and that the support is consistently offered during the full course of any investigation or other process (as indicated in 1.2).

v. To review the support offered in each case with staff involved.

vi. To identify any learning points for future cases and ensure staff are de-briefed following traumatic incidents.

3.4 Occupational Health Manager

i. Team Prevent would be advised of any case and should contact the employee when a referral has been made and recommend confidential counselling as appropriate.

3.5 Named Specialist

i. It is the responsibility of named specialists to offer support to the line manager/named contact in supporting staff involved in incidents, claims or complaints where appropriate. This also may include advice in relation to preparing to be a witness to attend court or Employment Tribunal. Depending on the nature of the case, a named specialist will be identified to

give specific advice as identified by the line manager/named contact in conjunction with HR.

3.6 Human Resources

i. To promote the fair and consistent application of the Trust's Staff Support Policy and to monitor the implementation of this policy to ensure procedures are managed fairly across the Trust.

ii. To ensure staff attending an Employment Tribunal and Regulatory Body Hearings e.g. NMC, HCPC, as a witness for the Trust are supported in preparation for any hearing, with appropriate support and guidance provided as applicable

3.7 Individual Staff Members

i. Any individual involved in cases illustrated in Section 1.2 has a responsibility to consider any support offered and to identify to line manager/named contact if the support offered does not meet their needs.

ii. To attend follow up and review meetings to ensure that ongoing support is considered and identify any learning points for future cases.

iii. Individual staff members are strongly advised to have access to professional and legal advice either through a trade union or trade protection body or through other insurance mechanism. The Trust cannot provide any financial support for legal purposes to staff in such circumstances.

4 Immediate Support Offered to Staff

4.1 The Trust recognises that staff can often feel vulnerable when involved in investigations and/or procedures. It is particularly important that individuals are appropriately supported during and after the investigation and/or procedure. Individuals, regardless of band or position, will often feel anxious about their involvement and their future role in the process. In all cases there will be a named contact at the Trust who will be responsible for ensuring support. Further information on support that can be offered to staff can be found in the Supporting Staff Toolkit. The checklist should be maintained on the individual's local personal record and the individual concerned should also retain a copy for regular review.

4.2 The process of supporting staff involved may be linked to some of these issues and line managers/named contacts should ensure that support to staff is maintained as a key focus Reasonable time off may be agreed in accordance with the Special Leave Policy and in conjunction with HR advice.

5 Ongoing Support Offered to Staff

The process of investigative and procedural issues can occasionally be very time consuming for staff involved. The progress can also be quite lengthy, and some cases will take years rather than months to conclude. This is particularly the status for claims, police investigations and professional conduct

investigations. Further information regarding ongoing support for staff can be found in the Supporting Staff Toolkit.

Managers should remember that, in the initial stages following an event, they or a staff member may be unaware of the impact of that event on their well-being or ability to undertake their full duties. For this reason, it is essential that on-going support is provided and regularly reviewed. This should involve a a one to one meeting no later than 2 weeks after the event. At this meeting, both the staff member and manager/equivalent should ensure support is underway and any follow up arrangements for members of staff experiencing difficulties should be put in place with immediate effect, if this has not already been commenced.

6 Follow up Arrangements for Staff Members Experiencing Difficulties Associated with the Event

6.1 Line managers and named contacts need to maintain contact with staff, in order to review the support arrangements; this includes staff who have adjusted their role or who are absent due to sickness.

6.2 Contact should be made at least fortnightly and this can include telephone support and arranging to meet with the individual concerned during the period and should also be documented.

6.3 Line managers should manage absence in accordance with the Trust's Supporting Sickness and Attendance policy and procedure and ensure that any appropriate referrals are made i.e. Occupational Health Department, Staff Advice and Liaison Service and the Alder Centre.

7 Monitoring

7.1 Monitoring will incorporate monthly HR dashboard reporting contained within Board and Corporate reporting processes and includes equality monitoring processes.

8 Training

8.1 Regular coaching and/or training will be made available to managers and supervisors to ensure all relevant policies are understood and implemented. A Supporting Staff Managers Toolkit is available to support managers in the implementation of this policy.

9 Further Information

Associated Documentation

Incident Reporting and Management Policy Inclusive of Serious Incident Procedure and After Action Review Procedure – RM2
Management of Incidents Policy Claims Policy – RM7
Complaints and Concerns Policy – RM6
Disciplinary Policy E5
Supporting Sickness and Attendance Policy – E4
Special Leave Policy -14
Anti-Fraud, Bribery and Corruption Policy – M64

Equality Analysis (EA) for Policies		
Please refer to Equality Analysis Step Wise Guide when completing this form		
Policy Name	Supporting Staff Policy	
Policy Overview	This policy provides a framework for managers and individuals for support and guidance for staff involved in situations and/or processes that they may find traumatic and stressful. The aim of this policy is to promote the support available for staff and to value, support and protect staff involved in incidents and/or processes that they may find traumatic and stressful. This policy provides ongoing support to support the welfare and wellbeing of the individuals concerned	
Equality Relevance Select LOW, MEDIUM or HIGH	HIGH	
If the policy is LOW relevance, you **MUST** state the reasons here.	N/A	
Form completed on:	Date: 19/03/2021	
Form completed by:	Name: Zoe Connor	Job Title: Senior HR Business Partner

If LOW relevance, proceed to Approval and Ratification Section. No further information required

If MEDIUM or HIGH Equality Relevance, complete all sections	
Equality Indicators Identify the equality indicators which will or could potentially be impacted by the policy. (see Equality Relevance to assess the impact on each protected characteristic)	Age ☐ Details: . There is no perceived differential or detrimental impact. The policy enables support to be provided in a fair and consistent manner that supports their best interests, wellbeing and welfare. Disability ☐ Details: There is no perceived differential or detrimental impact. The policy enables support to be provided in a fair and consistent manner that supports their best interests, wellbeing and welfare. Gender reassignment ☐ Details: There is no perceived differential or detrimental impact. The policy enables support to be provided in a fair and consistent manner that supports their best interests, wellbeing and welfare. Marriage & Civil Partnership ☐ Details: There is no perceived differential or detrimental impact. The policy enables support to be provided in a fair and consistent manner that supports their best interests, wellbeing and welfare. Pregnancy or Maternity ☐ Details: There is no perceived differential or detrimental impact. The policy enables support to be provided in a fair and consistent manner that supports their best interests, wellbeing and welfare. Race ☐ Details: There is no perceived differential or detrimental impact. The policy enables support to be provided in a fair and consistent manner that supports their best interests, wellbeing and welfare. Religion or Belief ☐ Details: The Trust currently provides facilities for differing religious beliefs. The policy enables support to be provided in a fair and consistent manner that supports their best interests, wellbeing and welfare. Sex ☐ Details: Although there are more female staff within this organisation, there is no perceived differential or detrimental impact. The policy enables support to be provided in a fair and consistent manner that supports their best interests, wellbeing and welfare.

	Sexual Orientation ☐ Details: There is no perceived differential or detrimental impact. The policy enables support to be provided in a fair and consistent manner that supports their best interests, wellbeing and welfare. Human Rights (FREDA principles) ☐ Details: There is no perceived differential or detrimental impact. The policy enables support to be provided in a fair and consistent manner that supports their best interests, wellbeing and welfare.
Equality Information & Gaps What equality information is available for protected groups affected by the policy? If none available, include steps to be taken to fill gaps.	Primarily all staff are affected, including managers, senior managers, staff side representatives and consequently to service users, patients and the wider community. Evidence considered: NHS Employers, ACAS, other NHS Trusts, HR Networks across the Northwest in relation to best practise guides, staff side representatives gave staff experiences, CIPD research forums. Equality monitoring takes place as part of the Trust's overall equality monitoring processes.
Stakeholder Engagement What stakeholders are engaged to help understand the potential effects on protected groups?	Trade Union Officials and Managers were consulted with during the writing and ratification of this Policy. Feedback from these groups was acted upon and the Policy was amended to reflect any comments made. This Policy was written in conjunction with legal requirements and in line with the NHS Terms and Conditions of Employment. PRG's membership constitutes members of our Trade Union and Network Groups.
Interdependency How will this affect other policies, projects, schemes from an equality perspective?	Other policies which may be impacted by the policy are: • Handling Concerns about the Conduct, Performance & Health of Medical and Dental Staff Policy - E27 • Disciplinary Policy – E5 • Capability and Performance Policy - E30 • Supporting Sickness and Attendance Policy - E4 • Respect at Work Policy – E24 • Grievance Policy – E7 • Anti-Fraud, Bribery & Corruption Policy – M64 • Raising Concerns (Whistleblowing Policy) – E29 • Reasonable Adjustments Guidelines
Summary of Equality Analysis Findings & Mitigation Include details of all actions to mitigate negative equality impact on protected groups.	No discernible impact has been identified however mechanisms for scrutiny and monitoring for further development are in place.
Monitoring Include details of how the equality impact will be monitored.	This policy will be reviewed again in three years time as per standard procedure unless legislative requirements deem a sooner review.

If MEDIUM or HIGH relevance, the EA should be reviewed annually. Complete Approval and Ratification Section.

Approval & Ratification of Equality Analysis		
Policy Author:	Name: Zoe Connor	Job title: Senior HR Business Partner
Approval Committee:	Employment Policy Review Group	Date approved: 09/02/2021
Ratification Committee:	People and Wellbeing Committee	Date ratified: 23/03/2021
Person to Review Equality Analysis:	Name: Sharon Owen	Review Date: 23/03/2024
Comments:	Click here to enter text.	

Tier 4 Service - Guidance for Managing Violence and Aggression within the Workplace

1 Introduction

1.1 Alder Hey Children's NHS Foundation Trust (AHCNFT) has a duty under the Health and Safety At work Act 1974, to protect staff from the effects of violence at work and aims to minimise incidents of violence and aggression but recognises that due to the unpredictable nature of such acts, it cannot be eliminated. However, violence and aggression are unacceptable and will not be tolerated.

1.2 The Tier 4 Service (T4) is a Children's Mental Health Unit within AHCNFT, which provides assessment and treatment to a broad range of mental health and behavioural conditions. As such, there is a higher incidence and probability of having to deal with violent and aggressive incidents within its patient group.

1.3 The T4 Service has considerable expertise in dealing with children who present with violence and aggression (V&A). It has an integrated approach to dealing with this which starts pre-admission and includes detailed risk assessment, Positive Behavioural Support plans and regularly updated risk management plans.

1.4 The T4 Service does not condone the use of violence and aggression by any young people; parents / carers or other visitors to the service and recognises violence; the threat of violence and intimidating abuse is particularly distressing and can be difficult to deal with.

1.5 This guidance should be read in conjunction with AHCNFT policy: **RM9 – Preventing and Managing Violence and Aggression at Work and Protecting Lone Workers Policy** (see on DMS)

2 Duties

2.1 The Risk Management Team and Local Security Management Specialist (LSMS) has delegated responsibility to investigate and advise / ensure appropriate actions are in place including preventative measures and actions.

2.2 The T4 service's identified Clinical Case Manager and Consultant Psychiatrist are responsible for ensuring thorough risk assessment and care plan needs are identified and the Team Coordinator is responsible for the day-to-day provision and update within the inpatient service.

2.3 The Consultant Psychiatrist is responsible for ongoing mental state monitoring and communication of this and needs to relevant parties.

2.4 The T4 Service Core Team involved are responsible for ensuring all incidents are discussed and consideration given to care plan changes and communicating this across the team and with the child / young person and parents / carers.

2.5 The Modern Matron is responsible for the operationalisation of this guidance; ensuring all staff understand and adhere to it and follow identified governance processes in place. They will consider ongoing staff support needs.

2.6 All employees / staff must co-operate / comply with this guidance and the measures of safety and attempt to minimise potential violent situations either by withdrawing where safe / appropriate to do so or by appropriate responses as a member trained in the use of approved restrictive interventions in line with the MHA Code of Practice 2015, and in consideration of the Mental Health Unit's (Use of Force Act) 2018 (Mental Health Units (Use of Force) Act 2018 - GOV.UK (www.gov.uk)

2.7 All employees must also make themselves aware of and manage factors which influence violent incidents including their own attitudes and interpersonal skills. The use of the T4 Service debrief model and process will support this.

2.8 It is essential that all employees / staff inform the LSMS at the earliest practicable time of any assault so that guidance and support can be provided.

3 Indicators of violence (signs):

3.1 Staff should be observant and mindful for the following indicators:

- Restless behaviour
- Deliberate provocative conduct
- Negative / aggressive facial expressions / body language
- Attention seeking behaviours
- Negative reactions to instructions
- Tension
- Threats and verbal abuse towards others
- Known or potentially violent patterns / triggers for an individual

3.2 **In cases of repeated abuse:**

Consideration should be given to:

- Change of staff
- Amendment to observation levels / approaches to this
- Positive behavioural support / management care plan
- Communication approaches

4 Incident reporting systems:

4.1 All incidents are reported on the Trust Ulysses system

4.2 The T4 Service also has a daily debrief process which reviews incidents of violence and aggression – Refer to MH2 for further details: **Safe and Therapeutic Responses to Disturbed Behaviour Policy – MH2** (on DMS)

4.3 In addition, staff can also call an additional issue meeting if there are ongoing concerns about safety to patients and staff – Refer to local T4 service guidance for further details.

5 Supporting staff:

5.1 Staff will be supported through the following:

- **Provision of a safe working environment** – this is supported through the T4 Service environmental risk assessment guidance and processes and skill mix / staffing levels which are determined in line with the identified observation level for a young person.

- **Provision of appropriate security systems** – this is supported through the T4 Service operational processes in the use of security processes that may be used as a control measure for violence and aggression. These include:

    - Service provision of security staff
    - CCTV
    - Fob system to prevent immediate access to defined areas
    - Locks and keypads to close-down areas
    - Personal alarms
    - View panels in doors
    - Lone worker app on work mobile phones

- **Systems in place for external outings / trips with children / young people** – This is supported through:

    - Clinical risk assessment with consideration of safe staffing off the unit and where required a stepped approach to managing outside of the unit environment in relation to planned positive risk taking
    - Observational data around interactions and responses to others and activities to support risk assessment and safety measures e.g., responses on a 1:1 versus within a group; responses to parent / carer; noise / busy environments; responses to walking / use of other transport means etc,
    - Mental state consideration prior to any planned leave taking place- includes wait and review process where concerns are noted
    - Option for additional environmental risk assessment of community venue e.g., the home or for a visit to museum etc.
    - Patient identification form for all admissions – includes description of distinguishable features in case of absconding so can be shared immediately with police
    - Leave monitoring form – completed prior to leaving building – includes note of ensuring Nurse in Charge aware / agreed leave; planned destination and estimated time of return; description of patient clothing and confirmation of work phone taken

- **Organisational procedures / processes** – this is supported through a range of unit guidance such as:
    - Environmental risk assessment and management guidance
    - Clinical risk assessment and management guidance
    - Self-harm assessment and management guidance
    - Harmful substances guidance
    - Safe and supportive observation of children / young people at risk guidance
    - Search of person and belongings guidance
    - Locked doors guidance
    - Visitor guidance

  And Trust policy in relation to:

    - MH2 – Safe and therapeutic responses to disturbed behaviour policy.
    - MH3 - Seclusion policy for the T4 Service
    - Guidance on Rapid Tranquillisation for the T4 Service

- **Information**- the T4 Service provides timely information on admissions; risk factors and proposed management / care plans in line with these as part of the admission process. There are also regular audits in place which look at incidents when restrictive practices have had to be utilised which will inform service development needs.

- **Training and development opportunities** – within the T4 service, all staff are expected to complete appropriate training in a range of risk assessment and management approaches for managing children / young people who attend the service as outlined in mental health policy and procedures. Refer to training section for details. In addition, a regular programme of clinical presentation and reflective practice is in place which supports this.

  In addition, the unit has supported some staff to undertake training in functional behavioural analysis which will support staff in the identification and management of challenging behaviours.

- **Clinical supervision processes** – All staff have access to both individual and group supervision processes where incidents / cases can be discussed to help inform and deal with problems of violence and aggression.

- **Appropriate support** - Staff can also be offered and supported to access counselling from the Trust counselling service through Occupational Health Service.

- **Debrief process** – the T4 service has a debrief process – Refer to **Safe and Therapeutic Responses to Disturbed Behaviour Policy – MH2** (on DMS) for further details.

- **Specialist advice** - They will also have the opportunity to receive specialist advice from the LSMS am and Risk Management Team –especially in instances where they may have been the victim of violence.

- **Working relationships with police** – The unit works to establish a clear working relationship with police and the Trust's Violence Reduction Officer as required, to ensure supportive and appropriate structures are in place.

6 Training and development of staff:

6.1 Staff are made aware of the level of risk and potential risks of individuals / groups of children / young people along with local arrangements for managing these within the unit.

6.2 **A local training and development programme is in place which covers:**

- Safe and supportive observations of children / young people at risk
- Clinical risk assessment and management
- Environmental risk assessment and management
- Positive behavioural support
- CALMS training
- The safe use of seclusion
- The safe use of rapid tranquillisation

7 Process for generic incident management:

7.1 In all instances, there should be documented evidence that senior staff have taken a stepped approach in collaboration with the child and parents to manage incidents of violence and aggression in addition to the usual processes in place covered by:

- Risk assessment and management planning
- Therapeutic activities
- Positive behavioural support plans
- Observations / supervisory processes

7.2 If the above is not having the required effect, consideration should also be given to collaboration of a range of approaches agreed in the context of the severity of the presentation and related factors such as mental / psychological state and capacity etc. such approaches may involve:

- **Verbal warning** – this should be undertaking by a Senior staff member and be communicated in a manner that the child / young person can understand it. It should identify the issue; reasons clarified around the behaviour; inform clearly that this type of behaviour is not acceptable and outline responsibilities and consequences of this should it continue / be repeated.

- **Written warning** – Follows after a verbal warning and produced in a format suitable to the individual. This should be written by a service senior clinician (e.g., Responsible Clinician / Consultant Psychiatrist or Inpatient Nurse Manager). It should cover what a verbal warning provides and should also identify any future sanctions that will be considered.

- **Behavioural contracts** – a drawn up written agreement which details behaviours and consequences along with a joint agreement of the plan including what should happen if there is a deterioration in expected / desired behaviours.

- **Alternative treatment options** – The Multidisciplinary Team (MDT) has a responsibility to consider and where possible implement alternative arrangements to how care is provided to reduce risk. For e.g., is the child / young person best managed as a day attender / partial admission or outpatient etc., in place of residential; consideration of transfer to a more suitable environment / placement; time limited / fixed term leave plan.

    - Where a time limited / fixed leave plan is considered appropriate, this requires agreement across the MDT as well as parents / carers; referrer and in agreement with commissioner and needs to be effectively risk assessed and a management plan agreed; communicated and understood with locality network as they may need to provide input / monitor during this period. An e.g., may be a fixed term 24 hour leave plan for the child / young person and parents / carers to think about the behaviour and their commitment to treatment by the service.

- **Criminal prosecution** – This should be undertaken in line with the individuals' capacity and mental state

7.3 In relation to concerns around a colleague not adhering to policy and procedure or concern around their approach in managing a child / young person, the member of staff should raise these immediately with their line manager, designated other. All staff will follow Trust policy and procedures in relation to safeguarding children - **Safeguarding Procedures** (see on DMS) with particular reference to **Section 18: People in positions of Trust – Managing allegations**

8 Process for Incident management and involvement of the police:

8.1 It is important where possible, that involvement of the police is proactively considered with the multi-disciplinary team (MDT) to try and understand causes and application of preventative measures e.g., staff application of different approaches at the earliest opportunity to prevent escalation.

8.2 Any decision to call the Police should be taken in consultation with a senior member of staff i.e., Consultant Psychiatrist, or Inpatient Manager within working hours.

8.3 If a serious incident of this nature arises out of hours, the Nurse in Charge should contact the Second On-Call Consultant Psychiatrist, so there is understanding and agreement as well as support as required.

8.4 Management / supervisory authorisation is not required before calling the police.

8.5 **Police can be called in an emergency** (i.e., 999). Police guidance regarding when to dial 999 is as follows:

"An emergency call should be made whenever there is the immediate threat of injury to the person or damage to or theft of property"

8.6 This will include incidents where the police are required to manage a particular incident e.g., a serious assault with a weapon or a hostage situation.

8.7 The Police may also be called if the level of violence and aggression is beyond that which the nursing team can safely manage. This should be an exceptional situation and should be dealt with as a serious and untoward incident (SUI). See **Incident Policy – RM2** (see on DMS)

8.8 **Following an emergency call to the police, staff must then:**

- Notify the Responsible Clinician or Out of Hours Psychiatrist.
- Notify Trust bleep holder (306) who will in turn notify Trust lead on call.
- Notify the nearest relative / carer
- Notify the child / young person
- Effectively communicate to all staff on duty
- Log the incident on Ulysses

8.9 If an incident has already occurred and the immediate threat of injury or further injury to persons is not present, then incidents are to be reported, subject to the wishes of the victim to local police.

8.10 **In all instances, staff must:**

- Be clear why they are calling police
- Understand and relay what assistance is required
- Identify what the level of risk is assessed as e.g., threat to life
- Identify if weapons are being used

The provision of this information will ensure appropriate priority weighting by the call centre.

8.11 Where appropriate, and/or following discussion with the care team, incidents must be reported to the police in a timely fashion which would assist in any possible investigation.

8.12 When reporting alleged assaults to the police, and police attendance is not required, this must be clearly stated and only a police incident number obtained. This will avoid unnecessary attendance by the police.

8.13 Incidents arising due to service users' mental health condition when they do not have capacity **may not** constitute assault in accordance with the legal definition, however, any victims have the right to report incidents to the police and must be supported by line managers to do so.

8.14 Staff should consult with the service users care team to seek advice and agree an appropriate course of action.

8.15 **Urgent but not an emergency –**where there is no significant loss of control e.g., missing service user but police attendance is required due to their vulnerability, staff must contact the police.

8.16 Following this, staff must then:

- Notify the RC or OOH
- Notify Trust bleep holder (306) who will in turn notify Trust lead on call

- Notify nearest relative / carer
- Inform the child / young person
- Communicate to all staff

8.17 Once police arrive:

- It is important the nurse in Charge liaises and provides them with information on:
  - The duration of the violent behaviour
  - Mental state of the individual
  - Any recent medications given / taken
  - Physical health concerns / history
  - Reasons for engaging the police
  - Desired outcome for engaging the police

- The police have the right and responsibility to decide what type of intervention to use to manage the incident, but it is the duty of staff to provide them with the information that will make the process easier and safer.

- Where the police attend to assist the service, in line with the Mental Health Units (Use of Force) Act 2018, they are required to use a body camera.

- It is important that staff remain engaged with the process and keep close contact with the police throughout.

9 Service Users and Informal Police Interview

If attendance by the police is for the purpose of interviewing a service user within the inpatient unit, the NIC must be informed immediately and:

- Notify the RC of police request to interview service user
- Notify nearest relative / carer
- Ensure appropriate room available
- Ensure parent / carer or appropriate agreed staff member available
- Where the young person refuses to be interviewed, the police will advise on next possible actions

10 Restorative meeting

10.1 These are often suggested by police where potential criminal acts have occurred. Restorative justice is a two-way communication between the victim and offender with support / facilitation by police to help the offender take responsibility for their act, express remorse and make amends. It holds offenders to account, providing them with an opportunity to learn from their actions. It also empowers the victim by giving them a voice and a chance to explain the real impact of the act.

When agreed, staff should:

- Notify nearest relative / carer
- Ensure appropriate room available

- Ensure parent / carer or appropriate agreed staff member available
- Where the young person refuses to be interviewed, the police will advise on next possible actions

10.2 In all instances, details and outcomes should be documented within the individual's notes where appropriate.

10.3 The local Police station contact details are as follows:

Huyton Police Station
Laythom Road
Huyton
Liverpool
L36 9XU

Nearest 'walk in desk' as above
Open Monday to Friday between 10 am and 8pm
And Saturday between 10 am and 6pm

0151 709 6010 (Main switchboard number at headquarters

EMERGENCIES phone 999

NON EMERGENCIES phone101

11 Post incident:

11.1 Following all incidents, the nurse in charge should ensure:

- Mental state review as this helps to establish the likelihood of a realistic criminal action being undertaken

- And assess risks of recurrence; determine next steps of treatment etc.

Document Control Sheet

Tier 4 Service - Guidance for Managing Violence and Aggression within the Workplace	
Version:	4
Name of ratifying committee:	Community and Mental Health Division Integrated Governance Committee
Date ratified:	4th October 2022
Name of originator/author:	Andrea O'Donnell, T4 Service Lead Greg Murphy - LSMS
Date issued:	January 2023
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Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
4	October 2022	Andrea O'Donnell	Current	Changed DJU to T4 service and made some updates to information and police contact details
3	September 2020	Andrea O'Donnell	Archived	Minor changes
2.1	May 2020	Andrea O'Donnell	Archived	
2	January 2020	Andrea O'Donnell	Archived	6 month extension. Executive approved.
1	November 2016	Andrea O'Donnell	Archived	

Review & Amendment Log Record of changes made to document since last approved version			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
Through out	Throughout	DJU changed to T4 Service	Name change
2.6	2	Added "And in consideration of the Mental Health Unit's (Use of Force Act) 2018	Essential to management of violence and aggression and staff and police requirements
4.2	2	Added links to MH2	Links not embedded
5.1	3	Added use of lone worker app in process and added systems in place for external outings	To firm up systems in place when going off unit premises
6.2	4	Changed to CALMS training	New name/provider
7.2	5	Added "….service senior clinician (e.g., RC/Consultant Psychiatrist or Inpatient Nurse Manager)."	To define who can write written warning
7.2	5	Added …as a day attender/partial admission or outpatient etc.,	New options that can be considered
7.3	6	Added section and links to safeguarding procedures with additional reminder around concerns related to staff	To ensure clear procedure followed
8.17	7	Added – "Where the police attend to assist the service, in line with the Mental Health Units (Use of Force) Act 2018, they are required to use a body camera."	To ensure awareness and expectation of the police to do this.
10.1	8	Added information on what is involved in a restorative meeting	For information
10.3	8	Updated police station details	Service site move