Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Reference Number: FOI202425/082
From: Other

Date: 20 May 2024

Subject: Violence policy and trust self-assessment

Q1 Please can you provide me with 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 Please see attached:
Managing Violent, Aggressive and Anti-Social Behaviour Policy
Bullying and Harassment at Work Policy
Lone Worker Policy

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 Please see attached:
Managing Violent, Aggressive and Anti- Social Behaviour Policy
Supporting Staff Following Work Related Trauma Policy
Patient Safety Incident Response Policy
Managing Attendance Policy

Please note:
The Supporting Staff Following Work Related Trauma Policy is currently in the process of being reviewed by HR.

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):
https://www.england.nhs.uk/publication/violence-prevention-and-reduction-standard/

A3 Information not held – the Trust does not submit a self-assessment against the NHS Violence Prevention and Reduction (VPR) Standard.

Bullying & Harassment at Work

Policy

For completion by Author			
Author(s) Name and Title:	Stephanie Graham, HR Business Partner		
Scope:	Trust Wide	Classification:	HR
Version Number:	6.0	Review Date:	02/05/2025
Replaces:	Addressing Bullying & Harassment at Work Version4.1		
To be read in conjunction with the following documents:	Freedom to Speak Up) Policy Grievance Policy Disciplinary Policy Handling Concerns about the Conduct, Performance & Health of Medical Staff Policy (MHPS)		
Document for public display:	Yes		
Executive Lead	Karen Nightingall		

For completion by Approving Committee			
Equality Impact Analysis Completed:		Yes	
Endorsement Completed:	Yes	Record of Changes	No
Authorised by:	People Delivery Group	Authorisation date:	02/05/2023

For completion by Document Control					
Unique ID No:	TW05(08)	Issue Status:	Approved	Issue Date:	11/05/2023
After this document is withdrawn from use it must be kept in archive for the lifetime of the Trust, plus 6 years.					
Archive:	Document Control		Date Added to Archive:		
Officer responsible for Archive:	IG and Document Control Facilitator				

Contents

Document Statement

Liverpool Heart and Chest Hospital is committed to providing a working environment free from harassment and bullying and ensuring all staff are treated, and treat others, with dignity and respect.

The policy covers harassment or bullying which occurs at work and outside of the workplace, such as on business trips or work-related events or social functions. It covers bullying and harassment by staff (which may include consultants, contractors and agency workers) and also by third parties such as visitors.

The Trust expects all employees to conduct themselves in a manner that reflects positively on the organisation and high standards of behaviours are required, as set out in its 'IMPACT' values & behaviours.

1. Roles and Responsibilities

1.1 Chief People Officer

The Chief People Officer is responsible for the development and implementation of this policy.

1.2 People Committee

The People Committee will monitor performance against this policy.

1.3 People Delivery Group

This group will be responsible for ratifying and reviewing the policy through delegated responsibility from the People Committee. The group will ensure appropriate management and staff side consultation through Policy Development Group (PDG) when reviewing the policy and will monitor its applications and outcomes.

1.4 Responsibilities of all Employees

1.4.1 It is the employee's responsibility to ensure they treat their colleagues and others with dignity and respect. The employee should always consider whether their verbal / written words or conduct could be offensive. Even unintentional harassment or bullying is unacceptable.

1.4.2 It is the employee's responsibility to bring any bullying and/or harassment at work complaint that they have to the attention of their Line Manager (or the Manager immediately more senior, where their concern relates to their Line Manager) without delay.

1.4.3 It is the employee's responsibility to attempt to resolve any complaint on an informal basis where appropriate and wherever possible and to capture records of any informal complaints.

1.4.4 Any employee asked to provide evidence that relates to a bullying and/or harassment at work complaint must do so, providing any relevant information they know or have.

1.4.5 All employees must familiarise themselves with the Trust Values and Behaviours.

1.5 Responsibilities of Managers

1.5.1 Managers must treat allegations of harassment or bullying seriously and address them promptly and confidentially, where possible.

1.5.2 Managers have an obligation to prevent bullying and/or harassment and to take immediate action once it has been identified. A Manager has the discretion to escalate concerns of bullying and/or harassment whether a complaint has been made.

1.5.3 It is the Line Manager's responsibility to ensure that bullying and/or harassment at work complaints brought to their attention are dealt with informally and document details of any informal intervention.

1.5.4 Where a formal complaint is raised, it is the Line Manager's responsibility to ensure that all employees involved are dealt with fairly and an informed outcome is provided within a reasonable time frame.

1.5.5 It is the Line Manager's responsibility to consider any complaint raised by any employee under their management control.

1.6 Role of Human Resources Department

The Human Resources Department has a responsibility to ensure that the policy is followed, fairly and consistently. Their duties will involve:

- Advising Managers on the application of the policy
- Advising Managers and staff where individuals feel that they are being harassed or bullied in the course of their employment.
- The provision of training in relation to the application of the policy
- Ensuring the effective implementation of the policy
- Monitoring incidence of bullying and harassment through the maintenance of an internal log held within the HR Department.
- Reviewing and amending the policy, as necessary.

1.7 Trade Unions

The trust recognises the important role Trade Unions play in addressing bullying & harassment and members are encouraged to approach these representatives regarding their concerns. The Trust will work in partnership with the Trade Unions in addressing unacceptable and inappropriate behaviours.

1.8 Occupational Health Service

Any employee who is involved in a claim of bullying and harassment may find it helpful to talk to the Occupational Health Service and a referral to Occupational Health will be made available.

1.9 Employee Assistance Programme

Any employee who is involved in a claim of bullying and harassment may wish to access the Trusts Employee Assistance Programme. This service is free and confidential for all staff.

2. Controlled Document Standards

2.1 This policy is applicable to all employees of Liverpool Heart & Chest Hospital and covers harassment or bullying which occur both in and out of the workplace, such as events relating to business of the Trust, training events or at any work-related social events or functions.

2.2 Every employee carries personal responsibility for their own behaviour in relation to this policy and is responsible for ensuring that their conduct is in line with the standards, values and behaviours set out in this policy.

2.3 Allegations raised regarding bullying and harassment will be dealt with promptly, taken seriously and treated confidentially. The Trust gives an assurance that there will be no victimisation against an employee making a complaint under this policy or against employees who assist or support a colleague in making a complaint.

2.4 Bullying and harassment may be treated as a disciplinary offence and, where allegations are founded, may lead to summary dismissal. Disciplinary action may also be taken if a complaint is found to have been submitted maliciously, vexatious or falsely.

2.5 If any employee is unhappy about the treatment that they have received in relation to an aspect of their work, this would need not be raised or managed via the scope of this policy. Work related concerns would be raised under the Trust Grievance Procedure.

2.6 Standards including Values and Behaviours.

2.6.1 The Trust expects all Staff to conduct themselves in a manner that reflects well on the organisation and high standards of behavior are required. To underpin and strengthen the Trusts' Patient & Staff Experience Visions a set of values and behaviors have been developed as stated below. (IMPACT)

2.6.2 Failure to adhere to the values and behaviours of the Trust may result in action being taken in line with this policy and could lead to disciplinary action. Depending on the severity of the alleged issues identified, this could be considered under either misconduct, serious misconduct or gross misconduct.

2.6.3 The Trust has launched 'Be Civil Be Kind' to provide support and a framework to address concerns raised when Trust Values and Behaviours are not demonstrated. It also promotes and recognises employees who live the Trust values.

2.6.7 The 'Be Civil Be Kind' Framework and Civility Charter should be utilised at the informal and formal stages of this policy. There are resources available on the dedicated page on the staff intranet.

3. Procedure

3.1. The following definitions of Harassment, Bullying & Victimisation are included to assist employees and managers to determine the nature of unwanted conduct that would fall under this Policy.

3.1.1 **Harassment**

The Equality Act defines harassment as *'unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual's dignity or by creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual'.* A single incident can amount to harassment.

It also includes treating someone less favourably because they have submitted or refused to submit to such behaviour in the past.

The applicable protected characteristics covered under the legislation are:

- Age
- Disability
- Gender reassignment
- Race, Nationality, colour or ethnic origin
- Religious Belief
- Gender
- Sexual Orientation
- Pregnancy
- Marriage or Civil Partnership

Harassment is unacceptable even if it does not fall within any of these categories.

An employee should always consider whether their words or conduct could be offensive to others as it is how the conduct is reasonably received, and not how it is intended, that is important.

Examples of harassment may include, but are not necessarily limited to:

- Unwanted physical conduct which can range from touching, pinching, pushing, brushing past someone or invading their personal space; to grabbing, shoving, punching and more serious forms of assault.

- Unwelcome sexual behaviour which you may perceive as harmless flirting including unwanted suggestions, advances, propositions or pressure for sexual activity.

- Making suggestions such as that sexual favours may advance a person's career.

- Continually suggesting social activity when it has been made clear by the other person that such activity is unwelcome.

- Behaving in a way that may be seen as inappropriate, such as offensive or intimidating comments / gestures or insensitive jokes / pranks;

- Sending or displaying pornographic or obscene material, through any method, that others may find offensive; or

- Ignoring, shunning or deliberately excluding someone from a conversation or activity in the workplace.

- Racist, sexist, homophobic or ageist jokes, or derogatory or stereotypical remarks about a particular ethnic or religious group or gender.

- Outing or threatening to out someone as gay or lesbian.

- Offensive emails, text messages or social media content.

- Mocking, mimicking or belitting a person's disability.

3.1.2 **Bullying**

Bullying is offensive, intimidating, malicious or insulting behaviour involving the misuse of power that can make a person feel vulnerable, upset, humiliated, underminded or threatened. Power does not always mean being in a position of authority but can include both personal strength and the power to coerce through fear or intimidation.

Bullying can take the form of physical, verbal or non-verbal conduct and does not need to be because the person has a specific characteristic, unlike harassment. For example it can include:

- Physical or psychological threats.
- Overbearing and intimidating levels of supervision.
- Inappropriate derogatory remarks about someone's performance.

As with harassment, an employee should always consider whether their verbal / written words or conduct could be offensive to others as it is how the conduct is reasonably received, and not how it is intended, that is important.

Legitimate and constructive criticism of an employee's performance or behaviour, or a reasonable request made for an employee to undertake a certain activity, will not constitute bullying.

Examples of bullying may include, but are not necessarily limited to:

- Shouting at, being sarcastic towards, ridiculing or demeaning others
- Physical or psychological threats
- Inappropriate and / or derogatory remarks
- Abuse of authority or power
- Unjustifiably excluding others from meetings or communications

3.1.3 **Victimisation**

Victimisation occurs when an employee is treated differently because they have made or supported a complaint or raised a complaint under the Equality Act or because they are suspended of doing so.

3.2 Support for Employees

Any employee involved in a Bullying & Harassment complaint can receive support via access to a confidential counselling service should they wish to make use of this. To access the telephone advice / support line and telephone counselling which is open 24/7 please call 0151 330 8103 or email:

staffsupportservices@merseycare.nhs.uk

3.3 Handling and Managing Bullying & Harassment Complaints

- In conjunction with this the following toolkits provide advice, support and practical tips:-

  - Bullying & Harassment at Work: A Guide for Managers and Employers and the ACAS
  - Bullying & Harassment at Work: A Guide for Employees

These toolkits can support both employees and managers with the interpretation and application of the following procedures.

3.4 Informal Approaches

3.4.1 The aim of this policy is to stop undesirable behaviour and to prevent recurrence. Where appropriate, every effort should be made to resolve the situation informally. Complaints should always be made as soon as possible after the incidents involved.

3.4.2 An employee who feels they are subject of minor incidents of bullying or harassment is encouraged to keep a note of the details of incident and the names of any witnesses.

3.4.3 If an employee is unhappy about the treatment that they have received from another person, they should, if they feel able to, always try to discuss this with the other person in an attempt to resolve the matter informally. You should explain clearly to them that their behaviour is not welcome or makes you uncomfortable.

3.4.4 If the employee does not feel comfortable talking with the other person, they should discuss their concerns with their Line Manager (or the Manager immediately more senior, where their concern relates to their Line Manager), who will attempt to resolve any issues on an informal basis. Informal intervention may include an informal discussion with the other employee, mediation or some other appropriate informal action. Please refer to the supporting Toolkit for advice and support. If an employee does not feel able to raise the matter this way they can do so in the following ways: -

- Contact their Trade Union Representative, if a union member
- Contact one of the Trust Freedom to Speak up Guardians

- Call the confidential Raising Concerns Hotline – Extension 1658
- Submit an incident form

3.4.5 It is advisable for any employee who feels they are being subjected to unacceptable behaviour to keep records of dates, times, witnesses, feelings at the time and any relevant documentation and to seek the help and support of someone who is able to help. This evidence may be required should the bullying or harassment continue to recur.

3.5 Formal Approach

3.5.1 Where the employee has attempted to resolve the matter informally but remains unhappy, or where the matter is sufficiently serious, it may be appropriate for the employee to raise their concerns formally to a Trust Manager who will take a written account for the employee to sign to demonstrate agreement. Alternatively, an employee can complete and submit the form in the Toolkit providing as much information as possible, including the name of the harasser or bully, the nature of the harassment or bullying, the date(s) and the times(s) at which it occurred, the names of any witnesses and any action that has been taken so far to attempt to stop it from occurring.

If an employee does not feel able to raise the matter this way they can do so in the following ways:-

- Contact their Trade Union Representative, if a union member
- Contact one of the Trust Freedom to Speak up Guardians.
- Call the confidential Raising Concerns Hotline – Extension 1658
- Submit a grievance form

3.5.2 The signed account will be reviewed by a Senior Manager and a Senior Member of the Human Resources Department to decide how best to proceed considering e.g. whether the complaint satisfies bullying and/or harassment, the timeliness of the complaint. A meeting may be required to gather more information from the complaint before making a decision about the appropriate course of action.

3.5.3 The Manager will make a decision whether or not to invoke the Trust Disciplinary Policy with regard to identified employees whose behaviour is in question. If a decision is made to investigate the allegation this this will be carried out in line with the Trust Disciplinary Policy.

3.5.4 The outcome of the investigation will be provided in writing to both parties.

3.6 Other Matters

3.6.1 If there are concerns that an employee has submitted a complaint that is believed by the Trust to be malicious, vexatious or false, the employee may be subject to disciplinary proceedings.

3.6.2 Any concerns in relation to the application of this policy have recourse in accordance with the Trust's Grievance Policy.

3.7 Confidentiality

3.7.1 All employees involved with the investigation and any subsequent process are required to respect the need for confidentiality. All complaints associated correspondence and interviews will be treated in strict confidence. Breaches in confidentiality will be subject to disciplinary action.

3.8 Harassment by People Not Employed by the Trust

3.8.1 It should be made clear that if any member of staff is subject to bullying or harassment by patients or their family members or anyone else not employed by the Trust, the Trust is legally obliged to, and will take reasonable steps to ensure that does not happen again.

4. Policy Implementation Plan

4.1 The Director of Workforce Development will be responsible for implementation of this policy.

4.2 This Policy has been consulted widely throughout the Trust with Managers and Staff Side Partners.

4.3 The policy will be implemented on a Trust wide basis. The policy will be made available on the intranet and disseminated to all wards / departments.

4.4 Managers have a responsibility to ensure staff have read and understood this policy and procedure. New employees will be informed of the policy as part of their Trust Induction.

4.5 Employees and management awareness will be provided via divisional and corporate structures. Employee awareness will be raised via the Trust Newsletter, Team Brief and Corporate Communications.

5. Monitoring of Compliance

The effective implementation of this policy will be monitored by the HR and Education Group with delegated responsibility from the People Committee.

6. References

- ACAS – Equality and Discrimination: understand the basics

http://www.acas.org.uk/media/pdf/e/7/Equality-and-discrimination-understand-the-basics.pdf

- ACAS - Discrimination – What to do if it happens

http://www.acas.org.uk/media/pdf/i/t/Discrimination-what-to-do-if-it-happens.pdf

- ACAS - Bullying & Harassment at Work: A Guide for Managers and Employers

http://www.acas.org.uk/media/pdf/c/j/Bullying-and-harassment-in-the-workplace-a-guide-for-managers-and-employers.pdf

- ACAS – Bullying & Harassment at Work: A Guide for Employees

http://www.acas.org.uk/media/pdf/r/l/Bullying-and-harassment-at-work-a-guide-for-employees.pdf

7. Appendices

8. Endorsed By:

Name of Lead Clinician / Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date
Karen Nightingall	Chief People Officer	June 21

9. Record of Changes

Section No	Version No	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason

Lone Worker

Policy and Procedure

For completion by Author			
Author(s) Name and Title:	Brian Cowan, Security Manager		
Scope:	Trust Wide	Classification:	Non-Clinical
Version Number:	v7.0	Review Date:	01/06/2025
Replaces:	v6.0		
To be read in conjunction with the following documents:	Security Policy, Health and Safety Policy, Managing Violent, Aggressive and Antisocial behaviour Policy, Mobile Phone Procedure and Lone Worker Device Procedure		
Document for public display:	Yes		
Executive Lead	Karen Edge, Chief Finance Officer		

For completion by Approving Committee			
Equality Impact Analysis Completed:		Yes	
Endorsement Completed:	No	Record of Changes	Yes
Authorised by:	Health & Safety Committee	Authorisation date:	13/06/2022

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Contents

Document Statement

The Liverpool Heart and Chest Hospital is committed to ensuring the health, safety and welfare of its employees and others that may be affected by its work activities. This policy enables the Trust to meet its obligation to protect such staff so far as is reasonably practicable from the risks of lone working. It also sets out the approach that the Trust is taking to managing the risks arising from lone working. This policy applies to all staff, hospital based, and community based including temporary and agency staff, contractors, volunteers, students and those on work experience. It forms an integral part of ensuring staff safety alongside the Trust's Health and Safety Policy and Security Policy along with specific local service guidance on lone working. The policy applies to all situations involving lone working arising in connection with the duties and activities of our staff.

- To increase staff awareness of the potential risks of lone working
- To ensure as far as is reasonably practicable that people working alone are not at more risk than other workers.
- To give guidance on assessing and controlling the risks ensuring that the risk of working alone is assessed in a systematic and ongoing way, and that safe systems and methods of work are put in place to reduce the risk so far as is reasonably practicable.
- Make sure that appropriate training is available to staff in all areas, providing them with the knowledge to assist them to recognise risk and provides practical advice on safety when working alone.
- Make sure that appropriate support is available to staff who have to work alone.
- Encourage full reporting and recording of all adverse incidents relating to lone working
- Reduce the number of incidents and injuries to staff related to lone working.

1. Roles and Responsibilities

Chief Executive

The Chief Executive has overall responsibility for ensuring the development of and compliance with this policy. The delegated authority for co-ordinating and monitoring implementation of this policy and the associated protocols/procedures is the Chief Finance Officer, who will be assisted in this task by the Health and Safety Committee.

Board of Directors

The general responsibilities of the Board of Directors are detailed in the Health and Safety Policy.

Chief Finance Officer

The above Director is accountable to the Board of Directors for implementation of this policy. The post holder has a duty to ensure there are systems in place to monitor implementation of this policy.

Department & Ward Managers

- Making sure that all staff are aware of the policy and follow it.
- Ensure a risk assessment has been completed; including the risk from the patient and where appropriate their home and community if a home visit is necessary, making sure that it is reviewed regularly. Guidance is provided in Appendix *1*
- Ensure appropriate control measures are in place. This will include the issue and guidance on the use of lone worker devices (Reliance devices). These are issued on a personal basis and usage should be monitored on a regular basis. This is to ensure staff are utilising the system to ensure their safety
- Ensure staff have received appropriate training, making sure that staff groups and individuals identified as being at risk are given appropriate information, instruction and training, including training at induction, updates and refresher training as necessary
- Report any incidents using the Trust incident reporting system DATIX.
- Ensure lone working duties are identified on new employee health assessment risk identification forms submitted to Occupational Health
- Putting procedures and safe systems of work into practice which are designed to eliminate or reduce the risks associated with working alone
- Making sure that appropriate support is given to staff involved in any incident; effectiveness of preventative measures through an effective system of reporting, investigating and recording incidents.

Employees

- Follow this policy

- Report to their manager or supervisor any problems or difficulties that they are aware of caused by working alone.
- Report any incidents to their manager.
- Report health issues which may be adversely affected by lone working.
- Taking reasonable care of themselves and other people who may be affected by their actions.
- Co-operate by following rules and procedures designed for safe working; This includes the use of lone worker devices provided by the Trust
- Reporting all incidents that may affect the health and safety of themselves or others and asking for guidance as appropriate.
- Taking part in training designed to meet the requirements of the policy.
- Reporting any dangers they identify or any concerns they might have in respect of working alone.

Health and Safety Committee

- Assist the Chief Finance Officer in co-ordinating and monitoring implementation of this policy, including the defining of competency/training requirements
- Identify, with managers, the resources required for staff training and other aspects
- Provide advice to managers developing protocols/procedures/safe systems of work relating to lone working.
- Review any incident reports relating to lone working

Security Manager

The Security Manager has an overview of matters relating to security, violence prevention and personal safety. The security manager will;

- Provide information and advice about lone working and report related risks to the Health and Safety Committee and to managers.
- Liaise and advise on Security of all the locations used in the Community Venues to deliver community services, carry out inspections, write reports and provide advice to the Trust on all matters of security.
- Provide advice to managers and staff at all levels on security measures and dealing with violence.
- Provide assistance to managers implementing risk reduction measures, action plans and post-incident management.
- Supporting staff during investigations of incidents of physical or verbal abuse.
- Monitor the effectiveness of implementation of this strategy by means of Incident report reviews and risk assessments. This will include monthly reports on lone worker device usage across the Trust

- Monitor, review and report the results of security incidents and risk assessments to the Health & Safety Committee. Action plans which may be organisational or service specific that are devised following a security incident and risk assessments are also reported and reviewed at the risk management committee.
- Ensure there is a prompt review of any significant violent incident and that it is used to evaluate policy guidelines and recommend security safety systems to avoid further incidents i.e. Access Control, Panic Alarms, Lone worker Devices and CCTV.

Occupational Health Service (Team Prevent)

- Provide advice following health assessment on suitability for lone working in response to new employee risk identification indicating lone working integral to duties including modifications, adjustments or restrictions to duties
- Provide advice and recommendations on request on fitness to undertake lone working where concerns raised by managers or employees relating to health issues

2. Controlled Document Standards

Duty of employers under the Health and Safety at Work Act 1974:

- Common law duty of care to employees.
- Specifically NHS organisations have responsibilities to manage security including, protecting all staff from violence and aggression in accordance with the Secretary of State Directions for health bodies, relating to the measures to deal with violence against NHS staff and directions for health bodies on security management measures, 2003 and 2004 respectively and as amended 2006.

The organisation also has to be fully compliant with UK legislation:

1. Health & Safety at Work Act 1974
2. Management of Health & Safety at Work Regulations 1999
3. Safety representatives and Safety Committees Regulations 1977(a)
4. The Health and Safety (Consultation with employees) Regulations 1996(b)
5. The Corporate Manslaughter and Corporate Homicide Act 2007
6. Criminal Justice and Immigration Act 2008

3. Procedure

The HSE defines lone workers as people who work by themselves without close or direct supervision; **"any situation or location in which someone works without a colleague nearby; or when someone is working out of sight or earshot of another colleague"**
Examples include, one person working in a fixed establishment, workers in remote locations, mobile workers, those working at other employers' premises or from home, those on domiciliary visits and those staff alone with patients. When addressing the issue of lone working, it is important to distinguish between employees finding themselves alone by chance, or due to the nature of their work. The first instance may be addressed by simply implementing a procedure whereby employees alert fellow workers to the fact that they are leaving an area for a given length of time, and the remaining person will be on his or her own.

The Law

There is no general prohibition in health and safety law of working alone, but there is a duty of care under the Health and Safety at Work Act etc. However, when determining a safe system of work, it is likely that there will be a need for additional controls to be put in place. These controls will be identified once a risk assessment has been undertaken. The law, however, does prohibit certain types of work to be undertaken by the lone workers, including certain types of fumigation and other work with substances hazardous to health, young people working with woodworking machines and persons working on live electrical systems

Risk Assessment

Lone workers should not face any more risks than other staff within the organisation. Setting up safe working arrangements for lone workers is no different to organising the safety of other staff, so we must all follow the general principles of risk assessment. If a risk assessment shows that it is not possible for the work to be done safely by a lone worker, other arrangements must be put in place. Risk assessment should take account of both normal work and foreseeable emergencies such as fire, illness and accidents.

The risk assessment process is summarised below, separated into five distinct stages and action points to support effective assessment of the risks involved in lone working.
Specific staff groups from within the organisation have been identified as high-risk lone workers as they either work with a high-risk section of the community or work outside normal Trust management hours (17.00 -08.00).

Risk assessments, using the Trusts risk assessment form, (appendix 1) Rapid risk assessment (appendix 2), Domiciliary Risk assessment (assessment 3) and Building risk assessment

(appendix4) are completed by local managers for lone workers within their areas of responsibility in order to identify the hazards and risks. Additional consideration will be given to the hazards and risks associated with specific individuals, such as pregnant workers and young workers. They will devise and implement safe working arrangements to ensure that the risks are either eliminated or adequately controlled.

The assessment should consider the following factors:

a) Is it necessary for the individual to work alone?

b) Foreseeable emergencies. It must be recognised that a lone worker is more vulnerable when the unexpected occurs, e.g. fire, equipment failure, illness, accidents and violence.

c) 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?

d) Whether the work can be done safely by a lone worker?

e) When considering the workplace, the following questions should be considered:

- Does the workplace present a special risk to the lone worker?
- Is there a safe means of entry and exit to the workplace?
- Can all plant, substances and goods be safely handled by one person?
- Will cash or valuables be handled, and will there be a risk of violence?
- Are there arrangements for food and drink and adequate welfare facilities?
- Is the worker vulnerable to sexual harassment or assault?

f) Ensure that:

- Lone workers have full knowledge of the hazards and risks to which they are being exposed.
- The lone workers know what to do if something goes wrong.
- Someone else knows the whereabouts of the lone workers and what they are doing

g) 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.

h) The remoteness of the workplace should also be considered when assessing the risks to lone workers, for example:
- Will the emergency services be able to approach close enough if necessary?

- Is the length of time to do the job defined?
- Is there adequate access to first aid?

i) Arrangements should be in place to protect or assist lone workers in the event of fire, accident, illness or an incident of violence.

j) Lone workers should receive appropriate training to ensure that they are competent and able to deal with foreseeable problems.

k) Staff should appreciate their responsibility for their own safety.

l) Lone workers should receive training in the use of any necessary tools and equipment. 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.

m) 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.

n) The manager must develop procedures to control the risks and protect employees and other individuals. The employees should know and understand such procedures.

Control Measures

There are a number of controls to consider and the most appropriate ones should be identified in the risk assessment. The following practical guidelines should be considered:

a) Authorisation for lone working is required from a manager.

b) Lone workers, outside normal working hours (this should be decided by local management) and in isolated buildings, should telephone security on ext 1999 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. For staff working in community buildings security arrangements for that building staff should be aware of and know the Local Security Manager.

c) A service manager should be available for consultation (by telephone) in the event of a person not registering themselves leaving the department.

d) Keep exit doors locked. Managers within the hospital Trust should allocate to someone the job of checking these doors are locked. Staff who work in Community Health Trust and Community Buildings should ensure that they are aware of the local security arrangements. Staff who provide domiciliary care should ensure that there exit route is not blocked or

hampered in any way when in the patients home, patients who display this level of risk care can be declined.

e) Special consideration should be given to pregnant workers who work alone (refer to the Trust Policy on New and Expectant Mothers).

f) Ensure a working telephone is available. Staff who work in the community should have a reliable mobile telephone.

g) Managers should ensure that “panic buttons” or personal alarms are working – individuals or Estates staff should check them at regular intervals (eg weekly, monthly or at the beginning of each work period).

h) A register of attendance (at a reception desk, for example) could be used to ‘log in’ to work. This should be completed and available for Fire Brigade/Security staff.

i) Lone workers should not undertake dangerous work (e.g. using dangerous chemicals) – this should be indicated by a risk assessment.

j) Checks by Security staff by telephone if they have not heard from an individual after an agreed length of time.

k) It is illegal to use handheld mobile phones whilst driving except in an emergency to call 999 and it is not safe to stop . Individuals are referred to the Trust’s Mobile Communications Policy which gives further guidance.

l) Home visits can produce particular risks (e.g. unsafe houses, potential for being attacked). A visit to the home of the patient may be necessary to aid the risk assessment. In particular, consider the point raised in the following checklist:

Are staff who visit: -

Trained to deal with violence and aggression (training in conflict resolution is provided by the Learning Department).

- Accompanied by a colleague, for high-risk activities (buddy system);
- Briefed about the areas where they work (the community)
- Aware of attitudes, traits or mannerisms, which can annoy clients etc.
- Given all available information about the patient and their family from all relevant sources (e.g. colleagues, police, the patient’s General Practitioner).

Have staff: -

- Understood the importance of previewing cases.
- Left an itinerary (which identifies expected time for visits and return to base).

- Made plans to keep in contact with colleagues.
- Have the means to contact a manager (i.e. mobile telephone).
- Have a manager's home telephone number (if outside normal working hours)
- An understanding of the Trust's Policy on Conflict Management and the Control of Violence and Aggression, the Security Policy and this policy. Be aware of the right to use force in line with common law providing it is to protect themselves or others.

  Any force **MUST** be:

  - PROPORTIONATE
  - REASONABLE
  - ABSOLUTELY NECCESARY
  - MINIMUM USE OF FORCE FOR MINIMUM PERIOD OF TIME

- Authority to arrange an accompanied visit, security escort, or use of a taxi.
- Lone worker device: personal alarm to be made available

Do staff: -

- Know how to control and defuse potentially violent situations Know how to complete the Trust Incident Report form if necessary.

Car Users should: -

- Remove their hospital parking permit (someone might think drugs are inside the car)
- Park in well-lit areas
- Ensure their car is in good condition, taxed and fully insured for business use.
- Not use hand held mobile phones whilst driving, unless in an emergency (Refer to the Trust's Mobile Communications Policy – (hyperlink)

Appendix 2 & 3 and 4 provide three examples of risk assessment and measures to help control these general risks. However, each type of lone working situation will need to be assessed and, where necessary, take account of local circumstances.

Reliance identicom Lone Working Devices: All Staff issued and trained in the use of these devices should have read and follow the Lone worker device procedure produced
In relation to the use of it.

4. Policy Implementation Plan

The Health and Safety committee is responsible for the implementation, monitoring and review of this policy. The Local Security Management Specialist (LSMS) is responsible for ensuring that this

document is reviewed and, if required, revised in the light of legislative, guidance or organisational change. The policy is available on the intranet. Staff are made aware of this policy at mandatory and induction training.

5. Monitoring of Compliance

This policy will be monitored through

- Any reported incident associated with lone workers within the Trust
- Attendance records for mandatory and induction training are maintained and monitored by the Learning and Development.
- Staff should report all incidents (including near misses) to their line manager at the earliest opportunity. These should be reported via the Trust's incident reporting system. The line manager should investigate all reports as per the Investigating, Analysing and Learning from Incidents, Complaints and Claims Policy. In order to monitor the implementation and effectiveness of this policy and associated local protocols, local statistics and incident reports will be reviewed regularly by the risk management committee Upon completion, a copy of the risk assessment should be held by the service manager and shared with staff and a further electronic copy should be forwarded to Integrated Governance for the LSMS & Risk Manager or the Health & Safety Advisor for their records. In the event of an emergency call out or site visit staff and managers can use the Rapid risk assessment from **Appendix2,** but if the visit is to be repeated again then a more in-depth assessment should be used as in **Appendix 3**.

6. References

1. "Not alone" A guide for the better protection of lone workers in the NHS. NHS CFSMS 2009 Version 2
2. Tackling violence against staff (Explanatory notes for reporting procedures introduced by sectary of state directions November 2003 - Updated June 2009)

7. Appendices

APPENDIX 1

Security Risk Assessment

Building:		**Location:**	
Directorate/Management:		**Date:**	

No	Subject area	Y	N	N/A	Potential Controls in place	Y	N	NA	Comments/remedial action required	Date of completion
1	Is access to area controlled (i.e. card access, digital lock etc)?									
2	Are staff likely to be verbally or physically assaulted due to clientele (alcohol/drug abuse, frustrated etc)?									
3	Are personal attack alarms provided?									
4	Are personal attack alarms correctly sited?									
5	Is CCTV surveillance provided?									
6	Is CCTV signage displayed?									
7	Is lighting available?									
8	Are staff aware of emergency telephone numbers to security?									

No	Subject area	Y	N	N/A	Potential Controls in place	Y	N	NA	Comments/remedial action required	Date of completion
9	Are security issues/concerns raised with your line manager?									

10	Are security issues/concerns raised with security management?									
11	Do staff complete the Trust incident form when such incidents occur and inform security?									
12	Are secure lockers provided for staff's personal belongings?									
13	Are security lockers provide for patients personal belongings?									
14	Are patients discouraged from having large amounts of money and expensive personal possessions in hospital?									
15	Are any staff likely to be lone workers, due to location or out of hours working?									
16	Are staff aware of the Lone Worker's Policy?									
17	Is there a key policy in place for the Department/Ward areas?									
18	Are doors to offices etc. locked out of hours?									
19	Is equipment (computers etc.) security coded?									
20	Do you wear your ID Badges at all times?									

No	Subject area	Y	N	N/A	Potential Controls in place	Y	N	NA	Comments/remedial action required	Date of completion

21	Do you deal with enquires from patients and visitors?				a) Communications skills b) Personal safety training c) Careful selection of staff in order to get the right people for the job d) Other					
22	Do you deal with complaints from patient's visitors and staff?				a) Communications skills b) Personal safety training c) Careful selection of staff in order to get the right people for the job d) Is there a personal attack alarm available? e) Other					
23	Are any of the following "high risk individuals" dealt with: • Violent/aggressive people • People acting suspiciously • Armed individuals • Psychiatric patients • Persons accompanied by the police/prison service personal • Persons affected by drugs or alcohol • Bereaved persons • Other				a) Communications skills b) Personal safety training c) Careful selection of staff in order to get the right people for the job d) Is there a personal attack alarm available? e) Is protective equipment? (e.g. stab vests) provided? f) Is protective equipment worn? g) Is CCTV monitoring in use? h) Are communications systems (e.g. radio)					

No	Subject area	Y	N	N/A	Potential Controls in place	Y	N	NA	Comments/remedial action required	Date of completion
					available? i) Is communication with external organisations (e.g. police) adequate? j) Is there a Trust system for identifying violent and aggressive individuals? k) Good workplace design (e.g. vision panel/screen) l) Other					
24	Do staff handle cash, valuables or drugs?				a) Secure area b) Trained staff c) Other					
25	Do staff undertake: • Domiciliary work • Travel between sites				a) Has a Lone Worker risk assessment been completed? b) Is information about the patient/family available? c) Other					
26	Does the design of the workplace present any risk e.g. • No segregation from public • Loose furniture / objects • Poor exit availability • Poor lighting • Mirrors				a) Fault's reporting procedure b) Trained staff c) Monitoring of area d) Improve design of workplace e) Other					

27	Can the public gain access to an unauthorised area?				a) Secure areas b) Lockdown Policy Change door code frequently (e.g. 3 monthly) d) Other					

28	Is there anything which increases stress for patients, visitors and staff or e.g. • Poor environment in waiting area • Poor working conditions • Lack of information • Long waiting times • Boredom				a) Information system available b) TV available c) Comfortable environment d) Adequate seating e) Adequate space f) Has a stress risk assessment for staff been completed g) Other					
29	Is lone working part of the job?				a) Has manager completed a lone worker risk assessment and implemented the actions identified?					
30	Are there any vulnerable groups (e.g. staff coming to work or leaving work in the dark)				a) Escort availability b) Adequate lighting c) Other					
No	**Subject area**	**Y**	**N**	**N/A**	**Potential Controls in place**	**Y**	**N**	**NA**	**Comments/remedial action required**	**Date of completion**

31	Are patients and visitors made aware of what behaviour is expected of them and that violence and aggression is not tolerated?				• Trust Policy in place • Notification of individuals • Implementation of "Zero Tolerance" • Other					
32	Are their any employee health issues which could be worsened by undertaking lone working?				• New Employee Health Assessment Risk Identification. • OH Management Referral where concerns raised for existing employee with medical condition.					

Conflict Management Action Plan

Location:		Date:			
Completed by:		Directorate:		Review Date:	
To be completed when further measures are required following completion of this document:					
Number:	Additional control measures required to reduce the risk to the lowest possible level:	Action to be taken by:	Date action to be completed by:	Actual date action completed:	Review date:

APPENDIX 2

Rapid Risk assessment for Emergency or Site & Home visits

Description of work activity or danger:
Potential violence when carrying out community or home visits
People exposed to risk:…… Location……
Risk assessment carried out by: …….. Date completed: ……..….
Review date:…….

Risks and issues of concern – circle Y / N which ever applies.

Are the staff involved in visit new or inexperienced in community work? Y / N
Are staff visiting unfamiliar clients / patients? Y / N
Are staff having to enter premises? Y / N
Is the visit in a high risk location*a? Y / N
Is the visit in an isolated area*b? Y / N
Will staff be using their own transport? Y / N
Are staff working at out of hour's times*c? Y / N
Are staff wearing an identifiable uniform? Y / N
Are staff carrying valuables or drugs? Y / N

Existing control measures – circle Y / N which ever applies.

Have staff got personal attack alarms? Y / N
Can you provide accompanied visits? Y / N
Do you have potential or known risk factors in a referral documents? Y / N
Do staff have a mobile? Y / N
Do Staff have a "Lone Worker Device" Y / N
Are systems in place to monitor staff movement? Y / N
Have staff attended personal basic safety or Conflict Resolution Training? Y / N
Do you have information from other agencies on high risk addresses or areas? Y / N
Do staff know how to access support out of hours or in the event of an emergency? Y / N

Risk level for Assessment: **Circle appropriate level**	**LOW / MODERATE / HIGH**

Guidance on calculating Risk level

If the risks answers are = YES and existing control measures answers in all sections are predominately = NO then risk level will be considered HIGH. No visit should be made without a full action plan being put in place. Any action plans must be reviewed regularly in line with available information or if the existing situations change. If the risks answers and existing control measures answers come out equal then risk level will be considered MODERATE and actions should be put in place to control the negative answers.
If the risks answers are predominately NO and existing control measures answers are predominately = YES then risk level will be considered LOW. No remedial actions may be necessary but each case should still be checked during active visiting.

Definitions
"High risk" - an area/location with a higher than average crime rate.
"Isolated area/location" - where no other occupied housing or building is within sight.
"Out of hours" - relates to a time period when no direct management back up is available

APPENDIX 3

Full Risk Assessment Form for Domiciliary Visits

Description of work activity or danger: *Potential violence when carrying out community or home visits*		**People exposed to risk:**
Department:	**Location:**	
Risk assessment carried out by:	**Date completed**:	**Review date:**

1. Main risks and issues of concern	**Enter Y / N**
Do staff carry out visits in high risk* locations?	
Do staff carry out visits in isolated* areas?	
Do staff visit unfamiliar clients / patients?	
Do staff visit high risk or unstable client group?	
Do staff work at out of hours* times?	
Are staff new or inexperienced In community work?	
Do staff wear an identifiable uniform?	
Do staff carry valuables or drugs?	
Other?	

Existing control measures – Enter Y / N as appropriate	
Do you assess new clients in a health centre or clinic?	Have your staff got personal attack alarms?
Do you provide accompanied visits when there are concerns about safety?	Do staff use work mobiles?
Do you include potential or known risk factors in referral documents or care plans?	Have staff attended personal basic safety?
Are their systems in place to monitor staff movement or programme?	Have staff attended Conflict Resolution?
Do you share information with other agencies on high risk addresses or areas?	Do staff know how to access management out of hours in the event of an emergency?
Are existing control measures adequate (YES / NO)	
If No what modifications or additional actions are necessary:	
Risk level for Assessment: Circle appropriate level	**LOW / MODERATE / HIGH**

Guidance on Calculating Risk Level

If the risks answers are = YES and existing control measures answers in all sections are predominately = NO then risk level will be considered HIGH and no visit should be made without a full action plan being put in place. Any action plans must be reviewed regularly in line with available information or if the existing situations change.

If the risks answers and existing control measures answers come out equal then risk level will be considered MODERATE and actions should be put in place to control the negative answers.

If the risks answers are predominately NO and existing control measures answers are predominately = YES then risk level will be considered LOW and no remedial actions may be necessary but each case should still be checked during active visiting.

Definitions
“High risk” - an area/location with a higher than average crime rate.
“Isolated area/location” - where no other occupied housing or building is within sight.
“Out of hours” - relates to a time period when no direct management back up is available

APPENDIX 4

Sample Full Risk Assessment for Working Alone in Buildings

Description of work activity or danger: *Working alone in buildings*	**People exposed to risk:**	
Department:	**Location:**	
Risk assessment carried out by:	**Date completed:**	**Review date**

1. Main risks and issues of concern	**Y /N**
Do staff work alone?	
Do staff meet with clients or patients in isolated locations?	
Is there enough security provision?	
Is there poor access to the building?	
Is there first aid if staff are taken ill?	
Do Staff activities require them to work in confined spaces?	
Do staff have to handle hazardous or dangerous substances?	
Other?	

2. Existing control measures – complete Y /N as relevant	
Do you provide joint working for high risk activities?	Have your staff got personal attack alarms?
Is there entrance security devices?	Do staff use work mobiles?
Is there security lighting around access points and parking areas?	Have staff attended personal basic safety?
Are panic buttons in place?	Have staff attended Conflict Resolution?
Is there a checking in procedure for the site?	Is there regular Health & Safety site checks?
Do staff know how to report incidents?	Do staff know how to access management out of hours in the event of an emergency?

3. Are existing control measures adequate YES / NO
If No what modifications or additional actions are necessary

Risk level for Assessment: Circle appropriate level	**LOW / MODERATE / HIGH**

Guidance on Calculating Risk Level

If the risks answers are = YES and existing control measures answers in all sections are predominately = NO then risk level will be considered HIGH and no visit should be made without a full action plan being put in place. Any action plans must be reviewed regularly in line with available information or if the existing situations change.

If the risks answers and existing control measures answers come out equal then risk level will be considered MODERATE and actions should be put in place to control the negative answers.

If the risks answers are predominately NO and existing control measures answers are predominately = YES then risk level will be considered LOW and no remedial actions may be necessary.

Definitions
“High risk” - an area/location with a higher than average crime rate.
“Isolated area/location” - where no other occupied housing or building is within sight.
“Out of hours” - relates to a time period when no direct management back up is available

8. Endorsed By:

Name of Lead Clinician / Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date

9. Record of Changes

Section No	Version No	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason
Whole document	6	1/10/2018	Policy format changed in line with current branding.	No deletion	No addition	Corporate branding changed since policy was previously ratified
Tittle page	6	1/10/2018	Changes made to front cover. Author now changed	Reference to Mark Jump	Reference to Michael McGee	Different LSMS to when policy was previously ratified
5	6	1/10/2018	Previous document had no reference section	No deletion	Reference to NHS Protect guidance	Poor referencing
5	2	1/10/2018	Reference to Lone worker device procedure	No deletion	Reference to Lone worker device procedure	Specific guidance how to use lone worker devices in separate document.
1	7	01/05/2022	Update to roles and responsibilities	No deletion	Change of department lead	Change of department lead
1	7	01/05/2022	Update to roles and responsibilities	No deletion	Addition of monthly reports to security manager role	Compliance
2	7	01/05/2022	Update Procedure	No deletion	Update control measures section k for clarification	Clarification
2	7	01/05/2022	Update Procedure	No deletion	Update control measures with regard to force	Clarification

Managing Attendance

Policy

For completion by Author			
Author(s) Name and Title:	Rachael McDonald, HR Business Partner		
Scope:	Trust Wide	Classification:	HR
Version Number:	5.1	Review Date:	09/06/2024
Replaces:	5.0		
To be read in conjunction with the following documents:	NHS Terms and Conditions Handbook / Terms and Conditions of Service NHS Medical and Dental / Equality and Inclusion Policy / Disciplinary Policy / Special Leave Policy / Capability and Performance Policy / Flexible Working Policy		
Document for public display:	Yes		
Executive Lead	Karen Nightingall		

For completion by Approving Committee			
Equality Impact Analysis Completed:		Yes	
Endorsement Completed:	No	Record of Changes	No
Authorised by:	People Delivery Group	Authorisation date:	23/06/2021 Extension authorised 07/11/2023

For completion by Document Control					
Unique ID No:	TW09(08)	Issue Status:	Approved	Issue Date:	07/12/2023
After this document is withdrawn from use it must be kept in archive for the lifetime of the Trust, plus 6 years.					
Archive:	Document Control		Date Added to Archive:		
Officer responsible for Archive:	IG and Document Control Facilitator				

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Document Statement

Liverpool Heart and Chest NHS Foundation Trust (The Trust) is committed to providing the highest quality care to its patients and recognises the importance of ensuring employees are supported to maintain high levels of attendance in order to achieve this.

Whilst it is recognised that on occasion, employees may require time away from work due to sickness, the Trust aims to manage the absence, minimise sickness rates and support employees to maintain the best possible levels of attendance.

This Attendance Policy sets out the Trusts approach to supporting and managing attendance in the workplace in a fair and consistent manner. Attendance at work is essential to the successful delivery of high-quality patient care and the effective delivery of all Trust services. However, from time to time employees may be prevented from attending work through ill health.

It is recognised that early intervention can be key to supporting employees to return to work and therefore, where needed and reasonably possible, measures will be taken to assist those who have been absent through sickness to return.

Any information provided to the Trust about an employee's health will be processed lawfully and in accordance with the Privacy Notice. It is recognised that such data is sensitive and will be handled in a confidential manner.

Wellbeing is of paramount importance in order to create a happy and healthy workforce that can thrive and flourish in the workplace. The Trust advocates an enabling and supportive environment in which early intervention can be key to helping employees to stay in work.

This policy does not form part of an employee's contract of employment and can be amended at any time.

1. Roles and Responsibilities

1.1 Chief People Officer

The Chief People Officer is responsible for the development and implementation of this policy.

1.2 People Committee

The People Committee will monitor performance against this policy.

1.3 People Delivery Group

This group will be responsible for ratifying and reviewing the policy through delegated responsibility from the People Committee. The group will ensure appropriate management and staff side consultation through Policy Development Group (PDG) when reviewing the policy and will monitor its applications and outcomes.

1.4 The Trust

The Trust is responsible for ensuring that appropriate policies & procedures are in place in relation to managing attendance, they are communicated to all staff and that managers are supported to implement them. It is also responsible for ensuring that conditions at work exist to promote the good health and wellbeing of the workforce, and to enable employees to maintain a high level of attendance.

1.5 Employees

Employees are expected to demonstrate their commitment to the Trust by attending work regularly and taking consideration of their own health and wellbeing. Employees should only be absent from work when permission has been given or it is not possible to attend due to illness.

Employees are responsible for:

Taking reasonable care for the health and safety of themselves (and of others who may be affected by their acts or omissions at work).

- Informing their line manager if any form of ill health begins to impact upon their ability to perform the duties of the role they are employed to do.
- reporting any absence from work due to illness or injury to their Line Manager or their delegate at least 30 minutes before the start of their shift/normal start time.
- Maintaining regular contact with their Line Manager or delegate as directed. Failure to maintain regular contact may result in disciplinary action being taken.
- Provide appropriate Self Declaration (SD1) form or a Doctor's Medical Certificate (FIT Note) or other requested documentation to cover any period of sickness absence
- Attend any meetings, hearings, appointments or return to work interviews as requested by their line manager or HR.
- Ensure that they have read this policy and comply with all requirements within this policy.

1.6 Managers

Managers are responsible for monitoring the attendance of their staff and for ensuring sensitive, fair, and consistent treatment of employees who are absent due to sickness in line with this policy.

Managers will:

- Ensure they comply with this policy and associated procedure, and that it is implemented in a fair and consistent manner with all staff.
- Promote a culture of good attendance throughout the Trust.
- Signpost employees to support mechanisms and interventions.
- Promote the health, safety and well-being of all employees, including the use of risk assessments to identify and manage any potential hazards.
- Maintain regular contact with staff who are absent, keep them up to date on relevant work-related matters, offer support and monitor their progress.
- Set an employee's expectations on the frequency of contact expected, making arrangements, where necessary, to cover work and to inform colleagues and clients (whilst maintaining confidentiality).
- Maintain accurate records in relation to absence, including return to work documentation, and ensure that the HR & payroll team are notified of sickness in accordance with procedures and timescales.
- Ensure they have an awareness of their employee's pay status and support to ensure that the individual has been notified of this information. Recording sickness absence in the system via E-Roster.
- Holding a return-to-work interview after every period of sickness absence and ending the sickness in Health Roster
- Regularly monitor sickness absence levels within their teams and taking further action as necessary where there are concerns about an employee's absence level.
- Comply with and instigating all procedures for managing sickness absence, without exception.
- Carry out regular reviews of attendance levels within the team and ensure that the policy is being applied where appropriate.
- 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 2013 (RIDDOR).

2. Controlled Document Standards

3. Procedure

3.1. Notification

Employees should be aware that it is their responsibility to personally notify their line manager (or nominated deputy) verbally of their sickness absence. Texting, emailing or speaking to someone other than the line manager (or nominated deputy) is not deemed to be a suitable method of notification.

Employees must advise their manager of the nature of the illness, the likely duration and their expected date of return to work. This must be done as soon as illness is known, and in all instances no later than 2 hours before their shift is due to start **or** in line with local notification procedures **(see individual ward/department).**

If the manager is unavailable, this information above should be given to the nominated person. If the issue is particularly sensitive, the manager should be contacted later that day at a convenient time.

Only in exceptional circumstances i.e., if the employee is admitted to hospital and not able to notify their manager personally, can an employee nominate someone to make contact on their behalf. Clear reasons for this nomination should be given by the individual who is reporting the sickness absence.

Failure to comply with the requirements of the reporting procedure may jeopardise entitlement to occupational and statutory sick pay and may result in disciplinary action being taken.

3.2 Medical Certificates

Self-certificates or medical certificates, as appropriate, must be submitted by employees to cover all periods of absence.

Appropriate certification should be provided to cover the entire sickness absence period, as follows:

Length of	Type of	When to	Who to
7 Calendar Days or less	Self- Certificate	As part of the return to work interview	Immediate Line Manager
More than 7 Calendar Days	Medical or GP Certificate / Statement of Fitness for Work	As soon as reasonably practicable and within 2 days of expiry date of last certificate	Immediate Line Manager

For absences of more than a week, you must obtain a certificate from your doctor (a 'Statement of Fitness for Work') stating that you are not fit for work and the reason(s) why. This should be forwarded to your Line Manager as soon as possible. If your absence continues, further medical certificates must be provided to cover the whole period of absence.

If your doctor provides a certificate stating that you 'may be fit for work' you should inform your Line Manager immediately. We will discuss with you any additional measures that may be needed to facilitate your return to work, taking account of your doctor's advice. This may take place at a return-to-work meeting. If appropriate measures cannot be taken, you will remain on sick leave and we will set a date to review the situation.

Where we are concerned about the reason for absence, or frequent short-term absence, we may require a medical certificate for each absence regardless of duration. In such circumstances, we will cover the costs incurred in obtaining such medical certificates, for absences of a week or less, on production of a doctor's invoice.

Back dated medical certificates will not be accepted as valid, unless there are extreme mitigating circumstances which meant that the employee was unable to obtain a certificate in time and the employee has obtained agreement from the manager that this can be accepted or the Trust has requested one for an absence of less than a week, as set out above and this has not previously been obtained.

All certificates will be treated as confidential and stored accordingly in a secure location.

Failure to properly submit certificates may result in pay being withheld and disciplinary action taken.

3.3 Maintaining Contact

Employees must maintain contact with their manager throughout their period of sickness. In cases of short-term sickness absence, it is expected that employees will contact their manager every day to in order to keep them informed of when they are likely to be fit enough to return to work unless the manager agrees to an alternative arrangement.

In cases of long-term sickness absence regular contact must be agreed as appropriate, for example a weekly telephone call, but as a minimum should include a monthly meeting to ensure appropriate support continues to be provided. In certain circumstances this may not be possible and in such cases, advice should be sought from HR.

Failure to maintain regular contact may result in further action being taken, including potential disciplinary action.

3.4 Sickness whilst at work

If an employee becomes ill or suffers an accident at work, they must inform their line manager, who will discuss with them the most appropriate course of action. Employees must not leave their place of work without consulting the line manager (or deputy in their absence). Failure to comply with this procedure maybe classified as unauthorised absence and may be subject to loss of pay and disciplinary action.

Employees who must leave work because of illness will be recorded as having an episode of sickness where they have worked less than half of their shift. However, where there is evidence that over a rolling 12-month period a member of staff has gone off sick on a number of occasions, having worked more than half their rostered shift, then this will be taken into consideration with regard to initiating action under this policy.

If an employee suffers an accident at work or believes that their illness/condition is attributable to their employment, they should complete the appropriate Accident/Incident Form as soon as possible.

4. Policy Implementation Plan

4.1 Resuming Procedure

When an employee is fit to return to work, they must personally notify their line manager (or nominated deputy if necessary) of this the date before their return. It is essential that an employee notifies their manager that they are fit enough to resume even when they are not due to be in work the following day i.e., on a Friday before the weekend, on the day before their rostered rest days, or, in the case of part time staff, the day before any days they would not usually work.

Failure to do this will result in these 'off' days also being included in the period of sickness absence. This could have implications on sick pay and sickness management trigger points.

For example, if an employee who works Monday, Tuesday, Wednesday calls in sick on a Monday but is feeling better by the Wednesday afternoon, even though they are not due in work on the Thursday (or the Friday) they must still ring to resume on the Wednesday. If they do not do this, they would be recorded as sick for the full week i.e. Monday to Sunday (assuming their return the following Monday).

However, an employee should only resume when they would be well enough to return to work had they been due in.

4.2 Return to Work Meeting

All employees returning to work from sickness absence must be seen by their manager as soon as possible, normally on their first day back. If, because of shift patterns or leave etc, it is not possible for the designated manager to conduct the return-to-work meeting, arrangements must be made for a deputy to carry out this process within three working days of the staff member returning to work.

A return-to-work meeting will be held following every episode of sickness absence. The manager or nominated person conducting this meeting must be assured that the employee is fit to return to work. The standard return work form must be completed which will support a discussion on the following areas:

4.2.1 Obtaining confirmation of the reason for the sickness absence and the period of absence (i.e. the number of calendar days lost due to the sickness absence)

4.2.2 Agreement on any temporary rehabilitation requirements, including potential phased return arrangements.

4.2.3 Workplace update, including any changes.

4.2.4 Review of the employee's sickness record over a rolling 12-month period dating back to the first day of the most recent sickness absence

4.2.5 Discussion on whether a referral to Occupational Health is appropriate

4.2.6 Confirmation of whether the employee has hit a trigger point in the policy and what the next steps will be.

However, this list is not exhaustive. Managers should store the completed return to work form locally, in a confidential area.

5. Occupational Health Advice

Referrals do not just have to be made whilst an employee is off sick, they can also be used to

support employees in work. Where employees are off sick, referrals can be made at any time and in some circumstances are required to be made immediately (see Section 6.1). Other referrals will be made in accordance with section 7.3.

Referral to Occupational Health must be made by the line manager using the appropriate referral process which is outlined on the Trust Intranet. The purpose of the referral form is to provide Occupational Health with appropriate background information on the employee, the reason for the referral and provide any relevant information that may be required

It may be necessary for several referrals to Occupational Health to be made in order to obtain continuing advice for the appropriate management of the particular absence. It may also be necessary to seek medical advice from the employee's GP and/or an appropriate Consultant as advised by Occupational Health. Occupational Health will ask the employee for consent to access this information in line with the requirements of the Access to Medical Reports Acts 1988 and 1990.

Where an employee is intending to return to work following a period of long-term absence, Occupational Health will offer advice on the employee's fitness to return to work and the support necessary to achieve a satisfactory sustained level of attendance. The option of a phased return to work should be reviewed including a mix of annual leave and time off given by managers.

Employees are required to attend Occupational Health when it is deemed appropriate that a referral be made. The line manager is expected to explain the purpose of the referral to the individual prior to making the appointment and outline why it is in their best interests to attend. Employees must contact their line manager and the Occupational Health Service if they cannot attend a planned or re-arranged appointment.

If an employee fails to attend an appointment, the appointment will be rearranged once. If the employee fails to attend a second time, Managers will make decisions at sickness reviews based on the information available to them without an Occupational Health Report. This may include decisions on potential dismissal.

5.1 Immediate Referrals to Occupational Health

5.1.1 Stress-Related Absence

Adequate and proper support for employees absent due to stress, anxiety or depression cannot be appropriately managed without medical advice. When an employee is absent from work, Managers should attempt to establish if the cause is stress related and if so, whether the condition is work or personally related. Where it is identified that stress is the cause, the line manager must refer the employee to Occupational Health immediately. Work related stress must also be reported to the Risk Management team and the line manager must carry out a stress risk assessment with the employee.

5.1.2 Muscular Skeletal Absence (e.g. back pain, RSI)

If an employee is absent due to a muscular skeletal injury immediate referral to Occupational Health should be made to identify support for their condition

6. Policy Stages

6.1 Sickness Types

Sickness absence broadly falls into two categories:

- Frequent and separate occurrences of short-term absence which may or may not be related
- Long term absence caused by illness or injury which lasts 4 calendar weeks/28 calendar days or more.

It is important to be able to distinguish between these two categories and to deal with them separately, however, this policy is also concerned with the management of attendance overall and therefore short and long term sickness absence are not mutually exclusive. There can be occasions where the pattern of absence is both short term and long term and in these instances both elements of the policy will interact with appropriate action based on the circumstances of the individual case.

In this situation, the sickness will be counted in its entirety. For clarity, this means that an employee already subject to a live stage review for one category of sickness absence within a rolling twelve month period, who subsequently hits a trigger for the same or another category of sickness absence will move to the next stage of the policy.

For example, if an employee is already on a monitoring stage for short term episodes, a period of long term absence will be classed as another episode. This will result in progression to the next stage of the procedure unless there are exceptional circumstances.

For further advice see the Trust Intranet or contact the HR Department.

6.2 Policy Stages

There are four key stages for managing sickness, both short term and long-term sickness as follows:

6.2.1 Stage 1: Informal Review meeting

6.2.2 Stage 2: Formal Review meeting

6.2.3 Stage 3: Final Formal Review meeting

6.2.4 Stage 4: Sickness Hearing (which may result in dismissal)

A stage meeting will be arranged when an employee meets one of the trigger points outlined in section 7.3. Following a stage meeting being held, if an employee reaches a further trigger point within a rolling twelve-month period, they will automatically progress to the next stage in the process.

The Trust recognises, however, that there are occasionally special circumstances where discretion/judgement should be taken into account, for example, terminal illness.

Where such circumstances apply, and only after seeking advice from a HR Business Partner, managers may apply discretion with regard to the application of formal sanctions and review periods. This may include where the absence is not of a concern to a manager, where an individual is receiving treatment which may require flexibility regarding the trigger points, or where the concern requires more immediate escalation following consideration of the individual circumstances. This may include escalation to stage 4 where there is medical evidence to support this (e.g. Occupational Health).

Discretion should only be applied following discussion with an HR Business Partner who will ensure that this is applied fairly, reasonably, consistently and ensure that conditions covered under the Equality Act are also considered

6.3 **Policy Triggers**

Policy Stages	**Trigger Levels**		**OH Referral**
	Short Term	**Long Term**	

Stage 1: Informal Review Meeting	**3 episodes or 7* calendar days** (single or cumulative) sickness absence in a retrospective rolling 12 month period or unacceptable Patterns** (see below for examples). **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 ? for chart/formula to calculate. Please note :- **** Pro rata for part time staff or any staff who do not work 5 day weeks***	**28 calendar days or 4 working weeks** consecutive absence or more in a rolling 12 month period Please note :- ****** Pro rata for part time staff or any staff who do not work 5 day weeks***	Immediate referral where absence is stress-related, depression or musculoskeletal (para 4.44 refers) **Short Term:** Where absences are self-certificated and there is no medical evidence the manager may recommend employee self-refer to establish any underlying reasons or the need for medical treatment. **Long Term:** Where it is not possible to establish a date for return
Attendance to be monitored and kept under review for 12 months from the date of return from the last occasion of absence. If no further trigger is breached over this 12 month review period Stage 1 will be closed.			
Stage 2: Formal	Where absence occurs again within a 12 month period	**2 months** consecutive absence or more in a rolling 12 month period	**Short Term:** Self-referral as per Stage 1 above.

Review Meeting			Exceptionally, the manager may refer to rule out any underlying reasons or need for treatment **Long Term:** Where the anticipated return does not occur and it is not possible to establish a date for return
Attendance to be monitored and kept under review for 12 months from the date of return from the last occasion of absence. If no further trigger is breached over this 12 month review period Stage 2 will be closed.			
Stage 3: Final Formal Review Meeting	Where absence occurs again within a 12 month period	**4 months** consecutive absence or more in a rolling 12 month period	Referral required prior to formal review meeting for both short and long term sickness absence
Attendance to be monitored and kept under review for 12 months from the date of return from the last occasion of absence. If no further trigger is breached over this 12 month review period Stage 3 will be closed.			
Stage 4: Sickness Hearing	Where absence occurs again within a 12 month period then at this stage consideration will be given to termination of employment.	**6 months** consecutive absence or more in a rolling 12 month period	Referral required prior to formal review meeting for both short and long term sickness absence

	If based on the facts of the case, the Manager deems dismissal not appropriate at this point; the outcome will be an extension of Stage 3 for a further 12 months.	Consideration will be given to termination of employment	
Appeal	Right to appeal stage 2, 3 & 4 outcome		

*** Unacceptable patterns for example, may relate to:*

- *Particular days of the week (e.g. Mondays - immediately after a weekend)*
- *Particular shifts*
- *School holidays*
- *Coinciding with sporting or other events*
- *Bank Holidays*
- *Weekends*

Continuation/repeat of an identified trigger pattern will result in progression through the Policy Stages.

6.4 Work Related Injuries

For staff on pay points 9 and above on the Agenda for Change pay bands payment during sickness does not include regularly paid supplements i.e. what they would have been paid had they been in work, and instead is calculated on the appropriate pay point only. The only proviso to this is where absence is due to a work related injury or disease in the actual discharge of their duties and the individual is not in receipt of an Injury Allowance.

The NHS Terms and Conditions of Service make provision for payment of an Injury Allowance which is payable when an employee is on authorised sickness absence or a phased return with reduced pay or no pay, due to an injury, disease or other health condition that is wholly or mainly attributable to their NHS Employment.

Common to both of these provisions is the determination of whether the employee's absence is due to an injury, disease or other health condition and wholly or mainly attributable to their NHS employment is for the employer, i.e. the Trust, to decide.

7. Stage Meetings

7.1 Stage 1: Informal Review Meeting

Informal Review Meetings maybe convened for one of the following reasons:

- Where the employee has hit on of the triggers outlined in section 7.3
- Where there is genuine concern for an employee's health and well-being
- To evaluate the impact or the potential for reasonable adjustments in a timely way
- To consider medical suspension

- Where there is a genuine concern that a pattern of sickness absence maybe occurring
- To discuss occupational health advice in a timely way
- To explore a return to work before the next policy milestone i.e. formal sickness review
- To maintain good levels of contact and support during a period of sickness absence such reviews must include updates on the workplace

However the above list is not exhaustive and there is no right to be accompanied at an informal review meeting.

7.2 Stage 2-3: Formal Review Meetings

The employee must be invited to a stage 2 or 3 meeting in writing and receive no less than seven calendar days' notice of the meeting.

The employee has the right to be accompanied by a trade union representative or a work colleague at stage 2 and 3 meetings. A HR representative will not usually be present for stage 2 meetings unless it is deemed appropriate in the circumstances. A HR representative will, however, attend stage 3 meetings.

If representation cannot be arranged for the appointed time/date, or the employee is unavailable to attend, a rescheduled review meeting will be arranged as quickly as possible, but no later than 7 calendar days after the original meeting date wherever possible. This meeting will take place as rescheduled and may proceed in the employee's absence if a reasonable explanation for non-attendance cannot be given.

At the meeting, the manager must explore the following with the employee:

7.2.1 If the employee has returned to work after short term absence, consider whether there are any underlying causes to the absence or absence record over a minimum rolling 12 month period, and consider if anything can be offered to support an improvement in the sickness absence levels. Consideration must be given as to whether there are any patterns to the sickness absence record over the minimum period.

7.2.2 If the employee has not returned to work, review current state of health potential length of absence and the likelihood of a return to work. Include consideration of any supporting occupational health advice or the need to request the support of occupational health.

7.2.3 Explore with the employee any reasonable adjustments that may support a sustainable return to work, including a phased return to work or a return to an alternative role on a temporary or permanent basis.

7.2.4 Explore the impact of the sickness absence on service delivery.

Managers are required to explain the purpose of the stage meeting and inform the employee what of the next steps will be should a further occasion of absence occur within a 12 month period.

At the stage 3 meeting, managers should ensure that the employee is made aware that any further absence could lead to their dismissal

Informed by the discussion at the meeting, one or more of the following actions may be taken:

7.2.5 A referral to occupational health

7.2.6 A HSE Stress Risk Assessment

7.2.7 A workplace Risk Assessment

7.2.8 An approach by the employee to Access to Work.

7.2.9 Agreement in relation to reasonable adjustment (s)

At the end of the meeting, the Manager should confirm the discussion in writing using the templates provided in the Attendance Management Guidelines for Managers pack.

7.3 Stage 4: Sickness Hearing

The employee will be given seven calendar days' notice of a Stage 4 Sickness Hearing and will have the right to be accompanied by a trade union representative or work colleague.

In the event that representation cannot be arranged for the appointed time/date, or the employee is unavailable to attend, a rescheduled hearing will be arranged as quickly as possible, but no later than 7 calendar days after the original hearing date wherever possible. This meeting will take place as rescheduled and may proceed in the employee's absence if a reasonable explanation for non-attendance cannot be given.

The employee must be informed in writing that he or she is required to attend the hearing with a senior manager with the delegated authority to dismiss and a representative from the Human Resources Department (The panel).

The letter must explain that the purpose of the meeting is to consider their continued employment because of continuing sickness absence or review an unsatisfactory sickness record. The notification must also include copies of any papers that maybe referred to at the hearing and issued no later than three working days before the hearing.

If the employee is unable to attend the hearing they may wish for their case to be submitted in writing or to be represented by their Trade Union or workplace colleague in their absence. The Trust may hold the hearing in the absence of the employee, a written submission or their representative if all reasonable steps have been exhausted.

The employee must present any papers they wish to be referred to at the hearing no later than three working days before the arranged hearing.

Following full consideration of all the facts of the case presented one of the following outcomes will apply:

1. The case should remain at a stage 4 level and the absence be under review for a further time period. The specific timescale will be determined on an individual basis and be clearly communicated as part of the outcome.
2. Adjourn to explore redeployment or obtain further medical advice or any other reason deemed appropriate by the panel.
3. Redeployment or another change to the contractual terms to enable and support a sustainable return to work (no pay protection will be applied in such cases)
4. Ill health capability dismissal - The reason for dismissal in accordance with this policy will be related to ill health capability, where the employee's health is preventing them from undertaking their duties, the Trust is unable to sustain the level of support required and all reasonable steps have been taken by the Trust to address and resolve the matter.

The outcome of the hearing must be confirmed in writing within five working days of the hearing. In the case of a dismissal the right to appeal will also be confirmed.

7.4 Appeal

Employee will be entitled to one appeal where they are issued with a formal sanction under this policy or where they are dismissed.

When considering whether to raise an appeal the employee will need to consider on what grounds they will raise that appeal. e.g. Trust's process and/or procedure have not been followed correctly.

Appeal against a formal sanction (Stages 2 & 3)

Such appeals should be lodged in writing to the manager immediately senior to the manager making the decision.

The letter of appeal must state the reasons why the employee disagrees with the original decision and should be received within seven calendar days of the date on which the decision was given to the employee.

The appeal meeting will compromise of nominated Manager within the relevant Division and they will be supported by a HR Representative. The employee will have the right to be accompanied by a union representative or work place colleague.

In the event that representation cannot be arranged for the appointed time/date or the employee is unavailable to attend, a rescheduled review meeting will be arranged as quickly as possible, but no later than 7 calendar days after the original meeting date.

This meeting will take place as rescheduled and may proceed in the employee's absence if a reasonable explanation for non-attendance cannot be given.

Appeal against a Dismissal

Such appeals must be lodged in writing to the HR Department, within seven calendar days' of the Sickness Hearing (where the outcome was given on the day). Where an outcome was given in writing, the employee will have seven calendar days' from the date they received the letter. The appeal letter must include the grounds on which the appeal is being made. The dismissal takes effect from the date of the decision and the lodging of an appeal will not stop the sanction taking effect.

The appeal hearing will compromise of a Senior Manager and they will be supported by a Human Resources representative in an advisory capacity. The Senior Manager who will act as chair to the appeal hearing may be of equivalent seniority to the senior manager who heard the original panel, but who has had no previous involvement in the case.

The purpose of the appeal panel is to review the decision awarded at the Sickness Hearing. It should be noted that an Appeal is not a re-hearing of the original case, but a review of the reasons submitted by the member of staff who was dismissed and why it should be reviewed.

The decision following an appeal hearing is final.

7.5. Failure to attend Sickness Absence Review Meetings

The employee must attend meetings unless their illness (or some other substantial reason e.g. unable to arrange trade union representation) prevents them from doing so. If appropriate, meetings can take place away from work or at the employee's home with their permission.

If the employee cannot attend the original scheduled meeting, they have the right to rearrange the meeting. The rearranged meeting where possible should take place within one working week, starting from the day after the date of the original meeting.

In the event of failure to attend the rearranged meeting, the employee maybe advised that the meeting will be held in their absence. A representative (trade union representative or work colleague) can attend on their behalf if they so wish, and decisions maybe made in their absence, based on the evidence available.

8. Resignation by mutual agreement

In the event that there is no likely date of return to work for the employee and reasonable adjustments or

redeployment have not been successful, or are not applicable due to the employee's medical condition, the option of resignation by mutual agreement can be taken as an alternative to the formal procedure outlined above. This must be agreed at a meeting by both parties. The right of representation must still be offered. The summary of this meeting must be confirmed in writing. The employee must also be given the right of appeal and the termination date must be mutually agreed.

9. Ill Health Retirement Applications

Employees who are members of the NHS Pension Scheme may decide to apply for ill health retirement benefits. Whilst the Trust can support the employee in completing the appropriate documentation, the decision as to whether or not the application is accepted rests solely with the NHS Pensions Agency, and the Trust is not able to influence that decision in any way. A decision to dismiss on the grounds of capability can therefore be made irrespective of any application for ill health retirement.

10. The Equality Act 2010

The act states that a person has a disability if a) they have a physical or mental impairment and b) the impairment has a substantial adverse effect on their ability to carry out normal day to day activities. The Trust has a number of responsibilities under the Equality Act 2010. In line with those responsibilities, the Trust will seek to make reasonable adjustments where possible or find an alternative post, to enable employees to remain in employment.

10.1 Reasonable Adjustments

Where the Occupational Health Department recommend a return to the original post with some temporary/permanent restrictions, including reduced hours, lighter duties or alternative shift patterns managers should consider the advice and any flexible solutions to enable the employee to return to work. However, the requirements of the service need to be considered when making such a decision and a set timescale for review/end date must be agreed where temporary adjustments are in place. Please see the Reasonable Adjustment Standard Operating Procedure for further information.

11. Phased Return/Rehabilitation

Where an employee has had a long-term absence and is fit to return to work on a restricted basis in terms of hours or duties, the manager should consider a return to work on a phased basis. This rehabilitation period is to allow an effective, sustained return to work. To establish whether it is medically appropriate for a phased return/rehabilitation period to take place, an Occupational Health Referral will be made by the Line Manager. Once this report has been received, there will be a discussion between the employee and the manager and during these discussions the medical advice from Occupational Health will be the driver. Each case will be treated on an individual basis and will be supported by an agreed and structured programme and should not last longer than four weeks. In all other cases where the employee has outstanding annual leave, the manager should discuss how this can best be used to support the return to work. Managers should also consider a short period of induction/re-training including Mandatory Training if appropriate.

Where Occupational Health has indicated that periodic review is necessary, on-going monitoring by the manager should take place. This should include regular contact with the employee and meetings to discuss any new information in the Occupational Health reports.

Should the employee require a longer than operationally feasible phased return to work, the employee may need to consider a more permanent reduction in hours

12. Re-deployment

Following advice from the Human Resources Department and Occupational Health, consideration may need to be given to redeploying the employee on a temporary/permanent basis to an alternative post. The Trust is not however under any obligation to create a suitable post, and if the post is on a lower grade, or working fewer hours, pay protection would not be applicable. Where redeployment to an alternative appropriate post is agreed the employee will move into the post and maybe subject to competition. e.g., other employees '*at risk'* of redundanc

12.1 Temporary Redeployment

It may be the case that an employee becomes fit to return to work but not to their substantive role. In these circumstances the manager, with the guidance of Occupational Health, will look to see if there are any suitable positions to redeploy the employee into on a temporary basis. A temporary basis is considered to be one which is expected to last less than 2 months.

Where an employee is temporarily redeployed to a different banded role they will remain on their substantive pay band, unless the arrangement continues beyond 2 months.

12.2 Permanent Redeployment

Employees who are unable, for health reasons, to continue with their present duties but who are considered fit for alternative duties/roles by Occupational Health shall receive preferential consideration for any suitable vacancies.

A suitable role is deemed to be one where the minimum criteria of the job description/person specification is met and which is either the same band or one band below their current post (no pay protection is provided for medical redeployment). Consideration should be given to roles where the employee could be trained to the required level within 4 weeks.

Where a suitable role is identified an informal interview (unless there are other staff in the same circumstances) should be held between the recruiting

manager and the employee to discuss the role and its requirements. The manager will not be able to reject a suitable candidate because of their sickness record or current health. Where an appointment is not made, a full explanation will be provided

13. Record Keeping

Effective management of attendance depends on accurate and comprehensive record keeping. Managers will record individual levels, frequency and reason for sickness absence (including absence as a result of a disability), and review records after each absence in order to identify problems or patterns at an early stage. This will enable managers to act pro-actively and provide the necessary support and assistance to improve attendance. In order to ensure that records are comprehensive, managers should also keep brief notes on all communications with absent employees, including telephone calls. All sickness information must be stored confidentially and securely.

14. Disciplinary Policy

Where an employee fails to follow the Trust Sickness Absence policy or where there are sufficient grounds to suggest that sickness is not genuine disciplinary action may be taken. Examples of where this may be applicable are as follows:

- Acting in a manner incompatible with their declared sickness absence and not refraining from activities, (domestic, social or sporting), which may be prejudicial to recovery or likely to bring

into question the reason for continued absence.

- Undertaking work in any other employment (including bank or agency) whilst off sick and claiming sick pay.
- Abusing the sickness absence procedures or sick pay scheme.
- Not advising the manager if they intend to go away or take annual leave whilst off sick

However, this list is not exhaustive.

15. Notification of Expiry of Full/Half Pay

Employees will be notified when full pay and half pay are due to expire.

16. Sickness and Annual Leave

16.1.1 When an employee falls sick for a period of 7 days or more and this has been medically certified (rather than self-certified) whilst away on annual leave, they must follow the reporting procedures detailed in this policy in order that they may, if they wish, re-claim part of their annual leave. This includes employees that are out of the country. When an employee is sick immediately prior to annual leave, they must contact their manager to confirm whether they are fit and able to take their leave.

16.1.2 To be able to claim contractual sick pay employees must notify their manager of their incapacity immediately, and the usual requirements for medical evidence in this policy will also apply, even when abroad. For pre-booked annual leave that falls during a period of sickness absence, employees and managers can agree how to track the leave depending on the specific circumstances. Employees can cancel any pre-arranged annual leave that would otherwise coincide with sick leave and should notify their manager as soon as practicable.

16.1.3 An employee who has been unable to take their full entitlement to annual leave owing to their sickness absence will be entitled to carry over a maximum of 20 days statutory leave into the next leave year, to be offset against any leave already taken in that leave year.

16.2 Taking annual leave whilst off sick

16.2.1 If an employee wishes to go away whilst they are off sick they must advise their manager of this in advance. Unless the holiday is medically advised as part of their recuperation the employee should use annual leave for any holidays taken during their period of sickness absence. Employees must also ensure that their activities are not prejudicial to recovery or likely to bring into question the reason for continued absence. Wilful disregard of this may result in disciplinary action.

16.2.2 Sickness during a bank holiday cannot be claimed back.

16.3 Carry Over of Annual Leave

16.3.1Where an employee has been unable to take their full annual leave entitlement within a leave year because of sickness absence, they will be allowed to request to take their accrued statutory annual leave (or the remaining balance if some has already been taken) during sick leave or to allow the untaken statutory annual leave to be carried forward into the new leave year where taking the leave has not been possible.

16.3.2 A request to take annual leave during sickness absence can be made at any time (during the paid or unpaid part of the sickness absence).

17. Medical Suspension

Medical suspension is rare and would only be considered in exceptional cases where the employee's health constitutes a risk to the safety of the individual, other staff or patients in the opinion of the Occupational Health Service, in consultation with the Line Manager and the HR Department.

All reasonable adjustments, including temporary redeployment and adjustment to working hours and tasks, should be exhausted before a manager makes the decision to medically suspend an employee.

An employee who is medically suspended should not suffer any financial detriment and should therefore continue to receive their normal full pay while suspended. For those staff who works on-call, regular overtime, or hours that attract specific enhancements, their line managers should ensure that their pay reflects the average pay they would have normally received had they had they still been in work. This does not include any regular bank shifts worked.

Should any medical suspension last beyond 20 working days/4 working weeks, the case will be handled in accordance with the long-term provisions of this Policy.

Medical suspension is entirely at the discretion of the Trust.

18. Policy Implementation Plan

The policy will be implemented on a Trust wide basis following consultation and ratification. The policy will then be made available on the intranet. Managers will be briefed on the content and training will be provided for managers.

Managers have a responsibility to ensure staff have read and understood this policy and procedure. New staff will be informed of the policy as part of their Trust induction.

Where absence due to disability related ill health occurs, managers must seek advice from Human Resources and/or Occupational Health. Reasonable adjustments must be considered wherever appropriate. Employees who consider they are affected by a disability or any medical condition which affects their ability to undertake their work should inform their line manager.

Absence due to pregnancy related ill health must also be considered carefully. Managers must exercise judgement and seek advice from Human Resources and/or Occupational Health when considering formal action. Refer to the guidance for managing attendance for further details.

Some employees may be unable to carry out the duties of their posts due to medical conditions but are given alternative duties on a temporary basis. Where a long term solution cannot be found, such employees are subject to this policy, on the basis that they are unable to carry out the duties of their substantive post owing to ill health.

Where Occupational Health recommend ill health retirement, refer to the Retirement Policy.

The policy will be reviewed on a three-yearly basis.

19. Monitoring of Compliance

Compliance with the policy will be monitored by the HR Department

20. References

Appendices

The table below shows in hours those who will trigger following the 7 calendar days in a rolling 12 month period as stated in the short term sickness of the policy.

Weekly Working Hours	Trigger Hours	Weekly Working Hours	Trigger Hours	Weekly Working Hours	Trigger Hours
7.5	10.5	18	25.2	28.5	39.9
8	11.2	18.5	25.9	29	40.6
8.5	11.9	19	26.6	29.5	41.3
9	12.6	19.5	27.3	30	42
9.5	13.3	20	28	30.5	42.7
10	14	20.5	28.7	31	43.4
10.5	14.7	21	29.4	31.5	44.1
11	15.4	21.5	30.1	32	44.8
11.5	16.1	22	30.8	32.5	45.5
12	16.8	22.5	31.5	33	46.2
12.5	17.5	23	32.2	33.5	46.9
13	18.2	23.5	32.9	34	47.6
13.5	18.9	24	33.6	34.5	48.3
14	19.6	24.5	34.3	35	49
14.5	20.3	25	35	35.5	49.7
15	21	25.5	35.7	36	50.4
15.5	21.7	26	36.4	36.5	51.1
16	22.4	26.5	37.1	37	51.8
16.5	23.1	27	37.8	37.5	52.5
17	23.8	27.5	38.5		
17.5	24.5	28	39.2		

Based on 7 calendar days = x1.4 wte.

Endorsed By:

Name of Lead Clinician / Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date

Record of Changes

Section No	Version No	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason

Managing Violent, Aggressive and Anti-Social Behaviour

Policy

For completion by Author					
Author(s) Name and Title:	Brian Cowan, Security Manager				
Scope:	Trust Wide	Classification:	Non-Clinical		
Version Number:	7.0	Review Date:	17/10/2024		
Replaces:	Zero Tolerance – The Prevention and Management of Violence and Aggression v 6.0				
To be read in conjunction with the following documents:	Security Policy Health and Safety Policy Lone Worker Policy Bullying and Harassment Policy Supporting Staff Following Work Related Traumatic or Stressful Incidents Lone working device procedure				
Document for public display:	Yes				
Executive Lead	Karen Edge, Chief Finance Officer				
For completion by Approving Committee					
Equality Impact Analysis Completed:		No			
Endorsement Completed:	No	Record of Changes	Yes		
Authorised by:	Health & Safety Committee	Authorisation date:	12/09/2022		
For completion by Document Control					
Unique ID No:	TW25(07)	Issue Status:	Approved	Issue Date:	04/10/2022
After this document is withdrawn from use it must be kept in archive for the lifetime of the Trust, plus 6 years.					
Archive:	Document Control	Date Added to Archive:			
Officer responsible for Archive:	IG and Document Control Facilitator				

Contents

Policy Statement

The Liverpool Heart and Chest Hospital NHS Foundation Trust is committed to tackling violent, aggressive, and anti-social behaviour against all Trust staff. The Trust aims to prevent incidents of violence occurring. It recognises that is not always possible but strives to achieve the lowest level possible through exerting suitable controls, including training staff in the appropriate use of risk assessment.

The Trust does not accept that members of staff should be subjected to verbal abuse, or physical violence of any nature. The Trust will encourage Police intervention and offer support to staff that have suffered mental and/or physical trauma. Any assault on a member of staff will be treated extremely seriously and may result in criminal charges being brought or access to Trust site being restricted.
Legal and Statutory:

The following general (statutory) duties apply:

- Duty of employers under the Health and Safety at Work Act 1974 s.2,3.
- Duty of employees under the HASAWA s.7
- Common law self defence

1. Roles and Responsibilities

Chief Executive

Has a duty to ensure the health and safety of all staff at a risk from violence and abuse

Chief Finance Officer

The Chief Finance Officer, as the nominated Security Management Director (SMD), will lead and communicate at board level on strategies to tackle violence against staff. This should take into account the NHS SMS document; 'A professional approach to managing security in the NHS (2003) and relevant health and safety legislation.' The SMD works to promote and champion strategies at board level which will tackle violence and aggression.

Head of Security

The Head of Security has overall responsibility for the delivery of the Operational Services and Budget. Has a duty to ensure implementation of policy including monitoring and performance of effectiveness. Has a duty to advise the Risk Management Committee on performance in managing challenging behaviour, violence, and aggression in the workplace.

Security Manager

Has a role providing advice to all staff regarding the management of violence & aggression, in accordance with all aspects of legislation . The Security Manager provides a link with Merseyside Police and will work with key colleagues, Health and Safety Advisors and staff representatives, to manage violence and aggression and anti-social behaviour.

All Managers have a duty to:

- Ensure that staff within their lines of responsibility are aware and understand this policy
- Ensure staff have relevant training for dealing with incidents of anti-social behaviour, violence, abuse and aggression
- Take all reported incidents of violence and aggression seriously
- Provide immediate support to staff who experience abusive, anti-social, violent or aggressive behaviour, by listening to the account of the incident and discussing with the member of staff the options available to them
- Ensure staff report all incidents as per the incident reporting policy
- Inform senior staff and the HR department as appropriate
- Conduct risk assessments were necessary
- Debrief teams following a violence and aggression incident

All Staff have a duty to:

- Attend appropriate training
- Report all incidents of challenging behaviour violence as they occur as per the Trust incident reporting system
- Ensure that they do not put themselves or their colleagues at risk of violence and aggression intentionally or unintentionally
- Support colleagues who have been the victim of a violent incident or witness to it.
- Co-operate fully in any subsequent investigation of an incident
- Take appropriate steps to protect themselves or others in line with the Health and Safety at Work Act 1974 and Professional Codes of Conduct
- Consider the use of an informal / formal warning where appropriate

Where it is alleged that members of staff have carried out acts of violence or aggression, this will be dealt with under the Trust's Bullying and Harassment and Disciplinary policies.

Trade Union / Health and Safety representatives have a duty to:

- Support their members in reporting cases of violence
- Provide on-going support to their members who experience abusive violent or aggressive incidents
- Report all incidents to external organisations as appropriate

Risk Management Team have a duty to:

Ensure all reported incidents are assigned to an appropriate managerial level and that reports are presented to the appropriate Standing Committee for their consideration.

2. Document Control Standards

The Trust has a statutory obligation to provide a safe and secure environment for its staff and others as well as a moral duty to take all reasonable steps to protect and support its staff. This policy is designed as an important step in improving the Trust's ability to tackle incidents involving violence and abuse.

3. Procedure

The nature of the Trust's activities, and absence of an Accident and Emergency Department, along with a review of incidents over a number of years, and risk assessment, suggests that the actual risk of an incident involving physical violence is extremely low. Incidents of verbal abuse are reported but are not frequent. Nevertheless, it is considered appropriate to have this policy in place to deal with any incident, no matter how unlikely. The purpose of this policy is to minimise the risk to staff, patients and visitors arising from incidents of violence and aggression.

N.B. whilst the majority of incidents involve patients or visitors, the policy applies equally to potential acts of violence or aggression perpetrated by Trust employees on their colleagues, patients or visitors. This policy applies to all LHCH staff, patients and visitors working both on site and within the community.

3.1 The Legal Position

The Trust is committed to tackling the issues of violence and aggression to staff and recognises it has a duty of care under the Health and Safety at work Act and the Management of Health and Safety Regulations. Any person also has the right to defend themselves or others from harm in accordance with Common Law. A person may use such force as is reasonable in the circumstances for the purposes of:

- self-defence
- defence of another
- defence of property

3.2 Arrangements for the Safety of Lone Workers including the requirement to undertake appropriate risk assessments

By its nature, lone working presents different risks to staff. Examples of where lone working occurs include home visits, buildings where staff are isolated from colleagues, staff who are called in for service provision outside of normal working hours.

Employees should be made aware of all known risks and written risk assessments should be made available to all staff who need to know.

All staff issued and trained in the use of Reliance lone worker devices should ensure they follow the standard operating procedure (SOP) regarding their use.

Those employees who make home visits must take into consideration the following

- Is the patient known to you?

- Is there a history of violence?
- Is there known alcohol or substance abuse
- Is the area isolated?

It is recognised that Trust employees may have to work unaccompanied to discharge their duties. Lone working can increase the risk to staff, it is therefore essential that all lone work situations be subjected to risk assessment. Risk assessment will identify measures to protect staff and should consider communication between the workers and their base location.

For those staff working at

- Another employers premises
- From home,
- On domiciliary visits
- Staff alone with patients

Risk assessments should be retained locally outlining risk and measures to reduce any potential risk, for example keeping in contact with a designated person.

Personal Attack Alarms are available for staff that has been identified by individual departments as being at risk.

If staff require a personal attack alarm line Managers should contact the Security Manager to be issued with one.

Entry/Issues Outside of Normal Working Hours Contact the security office if escorting is required to gain entry to Trust premises outside of working hours. The requirement to inform Security should be emphasised by Managers to Staff to ensure their personal safety and that of the premises.

3.3 Community Staff

Domiciliary staff are at greater risk of being victims of violent, aggressive or anti-social behaviour in the community. In instances where a patient/family member/friend/animal has demonstrated violent, aggressive or anti-social behaviour previously, reasonable adjustments should be made. The introduction of two person visits should be considered to reduce the risk the domiciliary staff.

Staff should escalate any incidents of this type of behaviour to the senior member of staff on duty and an incident form must be completed. This will be managed by one of the senior staff and the incident will then be discussed at the weekly Complex Care meeting. From this meeting, the relevant reasonable adjustments will be made.

Two person visits should always be implemented once the procedure for care of patients who are violent or abusive or demonstrating anti-social behaviour is introduced.

Community staff have access to lone worker devices and are trained in the use of them. These devices should be utilised if any staff member feels intimidated or under threat of violent, aggressive or anti-social behaviour.

3.4 Types of Behaviour that are not Acceptable

The following are examples of behaviours which are not acceptable on Trust premises or for staff working in the community.

- Assaultive or threatening behaviour
- Threatening or abusive language involving excessive swearing or offensive remarks
- Derogatory racial or sexual remarks
- Bullying and harassment
- Malicious allegations relating to members of staff, other patients or visitors
- Abusing alcohol or drugs in hospital or in the community. (However, all medically identified substance abuse problems will be treated appropriately).
- Drug dealing
- Wilful damage to Trust property
- Uncontrolled pets

3.5 Prevention

As with any risk to the wellbeing of patients, visitors and staff, prevention of abusive behaviour is preferable to action after the event.

The Trust recognises that, in circumstances which have potential to lead to abusive behaviour, appropriate action by Trust staff will often defuse the situation and avoid an incident.

It is, therefore, necessary to equip those members of staff who may be confronted with a potentially abusive person, with the appropriate skills.

The Trust will display suitable notices throughout the premises to bring the basic principle of this policy to the attention of patients and visitors.

Introduction of procedure of care outlining what behaviour is expected while receiving treatment within a community setting or on hospital premises.

3.6 Local Arrangements for preventing and managing Violence and Aggression including the requirement to undertake appropriate risk assessments

The management of aggressive behaviour should, as far as the situation allows, be nonphysical. Where the relatives or friends of the aggressor are available, they should be asked to support staff in the diffusion of the situation.

In adopting a non-physical approach to the management of violent, aggressive or anti-social behaviour staff should observe the following:

- Ensure that colleagues are aware of the situation.
- Be aware of the sources of help available if required.
- One member of the team must assume control of the incident.
- The aggressor should be approached where possible and his/her agreement sought to stop the behaviour or to comply with a request.

- The consequences of refusing the requests from staff should be explained to the individual(s) concerned.
- Any other patients or persons not involved should be asked to leave the area quietly.

Where non-physical methods have failed, or if there is any doubt about the outcome of any situation involving aggressive behaviour, security personnel must be called.

Physical restraint is not encouraged and should only be undertaken by staff who have been trained in restraint techniques. However, ANY person may use force to protect themselves or others provided the force used is justified as being:

- Proportionate
- Reasonable
- Absolutely necessary
- Minimum use of force for a minimum period of time

Any use of force must be recorded on a patients EPR and / or Datix report

Risk assessments should be carried out in any situation where there is perceived to be an increased risk of violence and aggression. Risk assessments should be retained locally outlining risk and measures to reduce any potential risk.

3.7 Sanctions

Visitors (anyone who is not a patient or staff member)

- Visitors who display any of the above behaviours will be asked to desist and offered the opportunity to explain their actions.
- Continued failure to comply with the required standard of behaviour will result in the removal of the offending individual from Trust property, if necessary, security staff will be summoned. The excluded individual may request an immediate review of the exclusion by the Director of Research and Innovation and should be informed of this.
- Any visitor behaving in an unlawful manner will be reported to the police and the Trust will seek the application of the maximum penalties available in law. The Trust will seek to prosecute all perpetrators of crimes on or against Trust property, assets and staff.
- The relevant Head of Department may decide to continue to exclude any individual removed from the premises or restrict their visiting only to specific times and, if necessary, under escort from security staff

3.7.1 Criminal Justice and Immigration Act 2008

The Criminal Justice and Immigration Act 2008 (CJIA) introduced new provisions to give staff and police working in the NHS the power to remove and to prosecute individuals causing a nuisance or disturbance on NHS premises

Sections 119 and 120 of the Act created a new offence of causing a nuisance or disturbance on NHS premises and a power for NHS authorised staff to remove a person suspected of committing this offence. The Act only applies to NHS hospitals. Patients or those seeking medical advice, treatment or care cannot commit the offence or be removed under CJIA powers.

3.8 Patients from the age of 16 years

- Following any incident, the immediate manager or Head of Department (or their deputy) will explain to the patient that his/her behaviour is unacceptable and explain the expected standards that must be observed in the future.
- If the behaviour continues, the responsible manager or clinician will give an informal warning about the possible consequences of any further repetition.
- Failure to subsequently desist will result in the application of the Procedure for Care of Individuals who are Violent or Abusive (hereafter referred to as the Procedure for Care) as a formal written warning of the consequences of such behaviours. This process also applies to patient who present with challenging behaviour.
- If a patient complies with the terms of the Procedure for Care, he/she can expect the following:
- That their clinical care will not be affected in any way;
- That, where substance abuse has been identified, appropriate assistance will be provided.
- That a copy of the Confirmation of the Procedure for Care of Individuals who are Violent or Abusive will be copied and scanned to the patients records on EPR.
- That the Trust security Manager will be informed.
- That The Liverpool Heart and Chest hospital NHS Foundation Trust will fully investigate all valid concerns raised by the patient.
- That the Procedure for Care will lapse after one year.

- **Failure to comply** with the Procedure for Care may, at the request of the relevant manager (or a nominated deputy) result in exclusion from the Trust. The decision of the Medical Director will be final in this respect.
- Such exclusion or removal of community care will last one year, subject to alternative care arrangements being made. The provision of such arrangements will be arranged by the relevant clinician normally in writing to the patients GP and requesting they refer the patient to another Trust or a community outpatient setting. In the event of an excluded individual presenting at the Trust for emergency treatment, that individual will be treated and stabilised with, if necessary, security staff in attendance. If admission is unavoidable security staff will, if necessary, remain in attendance. The need for security attendance will be determined by an appropriate member of staff (see Appendix 2).

Any patient or visitor behaving unlawfully may be reported to the police and The Trust will seek the application of the maximum penalties available in law. The Trust will prosecute all perpetrators of crime on or against Trust property, assets and staff.

4. Policy Implementation Plan

4.1 Policy Implementation

The policy will be implemented on a Trust wide basis following discussion and ratification by the Health & Safety Committee. The policy will then be made available on the intranet and disseminated to all wards / departments. Managers will be briefed on the content and training will provided for managers by the Human Resources Department.

Managers have a responsibility to ensure staff have read and understood this policy and procedure. New staff will be informed of the policy as part of their Trust induction.

The policy will be reviewed every 3 years.

4.2 Learning and Development Requirements

Training

- All staff will be made aware of the contents and principles of this policy at induction.
- All staff having direct contact with patients and relatives will be required to Participate in training in conflict resolution via ESR E learning package. Identified staff working in areas considered of higher risk will complete practical conflict resolution training as outlined below

Conflict Resolution Training is crucial to avoid panic reactions in unusual situations. The training will ensure that staff are competent to deal with circumstances which are new, unusual or beyond the normal scope of training, for example, when to stop work and seek advice from a line manager and how to handle violence, anti-social behaviour, aggression and/or abuse.

This training package includes:

- Causes of violence.
- Recognition of warning signs.
- Interpersonal skills.
- Managing aggression.
- Resolving conflicts.
- Assertion.
- The law relating to self-defence.
- Management arrangements for dealing with a violent incident
- Managers will be given further training as necessary, on the implementation of this policy, with emphasis on risk assessment.
- Managers may determine any local training requirements specific to their Operations. This for example may include the principles of Break Away techniques. Break Away training can be booked via the Support Services Manager.
- Managing Challenging Behaviour.

5. Monitoring of Compliance

The monitoring arrangements for implementation and performance of this policy includes audit of the key points / processes contained in this document. The policy will be audited and audit reviewed in the health & safety committee every three years prior to policy renewal.

6. References

This document should be read in conjunction with the following Trust documents:

- Health and Safety Policy

- Policy on bullying and harassment.
- Stress Management Policy.
- Lone Working Policy

7. Appendices

APPENDIX 1

PROCEDURE FOR CARE OF INDIVIDUALS WHO ARE VIOLENT OR ABUSIVE OR DEMONSTRATING ANTI-SOCIAL BEHAVIOUR IMPLEMENTATION CHECKLIST

1. In the event of inappropriate behaviour by a patient and following careful review by the individual's clinical team (or the on-call team out of hours), the Procedure for Care of Individuals who are Violent, Anti-social or Abusive (hereafter referred to as the Procedure for Care) can be instigated.

2. In the event of the senior qualified member of staff on duty of the relevant ward/department feeling that a Procedure for Care may be appropriate, he/she should contact a senior member of staff e.g. The a Matron / Head of Nursing. For out of hours the Hospital Co-ordinator should be contacted.

3. It is the responsibility of that senior person (see Appendix 2) to undertake the following:

The reporting officer should provide full details of the incident and the staff member's concerns, document them and decide whether a Procedure for Care is required. Wherever possible, get witnesses to the event to sign the record as true and accurate.

If the senior Officer considers that a Procedure for Care is required he or she will:

Inform and seek advice from the patient's consultant or senior member of the medical team (on call team out of hours), or their GP if necessary.

Inform the patient of the staff's concerns and fully explain the Procedure for Care, ensuring that there is no confusion as to the standard of behaviour required or the possible consequences of failure to comply

Complete all patient details on the Confirmation of Procedure for Care of Individuals who are Violent, Anti-social or Abusive (Appendix 2).

Ask the patient to sign the Confirmation of Procedure for Care of Individuals who are Violent Anti-social or Abusive (hereafter referred to as the Confirmation of Procedure for Care). If the patient refuses to sign, this should be documented, but explained to the patient that the document will be valid with or without the patient's agreement.

Ensure that a senior member of staff (any doctor, registered nurse, radiographer or other health care professional) witnesses the explanation to the patient and signs the Confirmation of Procedure for Care.

Give the patient a copy of the Confirmation of Procedure for Care and of the policy itself.

Prepare a copy of the standard letter (Appendix 3), for issue to the patient. This letter should be signed and sent by the Director of Nursing. A copy of the Policy should be attached.

If there is no improvement the patient will be provided with a final warning and the GP will be notified

Prepare a copy of the standard letter (Appendix 4) for issue to the patient. This letter should be given to the Director of Nursing and Operations with the letter to the GP for checking both the letter and that the procedure for care has been applied appropriately.

If there remains no improvement then the patient may have treatment withheld or withdrawn.

Prepare a copy of the standard letter (Appendix 5) for issue to the patient. This letter should be given to the Director of Nursing with the letter to the GP for checking both the letter and that the procedure for care has been applied appropriately. The Chief Executive will be responsible for signing any exclusion.

The full process must be recorded in the patient's medical and nursing documentation.

APPENDIX 1A

PROCEDURE FOR CARE OF INDIVIDUALS WHO ARE VIOLENT, ANTI-SOCIAL OR ABUSIVE IMPLEMENTATION CHECKLIST

If a Procedure for Care is required:

Inform and seek advice from the patient's consultant or senior member of the medical team (on call team out of hours), or their GP, if necessary. Consideration should be given to determine if the patient is in a confused state prior to escalation.

Ensure that the incident which triggered the procedure is documented in full, and signed by the member of staff and any witnesses

Inform the patient of the staff's concerns and fully explain the Procedure for Care, ensuring that there is no confusion as to the standard of behaviour required or the possible consequences of failure to comply

Complete all patient details on the Confirmation of Procedure for Care of Individuals who are Violent or Abusive (Appendix 2)

Ask the patient to sign the Confirmation of Procedure for Care. If the patient refuses to sign, this should be documented, but explained to the patient that the document will be valid with or without the patient's agreement

Ensure that a suitable member of staff (qualified or other health care professional) witnesses the explanation to the patient and signs the Confirmation of Procedure for Care

Inform the Director of Nursing

Give the patient a copy of the Confirmation of Procedure for Care and of the policy itself

Prepare (type) a copy of the standard letter (Appendix 3) for issue to the patient. This letter should be signed and sent by the Director of Nursing. A copy of the Policy should be attached.

The incident/behaviour must be documented in the patient's medical and nursing notes

Director of Research and Innovation to

- check the procedure has been applied correctly
- issue the letter to the GP
- inform security as required of any warnings issued

APPENDIX 2

CONFIRMATION OF PROCEDURE FOR CARE OF INDIVIDUALS WHO ARE VIOLENT, ANTI-SOCIAL OR ABUSIVE

WARD:..... HOSPITAL: .....

PATIENT'S FAMILY:.....

PATIENT'S FORENAMES: .....

HOSPITAL NUMBER(S): .....

HOME ADDRESS: .....

.....

HOME PHONE NUMBER: .....

GP'S NAME: ..... GP'S

ADDRESS: .....

.....

GP'S PHONE NUMBER.....

The consequences of a failure to comply with the Procedure for Care have been fully explained. I understand my GP will be informed.

• I agree to comply with the expected behaviours set out in the policy, which will be provided at The Liverpool Heart and Chest Hospital NHS Trust Signed:

……Date: ……. * Delete if refused

WITNESSES FOR THE TRUST

(Initiator of Procedure)

NAME:..... NAME: .....

DESIGNATION: ..... DESIGNATION: .....

Signed:..... Signed:.....

Date: ..... Date: .....

Examples of appropriate members of staff able to initiate the Procedure:

Trust Director, Senior Doctor (Registrar or above), or other appropriate healthcare professional.

Out of Hours – The Senior Manager on Duty/ or Hospital Co-ordinator

APPENDIX 3

LETTER TO PATIENT INFORMING THEM THAT A PROCEDURE FOR CARE HAS BEEN INITIATED

Dear

Acknowledgement of Responsibilities Agreement between <insert name of patient, visitor or member of the public> and <insert name of health body or location>.

It is alleged that on the you used/threatened unlawful violence/acted in an anti-social manner to a member of Trust staff whilst on Trust premises/Received care in the community (delete as applicable).

Behaviour such as this 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. This was made clear to you at the meeting you attended on to acknowledge responsibility for your actions and agree a way forward.

I would urge you to consider your behaviour when attending/receiving community care the in the future and comply with the following conditions as discussed at our meeting

<list of conditions>

If you fail to act in accordance with these conditions and continue to demonstrate what we consider unacceptable behaviour, I will have no choice but to take one of the following actions: (to be adjusted as appropriate)

- The matter will be reported to the police with a view to this health body supporting a criminal prosecution by the Crown Prosecution Service.
- The matter will be reported to the NHS Security Management Service Legal Protection Unit with a view to this health body supporting criminal or civil proceedings or other sanctions. Any legal costs incurred will be sought from yourself.
- Consideration will be given to obtaining a civil injunction in the appropriate terms. Any legal costs incurred will be sought from yourself.

A copy of this letter is attached. Please sign the second copy and return to me to indicate that you have read and understood the above warning and agree to abide by the conditions listed accordingly.

If you do not reply within 14 days I shall assume tacit agreement.

Sincerely,

Signed by the Director of Research and Informatics

Date

I, accept the conditions listed above and agree to abide by them accordingly,

Signed Date

APPENDIX 4

LETTER TO PATIENT, COPIED TO GP INFORMING THEM THAT THEY HAVE BEEN ISSUED WITH A FINAL WARNING UNDER THE PROCEDURE FOR CARE

Dear

Final Warning

I am writing to you concerning an incident that occurred on at the Trust. It is alleged that you used/threatened unlawful violence/acted in an anti-social manner to a member of staff whilst on Trust premises/receiving care in the community (delete as applicable).

Behaviour such as this is unacceptable and will not be tolerated. This Trust is firmly of the view that all those who work in or provide services to the NHD have the right to do so without fear of violence or abuse. This was made clear to you in my previous correspondence/meetings of . A copy of this health body's policy on the withholding of treatment from patients is enclosed for your attention.

If you act in accordance with what the trust considers to be acceptable behaviour, your care will not be affected. However if there is a repetition of your unacceptable behaviour, this warning will remain on your medical records for a period of one year from the date of issue and will be taken in to consideration with one or more of the following actions: (to be adjusted as appropriate).

- The withdrawal of NHS care and treatment, subject to clinical advice.
- The matter will be reported to the police with a view of this health body supporting a criminal prosecution by the Crown Prosecution Service.
- The matter will be reported to the NHS Security Management Service Legal Protection Unit with a view to this health body supporting criminal or civil proceedings or other sanctions. Any legal costs incurred will be sought from yourself.
- Consideration will be given to obtaining a civil injunction in the appropriate terms. Any legal costs incurred will be sought from yourself.

In considering withholding treatment this Trust considers cases on an individual basis to ensure that we need to protect staff is balanced against the need to provide health care to patients. An exclusion from NHS premises or removal of treatment within the community would mean that you would not receive care at this Trust or at your home address and (title i.e. clinician) would make alternative arrangements for you to receive treatment elsewhere.

If you consider that your alleged behaviour has been misrepresented or that this action is unwarranted, please pursue under the trust complaints procedure who will review this decision in the light of your account of the incident(s).

A copy of this letter has been issued to your GP and Consultant.

Yours faithfully

Signed by the Director of Research and Informatics

APPENDIX 5

LETTER TO PATIENT, GP AND CONSULTANT BY THE CEO ADVISING THAT TREATMENT WILL BE WITHHELD

Dear

Withholding of Treatment

I am writing to you concerning an incident that occurred on at the Trust/In the community

It is alleged that you used/threatened unlawful violence/acted in an anti-social manner to a member of staff whilst on Trust premises/receiving care in the community (delete as applicable).

Behaviour such as this is unacceptable and will not be tolerated. This Trust is firmly of the view that all those who work in or provide services to the NHD have the right to do so without fear of violence or abuse. This was made clear to you in my previous correspondence/meetings of . A copy of this health body's policy on the withholding of treatment from patients is enclosed for your attention.

Following a number of warnings where this has been made clear to you, and following clinical assessment and appropriate consultation, it has been decided that you should be excluded from Trust premises/Removal of treatment in the community. The period of this exclusion is and comes in to effect from the date of this letter.

As part of this exclusion notice you are not to attend Trust premises at any time except:

- In a medical emergency; or
- Where you are invited to attend as a pre-arranged appointment.

Contravention of this notice will result in one or more of the following actions being taken (to be adjusted as appropriate):

- Consideration will be given to obtaining a civil injunction in the appropriate terms. Any legal costs incurred will be sought form yourself.
- The matter will be reported to the police with a view to the Trust supporting a criminal prosecution by the Crown Prosecution service.
- The matter will be reported to the NHD Security Management Service Legal Protection Unit with a view to this health body supporting criminal or civil proceedings or other sanctions. Any legal costs incurred will be sought from yourself.

During the period of your exclusion/removal of community care the following arrangement must be followed in order for you to receive treatment

In considering withholding treatment the Trust considers cases on their individual merits to ensure that the need to protect staff is balanced against the need to provide healthcare to individuals

If you consider that you alleged behaviour has been misrepresented or that this action is unwarranted, please raise this in writing under the complaints procedure who will review this decision in light of your account of the incident (s).

A copy of this letter has been issued to your GP and Consultant.

Yours faithfully,

Chief Executive Officer

Date

APPENDIX 6

EXCLUSION-PROCEDURE CHECKLIST

- The decision to exclude/remove community care can only be taken by the patients clinician (or, in their absence, their nominated deputies), once alternative care arrangements have been made. This does not preclude the relevant clinician discharging a patient who no longer requires in-patient care in the normal manner.

- The responsible consultant must be informed and write to the patient's GP detailing the exclusion and the reasons for it and normally requesting that the GP makes appropriate alternative arrangements for the patient's management.

- The patient must be informed that they may challenge an exclusion/removal via the established complaints procedure.

- The Director of Research and Informatics will facilitate the dispatch of a written confirmation to the patient's home.

- The Chief Executive, Security Manager and relevant Department Managers must also be informed.

- A detailed record of the rationale for exclusion/removal of treatment and of the alternative arrangements for care should be kept in the patient's medical and nursing documentation.

- If an excluded individual returns in any circumstances other than a medical emergency, security staff should be called immediately. The Trust will subsequently seek legal redress to prevent the individual from returning to Trust property

APPENDIX 7

CHECKLIST FOR STAFF IN HANDLING VIOLENT OR POTENTIALLY VIOLENT SITUATIONS AT WORK

The following list identifies signs that may lead to violence. Staff should be aware of these signs especially “attention seeking behaviour”.

a) Restless behaviour involving pushing and jostling.
b) Deliberately provocative conduct.
c) A client who is unusually quiet or withdrawn or alternatively boisterous.
d) Over sensitive reactions to corrections or instructions.
e) A feeling of tension in the ward/department or in the interview.
f) Threats of violence, which should always be taken seriously.
g) Previous history of violence.

Reactions

Training and experience help, but the following are some basic ground rules:-

a) Appear calm, be reasonable and reassuring and keep clients informed.
b) Bear in mind any relevant information you may have about the client.
c) If the agitation persists, attempt to involve a more familiar worker who is not involved in the immediate conflict.
d) Make no physical contact unless absolutely necessary and then try not to be the first to do so.
e) Do not argue and do not give orders.
f) Work on the positive if possible. Look for a way out, as the client may well want the same thing.
g) Consider raising the alarm or summoning help.
h) If the situation escalates and control is being lost, consider getting out of the situation.
i) Do not put yourself in an isolated place. Always have a means of escape if the situation should escalate.

8. Endorsed By:-

Name of Lead Clinician/ Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date

9. Record of Changes

Section Number	Version Number	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason
Title		15/8/2017	Change of tittle to include anti-social behaviour	Removed the word zero tolerance	Added anti- social behaviour	NHS does have a tolerance to Violence Aggression Challenging behaviour if the patient's behaviour is a result of a clinical factor.
Policy Statement		15/8/2017	Addition of the wording anti- social behaviour	No deletion	Addition of the wording anti- social behaviour	Guidance needed to be given on how to manage anti- social behaviour
1.3		15/08/2017	Security SMD changed	Deleted reference to director of finance	Made reference to Director of Research and Informatics	The named SMD has changed. Policy now reflects this
1.5		15/8/2017	Addition of the wording anti-social behaviour	No deletion	Added anti- social behaviour	Guidance needed to be given on how to anti- social behaviour
2.1		15/08/2017	Policy also applies to community staff	No deletion	Made reference to the policy being for community staff also	Recent increase in violence, aggression and anti-social behaviour in the community. No specific guidance
2.1		15/08/2017	Addition of wording uncontrolled pets	No deletion	Guidance for staff who come into contact with dangerous pets	Recent increase in reports of dangerous dogs at home addresses of patient. Community staff increasingly coming into contact with such pets/
2.2		15/8/2017	Removed the words zero	Removed the word	No addition	NHS does have a tolerance

			tolerance	zero tolerance		to Violence Aggression Challenging behaviour if the patient's behaviour is a result of a clinical factor.
2.2		15/8/2017	Guidance on prevention measures of community workers	No deletion	Make reference to guidance document	Community staff feel vulnerable to certain patients. New community patient to sign patient trust agreement outlining appropriate behaviours while receiving care.
2.4.1		31/8/2017	Information on legislation available NHS	No deletion	Added description of how the Criminal Justice and Immigration Act 2008 can be used	Legislation can be used by accountable officers to remove individuals from NHS property of they are causing a nuisance or disturbance,
2.5		15/8/2017	Guidance for potential withdrawal of treatment of community patients	No deletion	Added community patients	Removal of treatment should be an option for community staff as well as staff working on LHCH site. Same process would be implemented as if the patient was an inpatient.

3.1		31/8/207	Removed NHS Protect guidance	Removed NHS Protect guidance	No addition as no NHS governing body has been appointed to manage security services.	From 1-4-2017 NHS Protect no longer provided governance and support for Local Security Management Specialist. To date no other governing body has been set up. Recent conversations with NHS Protect, CCG NHS England and the Department of Health have led to no further information.
3.3		31/8/2017	Guidance for community staff	No deletion	Guidance for community staff	Specific control measures introduced for community staff. 2 person visits to be introduced if patient presents a potential risk.
4.2		31/8/2017	Guidance on challenging behaviour	No deletion	Added the words Challenging behaviour	Training on how to manage challenging behaviour now part of the conflict resolution session. Short 13 minute video shown to staff on how to manage the sort of behaviour.
Appendix 1		31/08/2017	Guidance on Anti-social behaviour	No deletion	Added the words Anti-social behaviour	Procedure of care can now be applied to patients who demonstrate anti-social behaviour

Appendix 3		31/08/2017	Guidance on Anti-social behaviour	No deletion	Added the words Anti-social behaviour	Procedure of care can now be applied to patients who demonstrate anti-social behaviour
Appendix 3		31/08/2017	Change of Director responsible for security	Deleted “Nursing and operations”	Added Director or Research and Informatics	Change of Director responsible for security
Appendix 4		31/08/2017	Guidance for community staff	No deletion	Included community staff	Policy applies to both the removal of treatment on site and removal of treatment within a community setting
Appendix 4		31/08/2017	Change of Director responsible for security	Deleted “Nursing and operations”	Added Director or Research and Informatics	Change of Director responsible for security
Appendix 5		31/8/2017	Guidance for withdrawal of treatment of community patients	No deletion	Included community staff	Policy applies to both the removal of treatment on site and removal of treatment within a community setting
Appendix 6		31/08/2017	Guidance for withdrawal of treatment of community patients	No deletion	Included community staff	Policy applies to both the removal of treatment on site and removal of treatment within a community setting
Appendix 6		31/08/2017	Change of Director responsible for security	Deleted “Nursing and operations”	Added Director or Research and Informatics	Change of Director responsible for security

Patient Safety Incident Response Policy

For completion by Author			
Author(s) Name and Title:	Ria Carter, Risk Management Lead Nurse		
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Archive:	Document Control		Date Added to Archive:		
Officer responsible for Archive:	Information Governance and Document Control Facilitator				

Contents

1. Glossary of Terms

Term/Acronym	Definition
AAR	After Action Review (AAR) is a method of evaluation that is used when the outcomes of an activity or event, have been particularly successful or unsuccessful.
Arbitrary or Subjective	Chosen randomly or influenced by/based on personal beliefs or feelings, rather than on facts
Division	A grouping of multi-disciplinary staff working together to provide care within a certain speciality.
CQC	Care Quality Commission - independent regulator of health and social care in *England*
Definitions of Harm	Unanticipated, unforeseen incidents (eg, patient injuries, care complications, or death) which are a direct result of the care dispensed rather than the patient's underlying disease
Duty of Candour	Being open and honest with patients and families when treatment or care goes wrong. This is undertaken verbally and in written form also.
Emergent Property	A characteristic an entity (patient safety) gains when it becomes part of a bigger system
Governance Structures	System that provides a framework for managing organisations
HFACS	Human Factors Analysis and Classification System a user-friendly, cost-effective and evidence-based approach to incident investigation, based on the goal of understanding organisational systems.
HSE	Health and Safety Executive
HSIB	Health and Safety Investigation Branch
Human Error	A human error is *an action or decision which was not intended that has negative consequences or fails to achieve the desired outcome*
Inequalities data	Facts and statistics collected relating to health inequalities which are unfair and avoidable differences in health across the population, and between different groups within society.
Integrated Care Board (ICB)	Statutory organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS.
Just Culture Approach	The treating of staff involved in a patient safety incident in a consistent, constructive and fair way.
MHRA	Medicines and Healthcare products Regulatory Agency
Neonatal Death	A baby born at any time during the pregnancy who lives, even briefly, but dies within four weeks of being born
Never Events	A nationally recognised category of incidents that could cause harm to people that should never happen and can be prevented.
NHSE	National Health Service England
Paradigm Shift	An important change that happens when the usual way of thinking about or doing something is replaced by a new and different way
Principles of Proportionality	The least intrusive response appropriate to the risk presented
PSII	Patient Safety Incident Investigation.
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
SEIPS	System Engineering Imitative for Patient Safety - a framework for understanding outcomes within complex socio-technical systems.

SI	Serious Incident
SOP	Standard Operating Procedures
Stakeholder	People or groups who have an interest in what an organisation does, and who are affected by its decisions and actions.
Statistical Process Control (SPC)	A tool used in the NHS to understand whether change results in improvement. It provides an easy way for people to track the impact of improvement projects.
Swarm Huddle	Swarm-based huddles are used to identify learning from patient safety incidents. Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk.

2. Purpose

This policy supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out Liverpool Heart and Chest Hospital NHS Foundation Trust's approach to developing and maintaining effective systems and processes for responding to patient safety incidents 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 the 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.

The PSIRF sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. **Instead, organisations are now able to balance effort between learning through responding to incidents or exploring issues and improvement work.**

3. Scope

This policy is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across all patient facing services and departments delivering NHS and Private Patient care.

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, therefore, do not solely focus on the actions of individuals, or 'human error', even when these are reported to be 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. Roles and Responsibilities

Chief Executive and Executive Board

- Ensures the Trust has adequate systems for the reporting of all incidents and near misses
- The Chief Executive and Board provide the strategic leadership to promote and develop the Trust's safety culture. This includes responsibility for effective risk management within the Trust and to ensure the organisation complies with its statutory obligations. This is in line with national guidance in regards to Well-Led organisations (Monitor and CQC April 2015).

Director of Risk and Improvement

- Has the Executive Lead for Risk Management
- Ensures organisational learning occurs following the investigation into reported incidents and near misses.
- Implementation of this policy
- Will ensure the Trust Board are appraised accordingly, in line with our PSIRF processes and given full oversight via the Trust Patient Safety Panel.

Head of Risk Management

- Will support the Director of Risk and Improvement in ensuing the policy is implemented
- Will act in an advisory capacity to the Risk Management Team with regards to the grading of incidents
- Will ensure the investigation process is followed by the Divisions in regards to completion of timely Rapid Reviews for all relevant incidents
- Will work collaboratively with the Patient Safety Lead Nurse/PSIRF Implementation Lead to ensure the investigation process is followed with regards to timescales and the completion of Patient Safety Incident Investigations (PSII's).
- Will ensure the Trust Board are appraised accordingly, in line with our PSIRF processes and given full oversight via the Trust Patient Safety Panel.

Risk Management Team

With oversight from the Patient Safety Lead Nurse/PSIRF Implementation Lead, the Risk Management Team will:

- Ensure all reported incidents and near misses are recorded, assigned a manager
- Review incidents and trends on an organisation wide basis
- Ensure monthly reports extracted from the InPhase system detailing all reported incidents and near misses within clinical areas or departments are forwarded to Divisional Directors of Operations, Associate Medical Directors, Divisional Directors of Nursing and Heads of Departments.
- Maintain a contemporaneous record of all PSII's performed within the Trust

- Report relevant incidents to monitoring organisations as required (i.e. Monitor, Care Quality Commission)
- Ensure reports are available on request from Knowsley Place
- Will ensure that the Executive Team are alerted as per policy, if an incident is reported that may possess the potential to require a PSII.

Divisional Triumvirate/ Clinical Leads

Divisional Directors of Operations' (DDoO's), Divisional Directors of Nursing (DivDon's), Associate Medical Directors (AMD) and clinical leads in each service are responsible for the implementation of this policy in their service area which ensures:

- The Service meets its obligations as described within this policy, which includes the Duty of Candour and the requirement to engage compassionately with those involved in incidents.
- That appropriate and effective incident reporting processes are in place within the designated area.
- All staff within their work environment to include all bank and agency staff, are made aware and given guidance on the incident reporting process.
- Action is taken to contain an incident when identified in order to minimise harm.
- Incidents are reviewed as in line with the recommended investigatory time frame, and discussed within the Divisional Patient Safety Panel where applicable
- Support and updates are provided at the weekly Patient Safety Incident Response Group in relation to divisional incidents.
- Identified actions from incidents are acted upon in a timely manner as per the timeframes within the action plan
- Themes and trends from incidents are acted upon and learning is shared within their division
- In situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, these risks are escalated vis the risk identification process.
- Effective and timely communication with staff and patients, their carers and family and the provision of appropriate support.

All staff

All staff will follow the procedure outlined in this policy which includes:

- Attending to people's immediate needs following an incident and maintaining / re-establishing a safe care environment
- Being familiar with and implement the procedure for reporting any patient safety incidents
- Ensuring effective incident management by completing a web-based incident report form on InPhase when either directly involved in an incident or injured as a result of an incident.
- Reporting all incidents including near misses within their span of duty.
- Co-operating with all reviews or investigations that the Trust undertakes. This is in line with various NHS and Professional Codes of Conduct and Trust policy.
- Will ensure that all nosocomial infections are reported as incidents

Freedom to Speak Up Guardian/Speak up Advocates

The Freedom to Speak Up Guardian is responsible for supporting staff when they have a concern so that they feel able to raise matters freely and safely in relation to patient safety, treatment or standards of care. This role is key in helping to increase the profile of raising concerns in the Trust and the Guardian can provide confidential advice and support to staff in relation to concerns they have. The Guardian provides support to ensure that employee concerns have been fully explored.

5. Our patient safety culture

Liverpool Heart and Chest Hospital NHS Foundation Trust promotes a just culture approach (in line with the NHS Just Culture Guide) to any work planned or underway to improve safety culture. Research into organisational safety has repeatedly found that an open and transparent culture, where colleagues feel able to report incidents and raise concerns without fear of recrimination, is essential to improving safety.

The Trust encourages and supports incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients or staff. Staff should never be left feeling isolated and uninformed about what will happen following a patient safety incident. LHCH has a continuous learning culture and offers a wide range of learning and developmental opportunities, promoting a culture that encourages lifelong learning for all staff. Please refer to the Incident Reporting Policy for more information on how incidents are reported and managed in an open and transparent manner to focus on learning without blame.

We have a very positive patient safety culture within LHCH, with a variety of patient safety initiative already strongly embedded across the organisation. Examples of these are:

1. HALT
2. Safety Seven
3. Freedom To Speak Up
4. Daily Trust Safety Huddle

We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made, we will ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the Trust, or more widely, as appropriate. Any patient safety issue, incident or concern that have been raised will be discussed with relevant departmental and divisional managers to ensure that we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up to date with its progress.

We want everyone in the Trust to feel safe to speak up and confident that it will be followed by a prompt response. Further information is provided in the “Freedom to Speak up Policy for the NHS” alongside additional policies including the “Disciplinary Policy” that sets out the process for managing employee conduct. All policies can be found on the staff Intranet.

All our staff are required to complete the first module of Speaking up which is mandatory across the Trust.

People need to feel confident that if they call out poor behaviour, they will not experience detriment or retaliation. Creating and promoting psychologically safe spaces by promoting positive working relationships helps make staff feel secure, supported, and confident to speak up. Speaking up will ensure that as a Trust we have the right culture to hear staff concerns and recommendations for improvements, and to respond fairly and appropriately to those speaking up for patient safety in our organisation. More information can be found within our Trust Freedom to Speak Up Policy on the staff intranet.

We support our managers/supervisors to listen to the issue raised and take action to resolve it wherever possible. In most cases, it’s important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation. Where an investigation is needed, this will be

objective and conducted by someone who is suitably independent (this might be someone outside our organisation or from a different part of the organisation) and trained in investigations. It will reach a conclusion within a reasonable timescale and a report will be produced that identifies any issues to prevent problems recurring.

The FTSU Guardian will review the concerns raised with the Executive and Non-Executive Leads for FTSU to ascertain if there are themes. The FTSU Guardian submits data to the National Guardians Office each quarter who in turn reviews all submissions nationally to see if there are any themes locally or nationally. Our most senior leaders receive a report quarterly providing a thematic overview of speaking up by our staff to our FTSU guardian(s).

Good governance is essential, and we will ensure that all staff have easy access to information on how to speak up and that individuals will be referred to the national Speaking Up Support Scheme: https://www.england.nhs.uk/ourwork/freedom-to-speak-up/developing-freedom-to-speak-up-arrangements-in-the-nhs/staff . Further supporting documents include:

- Maintaining High Professional Standards Policy
- Guidelines for supporting staff involved in Traumatic/Stressful Incidents/Complaints or Claims
- NHS England Fit and Proper Person Test

The Trust encourages and supports incident reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients (or staff). Please refer to the “Incident Reporting Policy” for more information on how incidents are reported and managed in an open and transparent manner to focus on learning without blame. PSIRF will create much stronger links between a patient safety incident and learning and improvement. We will aim to work in partnership with those affected by a patient safety incident, staff, patients, families, and carers. Engagement is key.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or define avoidability or cause of death.

To boost our safety culture, we have a daily Trust wide safety huddle for any member of staff at any level to attend and safety huddles at all levels of our Trust where any patient safety concerns can be raised and followed up. The safety huddle is then minuted and shared Trust wide via email. Departments have safety huddles in order to identify risks emerging or known and the insight offered from incidents that have occurred and therefore an opportunity to share any learning.
We also have a network of patient safety champions (PSCs), with the aim of improving identification, reporting and resolution of safety issues in clinical areas.

Our PSCs, drawn from a range of clinical and non-clinical backgrounds, will be a key link between staff in clinical areas, ward and department managers, the Risk and Governance team, the Patient Safety Lead and Trust senior management.

Some key aspects of the PSC role is:

- Collaborate with departmental / ward managers in representing their base department at Safety Huddle, Team Brief and Sharing and Learning events
- Raise the profile of safety campaigns locally
- Help to embed the *Be Civil, Be Kind* and Just Culture campaigns in their department
- Promote the introduction of the new Safety / Governance Sharepoint and assist colleagues in its usage

- Link with colleagues to identify and escalate local safety concerns / issues
- Collaborate with other champions and the PSL in safety walk-rounds of clinical areas
- Attend the Safety Champions Forum bimonthly to network and share ideas and learning
- Share and introducing examples of best practice from other departments to their own
- Represent LHCH at local and national events relevant to Patient Safety
- Identify and share good practice
- Assist the Trust and their local area with awareness of the new Patient Safety Incident Response Framework

6. Patient safety partners

The Trust has established 3 roles for patient safety partners in line with the NHSE guidance Framework for involving patients in patient safety . Patient Safety Partners (PSP) will have an important role in supporting our PSIRF providing a patient perspective to developments and innovations to drive continuous improvement.

A Patient Safety Partner (PSP) is involved in the designing of safer healthcare at all levels in the organisation. This means maximising the things that go right and minimising the things that go wrong for patients when they are receiving treatment, care and services from us. PSPs will use their lived experience as a patient, carer, family member or a member of the local community to support and advise on activities, policies and procedures that will improve patient safety and help us to deliver high quality care.

PSPs will work alongside staff, volunteers and patients, attend meetings (face-to-face and online), be involved in projects to co-design developments of patient safety initiatives, and join (and participate in) key conversations and meetings in the Trust focusing on patient safety. They will have a mind-set for improving outcomes, whilst representing the patient, carer, family view and ensuring committee/meeting members are “walking in the patients’ shoes”. More information can be found within our Trust Patient Safety Partner Policy on the staff intranet.

PSPs are provided with any support requirements they may need to maximise their opportunities for involvement and ensure they are fully supported and enabled.

Key aspects of their role and examples of work they will undertake and support within LHCH include:

- Helping make sure patient safety is at the forefront of all we do
- Membership of safety and quality committees, such as Sharing and Learning and Infection Prevention Committee meetings
- Involvement in patient safety improvement projects
- Working with the Trust Board to consider how to improve safety
- Involvement in staff patient safety training
- Participation in investigation oversight groups
- Regular networking with other local and regional PSP’s

PSP poster role.pdf

7. Addressing health inequalities

As a provider of acute and community services, the Trust has a key role to play in tackling health inequalities in partnership with our local partner agencies and services. However, most of the fundamental factors driving inequalities in health are beyond the responsibility of the health care system, for example our education system; economic and community development in our most deprived neighbourhoods; employment levels; pay and conditions; and availability and quality of housing.

Through our implementation of PSIRF, we will seek to utilise data 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 patients, families and carers following a patient safety investigation must also recognise diverse needs 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.

The Analytics, Data Engineering and Research teams have been working together with the divisions to explore the health inequalities of access to care within Liverpool Heart and Chest Hospital. Health inequalities work at LHCH will be developed by a new Health Inequalities working group chaired by the Associate Director of Data & Analytics. This group will provide a quarterly report as part of the Strategic Operating Framework. These reports will be presented to Operational Board and then onto Board of Directors.

8. 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 patients, families 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.

It is recognised from experience and research that patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents, and / or may have different questions or needs to that of the Trust. Engaging with those affected by a patient safety incident substantially improves our understanding of what happened, and potentially how to prevent a similar incident in future.

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.

This policy therefore reinforces existing guidance relating to the duty of candour and 'being open' and recognises the need to involve patients and families as soon as possible in all stages of any investigation, or improvement planning, unless they express a desire not to be involved.

Involving Patients & Families

The Trust recognises the importance of and is committed to involving patients and families following patient safety incidents, engaging them in the investigation process and to fulfil the duty of candour requirements. It is recognised from experience and research that patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents, and / or may have different questions or needs to that of the organisation. This policy therefore reinforces existing guidance relating to the requirements of statutory duty of candour, compassionate engagement in the event of any incident, and 'being open', and recognises the need to involve patients and families as soon as possible in all stages of any investigation, or improvement planning, unless they express a desire not to be involved. Further guidance in relation to involving patients and families following a patient safety incident is available from NHSE at: https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/#heading-2 and within our Trust Be Open Policy,

Involving Staff, Colleagues and Partners

Similarly, involvement of staff and colleagues (including partner agencies) is of paramount importance when responding to a patient safety incident to ensure a holistic and inclusive approach from the outset. Again, this reinforces existing guidance such as our incident reporting and management policy, though it is recognised this approach must not be restricted to only those incidents that meet a threshold of harm or predefined categories. We will continue to promote, support and encourage our colleagues and partners to report any incident or near-misses, with an enhanced focus on incident, or groups of incidents, which provide the greatest opportunities for learning and improvement.

We welcome speaking up as it is vital that our staff feel safe and are encouraged to speak up in order to raise their concerns to keep patients and staff safe to support the working environment for our staff. Anyone can speak up including health care professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainee's, junior doctors, locum doctors, bank and agency workers and former employees.

We encourage our staff to report concerns internally for us to act promptly as this is the quickest way for us to respond to incidents. However, you can report concerns externally to the Care Quality Committee (CQC) for quality and safety concerns about the services it regulates.

This is an approach which is already embedded within LHCH, and as an organisation we will continue to provide support and guidance utilising the principles of good change management, so staff remain engaged and involved throughout the processes. We will therefore ensure regular communication and involvement through our communication framework and our wider organisational governance structures.

It is also recognised that staff and colleagues need to continually feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame. We will continue to closely monitor incident reporting levels and continue promote an open and just culture to support this.

See also the trust guidance and policies on duty of candour / being open and FTSU, as well as NHSE Involving those affected by incidents: B1465-2.-Engaging-and-involving...-v1-FINAL.pdf (england.nhs.uk).

Just Culture poster.pdf

9. 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.

As a Trust we welcome this approach so we can focus our resources on incidents, or groups of incidents that provide the greatest opportunities for learning and improving safety. It is also recognised that our planning needs to account for other sources of feedback and intelligence 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 our plans should reflect:

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

They will also be:

1. Updated as required and in accordance with emerging intelligence and improvement efforts
2. Published on our external facing website

Our associated patient safety incident response plan (PSIRP) will reflect these standards and will be published alongside this overarching policy framework. This will be updated every 12 months.

Resources and training to support patient safety incident response
PSIRF recognises that resources and capacity to investigate and learn effectively from patient safety incidents is finite. It is therefore essential that as an organisation we evaluate our capacity and resources to deliver our plan. The PSIRP provides more specific details in relation to this

including the number of comprehensive investigations that may be required for single or small groups of incidents that do not fall into one of the broader improvement workstreams/priorities. The Trust has in place governance arrangements to ensure that learning responses are led by appropriate individuals, i.e. staff who were not involved in the patient safety incident itself or by those who directly manage those staff. Learning responses are not taken in isolation. Subject matter experts with relevant knowledge and skills will be involved, where necessary, throughout the learning response process to provide expertise, advice, or proof reading.

Currently Patient Safety is led through the Risk Management Team and the Clinical Trust Patient Safety Lead and these have the following working time equivalent posts to support and facilitate the PSIRF framework, as part of their roles:

- 1 x Clinical Trust Patient Safety Lead
- 1 x Head of Risk Management
- 1 x Patient Safety Lead Nurse
- 1 x Governance Systems Analyst
- 1 x Risk Management Co-ordinator

There is also a pool of 15 trained individuals who can undertake comprehensive investigations, though the majority have a substantive clinical or governance role. Again, our PSIRP will detail more specifically which incidents will require a comprehensive investigation with an indication of how many of these we expect to complete in a year. The pool of investigators have been trained by an external facilitator who is listed as an approved provider of Levels 3-5 patient safety training, within the NHSE website.

All staff are required to complete mandatory patient safety training Levels 1 and 2, which covers the basic requirements of reporting, investigating and learning from incidents. This is a starting point for all our staff and includes and covers, listening to patients and raising concerns, the systems approach to safety, where instead of focusing on the performance of individual members of staff, we try to improve the way we work, avoiding inappropriate blame when things don't go well, creating a just culture that prioritises safety and is open to learning about risk and safety.

It is therefore expected that Divisional managers will involve all relevant staff in more routine / low risk incident reviews, though further advice and guidance can always be provided by the Risk Management Team if required. It is important that the organisation seeks regular feedback from colleagues with regard to investigating and learning from incidents and considers whether any additional or bespoke training is required, either more widely or targeted at specific staff groups or individuals.

Those trained to level 3-5 will be facilitators of Patient Safety Review's across the Trust going forward, and then cascade this training to colleagues to promote facilitating PSR's following patient safety incidents.

Engagement leads will have completed level 1 and level 2 training and will have undertaken a minimum of 6 hours training relating to "Involving those affected by patient safety incidents in the learning process".

Those in PSIRF oversight roles will have completed level 1 and level 2 training, a systems approach to learning from patient safety incidents equivalent to 2 days/12 hours training, oversight of learning from patient safety incidents which is equivalent to 6 hours training and involving those affected by patient safety incidents in the learning process, 6 hours of training.

Our patient safety incident response plan
Our plan (PSIRP) sets out how we intend to respond to patient safety incidents over a period of 12 to 18 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 PSIRP is based on a thorough analysis of themes and trends from all incidents from 2018-2022 (including low harm, no harm and near misses), complaints and concerns, learning and recommendations from Serious Incidents (conducted under the previous framework), mortality reviews, legal claims and inquests, risks and risk registers and feedback from staff and patients. The priorities identified in the PSIRP will be regularly reviewed against quality governance reports and surveillance to ensure they are responsive to unforeseen or emerging risks.

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

- Serious Incident Investigations (last 5 years)
- Health inequalities data (associated with SI review)
- Complaints / PALS
- Safeguarding reviews
- Mortality reviews
- Freedom to speak up concerns
- Trust staff survey annual results
- Legal claims (new / ongoing / settled)
- Inquests
- Quality improvement and Service evaluation projects

Reviewing our patient safety incident response policy and plan
As referred to above, our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date. It is recognised that 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 to 18 months.

Updated plans will be published on our website, replacing any previous versions.

A rigorous planning exercise will be undertaken every four 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.

10. Responding to patient safety incidents

PSIRF guidance states:
"Where an incident type is well understood – for example, because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at the

contributory factors are being implemented and monitored for effectiveness – resources may be better directed at improvement rather than repeat investigation (or other type of learning response)." (PSIRF supporting guidance, Guide to responding proportionately to patient safety incidents. NHSE 2022)

Patient safety incident reporting arrangements
Patient safety incident reporting will remain in line with the Trusts Incident Reporting Policy, with all staff encouraged where possible to report all patient safety incidents using our InPhase system. The level of harm will also be recorded by the reporter. See the table below for definitions of harm. These reports will then be routinely uploaded to the national data base (Learning From Patient Safety Events-LFPSE) to support national learning.

Some incident types will require specific reporting and/or review processes to be followed. This is documented in our PSIRF Plan as well as the required response/action.

Daily review mechanisms are already established to ensure that patient safety incidents are responded to proportionately and in a timely manner. This will also consider the requirements for The Duty of Candour, as per the Be Open Policy.

New guidance on Level of Harm selection on the Learning From Patient Safety Events can be found here: https://www.england.nhs.uk/long-read/policy-guidance-on-recording-patient-safety-events-and-levels-of-harm/, and details on previous harm grades and new harm grades are listed below.

Previous harm grades	**New physical harm grades**	**New psychological harm grades**
No Harm	No physical harm	No psychological harm
Low harm	Low physical harm	Low psychological harm
Moderate harm	Moderate physical harm	Moderate psychological harm
Severe harm	Severe physical harm	Severe psychological harm

Most incidents will only require a local review within the service, however, if it is felt that there is an opportunity to learn from and improve, these should be escalated appropriately to the Divisions.

Divisional operational and senior managers along with governance teams will ensure any incidents that require cross-system or partnership engagement are identified and shared through existing channels and networks, and that partnership colleagues are fully engaged in investigations and learning as required. Likewise, we will ensure we are responsive to incidents reported by partner colleagues that require input from the Trust, primarily by directing enquires to the relevant clinical teams or colleagues and seeking assurance that engagement, information sharing and learning has been achieved, or taken forward.

11. Responding to cross-system incidents/issues

With regards to any cross-system incidents, an appropriate member of the Risk Management team will email to our lead commissioner by emailing sui.function@nhs.net from PSIRF@lhch.nhs.uk to trigger ICB/S processes under PSIRF. Certain incidents require external

reporting to national bodies such as HSIB, HSE, RIDDOR and MHRA, this will also be the responsibility of the Head of Risk Management to undertake.

Regionally, all Trusts have set up a generic PSIRF email account for their respective Trust, to ensure no missed communications and a smooth dialogue can occur between other Trusts were required.

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 integrated care system should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process.

12. Mortality process and issues

Our Trust has a well-established a monthly Mortality Review Group to provide oversight of compliance with the mortality review process and to provide the Trust with the assurance that causes, and contributory factors of all in-patient deaths have been considered and are appropriately responded to in an open and transparent manner.

Under PSIRF, not all deaths reviewed by a coroner will be subject to a full Patient Safety Incident Investigation (PSII). Under the new Framework, the learning response within the NHS should not be expected to make judgments about cause of death. 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 be shared with the coroner.

As we have said, not all deaths reviewed by a coroner will receive a full patient safety incident investigation (PSII). In some cases, there will be a different learning response such as a case review, MDT, Swarm Huddle or an After-Action Review. The output from that response will be shared with the coroner.

The mortality review process will continue as per Mortality Review Policy, with a Structured Judgement Review carried out initially. If following the Structured Judgement Review, there is an incident which falls into the National Priorities category or has the potential to be a Patient Safety Incident Investigation then the processes for these would follow as per Appendix 3, or if there is a potential for learning or more information required, then a methodology from the PSIRF toolkit should be utilised, and the Patient Safety Review route (Appendix 2) followed. The mortality review policy will also be updated in line with PSIRF processes.

Patient safety incident response decision-making
As explained above, reporting of incidents should continue in line with existing Trust policy and guidance. The Trust also has governance and assurance systems to ensure oversight of incidents both Divisional and Trust wide. Corporate and Governance teams work with clinical and operational managers 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 (eg – CQC concerns)
- Identification of any incidents requiring external reporting or scrutiny (eg – Never Events, Neonatal deaths, RIDDOR)
- Identification of any other incidents of concern, such as serious near-misses or significant failures in established safety procedures
- Identification of any incidents that have significant learning for the organisation.

The Head of Risk Management and Patient Safety Lead Nurse review the data regularly to identify and track emerging themes and trends outside of normal variation, this information is presented to the Quality, Safety and Experience Committee on a quarterly basis. This information will be reviewed regularly against our identified priorities in the PSIRP to determine whether any shift in focus is required, which will be agreed by the Quality Safety Experience Committee if required.

As outlined in the Incident Management Policy, the process for completion of a Patient Safety Rapid Review, to determine any further investigation or escalation required will remain. This, however will now include a wider range of options for further investigation outlined in the PSIRF. 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.

The Trust will have 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 Patient Safety Incident Response Plan.

To improve safety and manage risk within our Trust it is important that all events from which learning can be extracted are identified and managed with this framework to support improvement.

It is recognised that some incidents may still require a case based comprehensive investigation, like a Serious Incident investigation under the old framework. Where this is the case, reference must be made to available investigatory capacity and resources as detailed in the PSIRP. In cases such as this, there will also be an Engagement Lead assigned to the investigation to support with patient, family and staff involvement. In incidents such as this, the Divisional and Trust Patient Safety Panels will use the following criteria to assist in determining whether a PSII is warranted or not:

Locally-defined patient safety incidents requiring PSII:

Criteria for selection of incidents for PSII:

a. actual and potential **impact of outcome** of the incident (harm to people, service quality, public confidence, products, funds, etc)
b. **likelihood of recurrence** (including scale, scope and spread)
c. **potential for learning** in terms of:
   - enhanced knowledge and understanding
   - improved efficiency and effectiveness (control potential)
   - opportunity for influence on wider systems improvement.

Locally-defined emergent patient safety incidents requiring PSII (Ad Hoc):

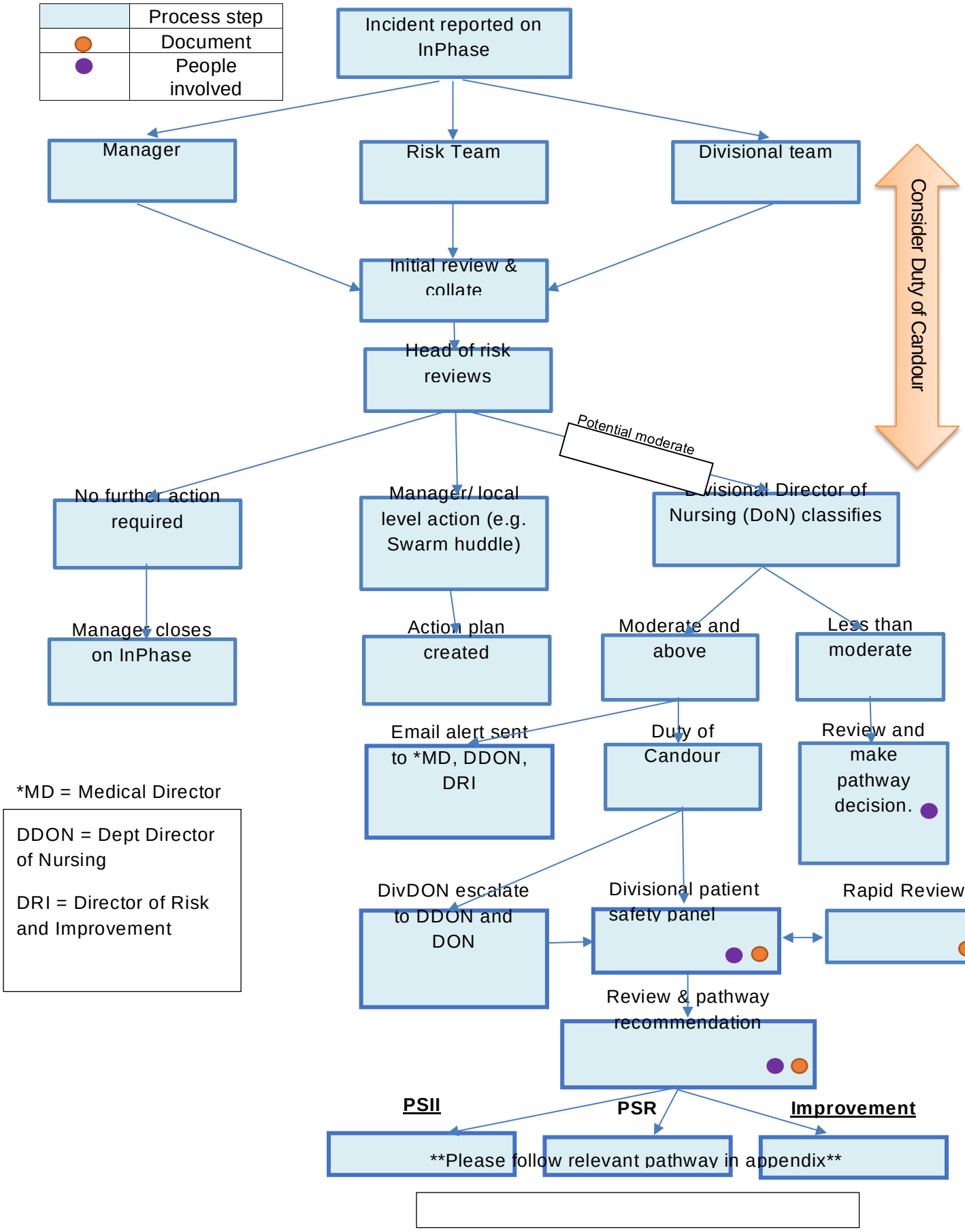
An unexpected patient safety incident which signifies an **extreme level of risk** for patients, families and carers, staff or organisations, and where the **potential for new learning and improvement is so great** (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.

The process for reporting incidents will not change and the decision-making process can be seen in the flow chart below and within Appendix 1-3. Our Trust has a weekly safety meeting where the responsibility will be for the review of investigations relating to local priorities or moderate harm incidents and the consideration of incidents for PSII or PSR and for an oversight of the outcomes to ensure that any recommendations are established in a system-based approach and safety actions are completed with Divisional representation. The newly formed Patient Safety Incident Response Group (PSIRG) will be responsible for:

- Identifying the Lead investigator
- Establish a team
- Setting Terms of Reference
- Allocate tasks
- Agree timescales and reviews-
- Patient Safety Incident Investigation (PSII) to be completed using PSII template. Recommendations added to Investigation system for tracking.
- Divisions will monitor the QI programmes for local priorities. This gives the Board assurance that as a Trust we are complying with the PSIRF response standards.

Below is the incident process that LHCH will follow for the reporting and escalating of incidents and appendices for required supporting templates and documents, further templates for alternative incident response processes are within the Appendices (1-3):

Initial PSIRF Process



Certain patient safety incidents are reportable externally via a mandatory reporting system e.g. specific categories of infection and hospital acquired pressure ulcers. This reporting will remain unchanged. For these incidents a review will be initiated by the specialist services using a tailored patient review template. These will be sent to the relevant local managers. If moderate or above harm is suspected the review will then be submitted to the relevant Divisional Director of Nursing as outlined in the PSIRF process above.

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.

"The first step when embarking on a process to learn and improve after a patient safety incident is to make efforts to understand the context and develop a deep understanding of work processes. It can be tempting to rush to identify what needs to change, but this cannot be done without understanding work as done, and the system factors that influence this. A thorough understanding of the work system can be gained using a learning response method such as investigation, multidisciplinary team review or after action review, supplemented with a system-based framework to guide thinking (eg SEIPS, Yorkshire Contributory Factors Framework, HFACS, etc)." (NHSE PSIRF Guidance: Safety Action Development, p17)

One of the most important factors in ensuring timeliness of a learning response is thorough, complete and accurate incident reporting when the circumstances are fresh in the minds of the incident reporter and the wider team. These principles are set out in the current incident reporting guidance but must be reinforced through the PSIRF.

The PSIRP provides more detail on the types of learning response most appropriate to the circumstances of the incident. Highly prescriptive timeframes for learning responses may not be helpful so the following are included as a guideline only:

- Initial incident investigation including further Rapid Review investigation – as soon as possible, within 5 working days of reporting
- Further learning response (eg: MDT Review, After Action Review, Swarm huddle) – within 10 working days of reporting
- Comprehensive Investigation (PSII) – 60 - 120 working days depending on complexity, the timeframe for the completion of a PSII will be agreed with those affected, as part of the terms of reference, as long as they are wanting to be involved.

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.

A toolkit of our Trust agreed learning response types are attached below. We have agreed to use the following learning responses when reviewing an incident, to assist us in information gathering and highlighting any learning:

- Swarm Huddle – **What is it:** *A meeting to explore an incident in a non-punitive way and deliver learning. It is a facilitated discussion on an incident or event to analyse what happened, how it happened and decide what needs to be done immediately to reduce risk.*

It enables understanding and expectations of all involved and allows for learning to be captured and shared more widely. Safe space, invitees only (those involved in incident). **When to use it:** *Swarms can be used soon after any activity or event (within a working week ideally) where care has not gone as planned - this can prevent key information being lost. Swarms can reduce blame and rumours about an incident by focussing on learning and improvement and an understanding of 'work as done'.*

- After Action Review - **What is it:** *A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely. Safe space, invitees only (those involved in incident).* **When to use it:** *AARs can be used after any activity or event that has been particularly successful or unsuccessful. It is also often used at the end of a project to help populate a lessons learnt log. It is important to disseminate learning widely so that good practice can be shared and others can learn from mistakes.*

- MDT Review – **What is it:** *An open discussion to determine the key contributory factors and system gaps in patient safety incidents. Good tool to use when it is more difficult to collect staff recollections of events either because of the passage of time or staff availability.* **When to use it:** *Identify learning from multiple patient safety incidents (including incidents where multiple patients were harmed or where there are similar types of incidents). To explore a safety theme, pathway, or process. Thematic analysis.*

- Rapid Review – **What is it:** *A timely and affordable approach that can provide actionable and relevant evidence to strengthen policies and systems in healthcare. It is a form of rapid investigation that takes account of a broad range of data sources to inform the scope of enquiry. The approach aims to rapidly assess the evidence base using a systematic methodology to produce a transparent overview of the secondary-level evidence landscape that can be used to inform further work.* **When to use it:** *It is useful to help refine a broad question, as well as identify potential gaps in the evidence.*

Further details can be found from NHSE at: https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

LHCH Rapid Review including Divisional

Swarm template draft LHCH V1.0.doc

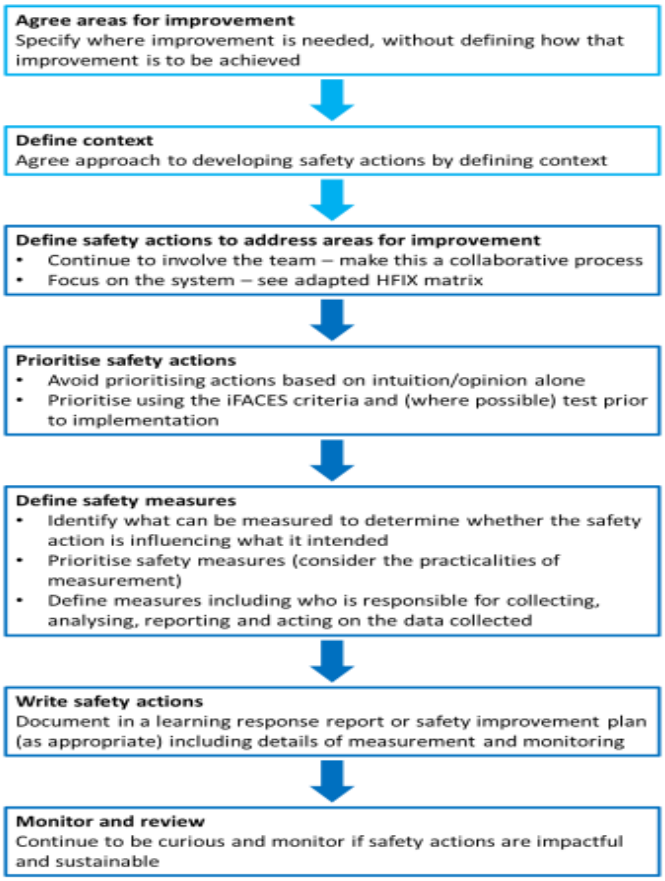
After Action Review LHCH.docx

Safety action development and monitoring improvement

PSIRF moves away from the identification of 'recommendations' which may lead to solutionising at an early stage of the safety action development process.

"Learning response methods enable the collection of information to acquire knowledge. This is important, but it is only the beginning. A thorough human factors analysis of a patient safety incident does not always translate into better safety actions to reduce risk. You must move from identifying the learning to implementation of the lessons. Without an integrated process for designing, implementing, and monitoring safety actions, attempts to reduce risk and potential for harm will be limited."

The following diagram summarises how safety actions should be developed and overseen:



Recognising that the first step when embarking on a process to learn and improve after a patient safety incident is to make efforts to understand the context and develop a deep understanding of work processes. It is important to understand “work as done” and the systems factors that influence work. Areas for improvement can relate to a specific local context or to the context of the wider organisation. Findings from PSIIs and PSRs provide key insights and learning opportunities, but they are not the end of the story. PSIRF moves away from the identification of ‘recommendations’ which may lead to solutions at an early stage of the safety action development process.

By identifying and agreeing aspects of the work system where change could reduce risk and potential for harm (ie ‘areas for improvement’ or system issues). Actions to reduce risk (ie safety actions) are then generated in relation to each defined area for improvement. Following this, measures to monitor safety actions and the review steps are defined.

A Quality Improvement approach is valuable in this aspect of learning and improvement following a patient safety investigation. It will therefore be necessary to ensure close links are developed and maintained with the Quality Improvement Team so their expertise and guidance can be utilised when developing the learning response and safety actions. PSIRF therefore provides an opportunity to strengthen this and for the QI and Patient Safety functions to work more closely together. Quality Improvement to support embedded learning and improvement following a patient safety investigation is key to improving patient safety outcomes. Close links have been and will continue to be developed and maintained with the Improvement Team. PSIRF provides an opportunity to strengthen this and for the QI and Patient Safety functions to work hand in hand.

Safety actions arising from a learning response should follow the SMART (Specific, Measurable, Achievable, Realistic, Time-bound) principles and thought must be given to monitoring and measures of success. Further guidance on this can be found in NHSE Guidance at https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf

Monitoring of completion and effectiveness of safety actions will be through organisational governance processes reporting within Divisions and their associated governance meetings with audit support and will be further reported to Quality Safety Experience Committee. The Risk Management Team will maintain an overview across the organisation to identify themes, trends and triangulation with other sources of information that may reflect improvements and reduction of risk.

It is important that monitoring of completion of safety actions does not become an end in and of itself, but rather a means to improve safety and quality outcomes and reduce risk. The Trust must therefore develop governance systems focused more on measuring and monitoring these outcomes, utilising subjective as well as objective measures.

Safety improvement plans at Liverpool Heart and Chest Hospital
As referred to throughout the policy, the Trust has developed a Patient Safety Incident Response Plan (PSIRP) that clarifies what our improvement priority areas or emergent themes 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.

These themes, as detailed in the PSIRP, are based on an extensive analysis of historic data and information from a range of sources (eg: incident trends, complaints, mortality reviews, risk registers, legal claims and inquests) and feedback from staff and patients. Whilst the PSIRP identifies the broad organisational priorities, it is recognised there may be more specific priorities and improvements identified at a more local specialised level, which although will not form part of the overarching plan, can still be approached utilising the more holistic and inclusive PSIRF approach. The Risk Management Team will provide support and guidance, as required, to teams in this regard. The QI team can also assist in these improvements and identify where there is overlap with existing and developing QI programmes across the Trust.

The Trust has overarching safety improvement 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 Patient Safety Incident Review Group (PSIRG) and approved by the Trust Patient Safety Panel. Monitoring of progress will be overseen by a forum agreed by the Trust Patient Safety Panel, and fed into the Quality, Safety and Experience Committee.

The Trust is reviewing governance processes in line with the PSIRF guidance so it is clear how the PSIRP improvement priorities will be overseen through Quality and Corporate governance structures and processes. Specialty level improvements will be managed locally with assurance and reporting to the associated work group, then, Corporate oversight and assurance committees to provide ‘ward to board’ assurance.

13. Oversight roles and responsibilities

"When working under PSIRF, NHS providers, integrated care boards (ICBs) and regulators should design their systems for oversight "in a way that allows organisations to demonstrate [improvement], rather than compliance with prescriptive, centrally mandated measures". To achieve this, organisations must look carefully not only at what they need to improve but also what they need to stop doing (eg panels to declare or review Serious Incident investigations). Oversight of patient safety incident response has traditionally included activity to hold provider organisations to account for the quality of their patient safety incident investigation reports. Oversight under PSIRF focuses on engagement and empowerment rather than the more traditional command and control."

Responsibility for oversight of the PSIRF for provider organisations sits with the Trust Board. The Executive Lead is the Director of Nursing and Quality who holds responsibility for effective monitoring and oversight of PSIRF. The 'Responding to patient safety incidents' section above also describes some of the more operational principles that underpin this approach.

The Trust recognises and is committed to close working, in partnership, with the local ICB and other national commissioning bodies as required. Representatives from the ICB will sit on PSIRF implementation groups. Oversight and assurance arrangements will be developed through joint planning and arrangements must incorporate the key principles detailed in the guidance above, namely:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Policy, planning and governance
3. Competence and capacity
4. Proportionate responses
5. Safety actions and improvement

As referred to above, 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 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.

14. Complaints

Any complaints relating to this guidance, or its implementation can be raised informally with the Risk Management Lead Nurse, initially, who will aim to resolve any concerns as appropriate.

Formal complaints from patients or families can be lodged through the Trust's complaints procedure at http://nww.staffintranet.lhch.nhs.uk/media/2558/complaints-policy-v36.pdf.

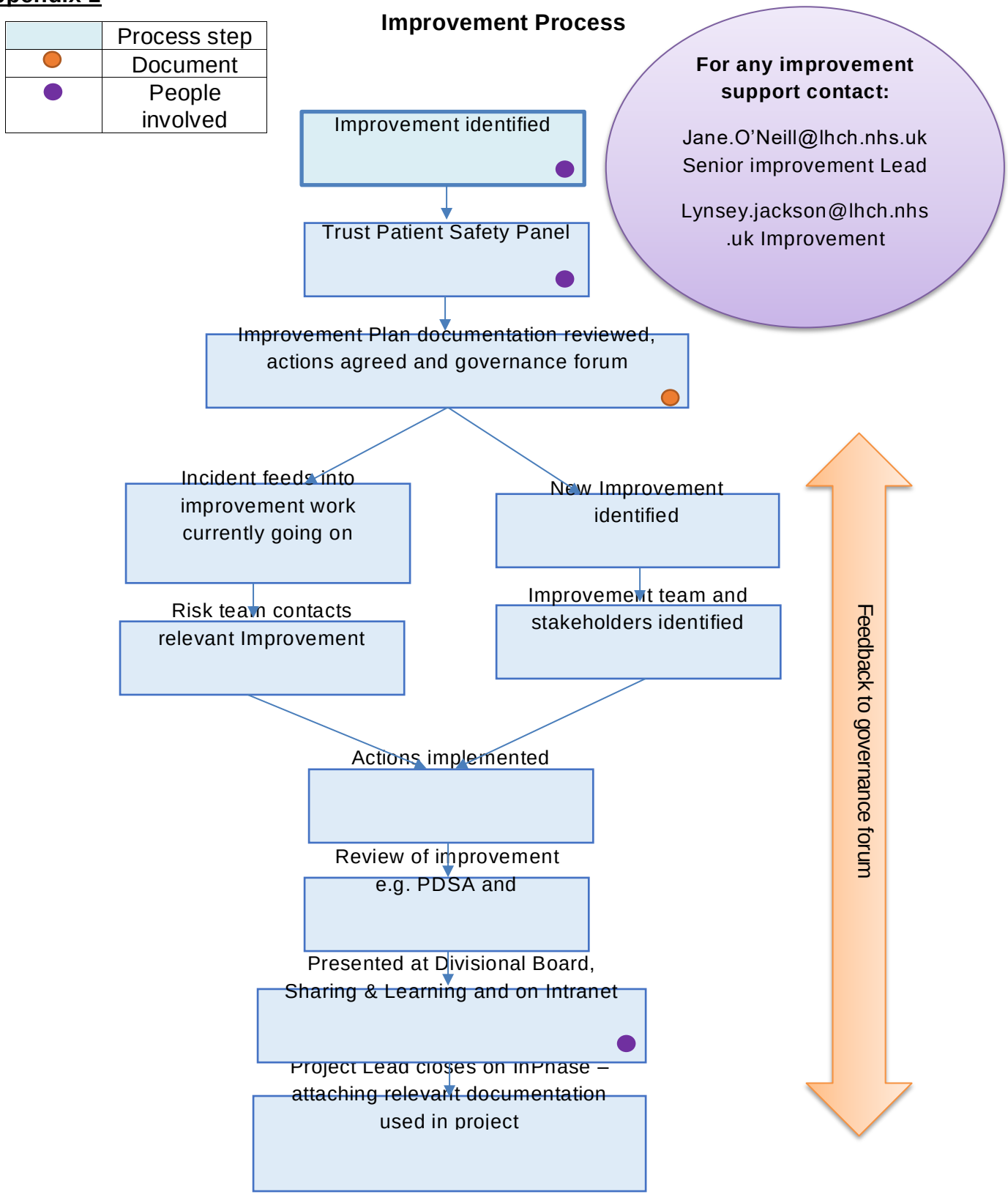
At the earliest opportunity speak to the manager of the ward, matron, department, or doctor in charge of your care to let them know what you are not happy with. They will do all they can to resolve the issues that you raise or by contacting the Patient and Family Support Team below:

Laura Allwood

Patient and Family Support Manager
Liverpool Heart and Chest Hospital NHS Foundation Trust
(0151 600 1257
*laura.allwood@lhch.nhs.uk

15. Appendices

Appendix 1

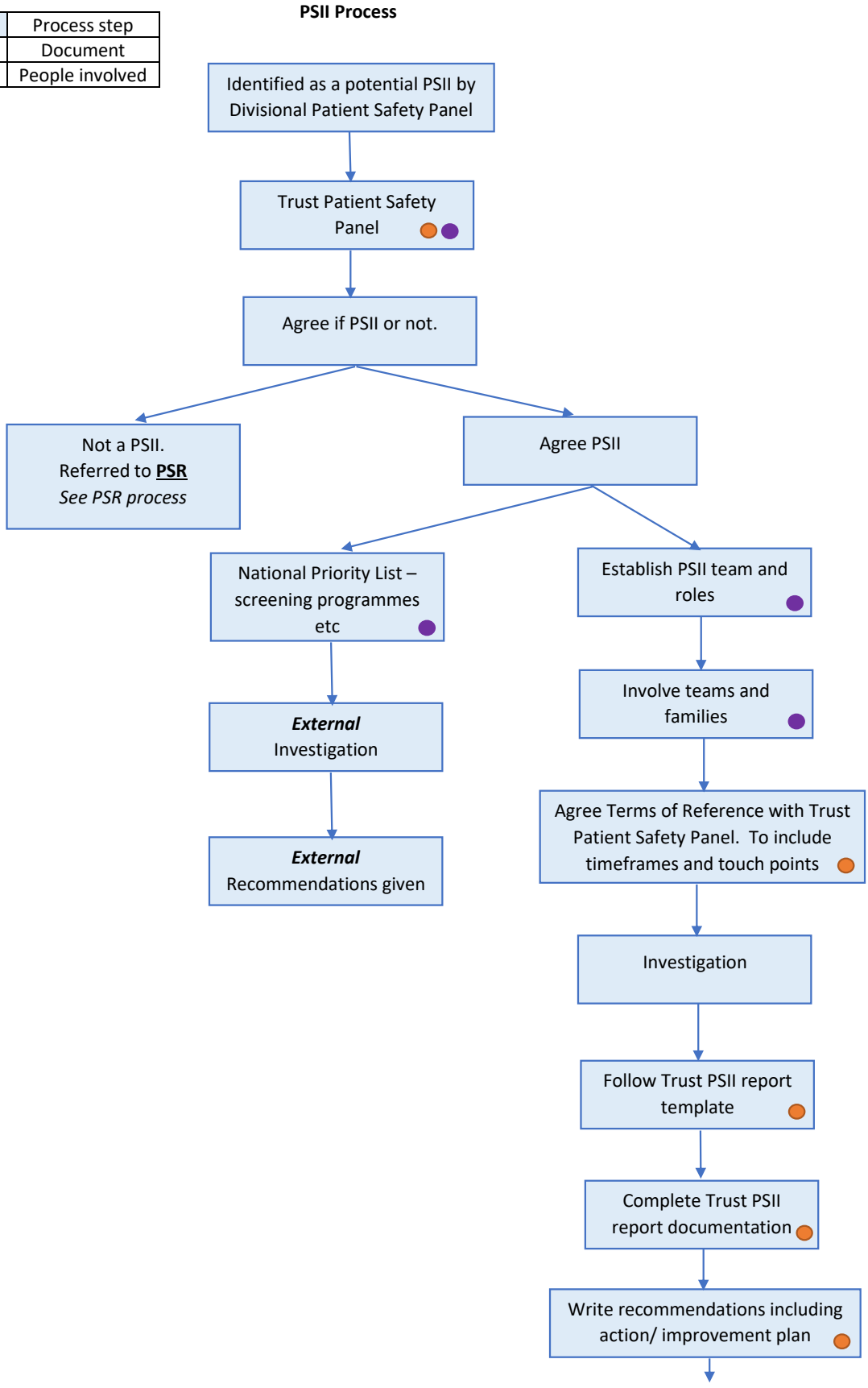


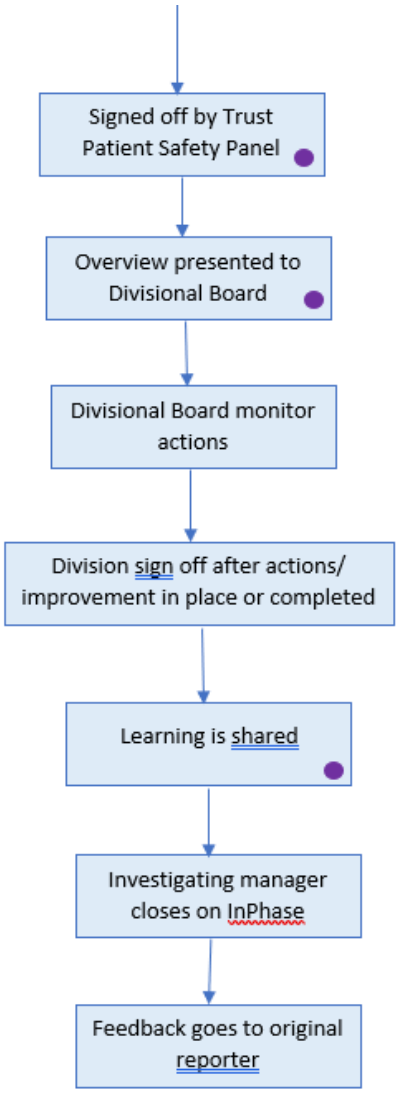
Appendix 2

PSR process Map

Appendix 3

	Process step
●	Document
●	People involved




Signed off by Trust Patient Safety Panel
Overview presented to Divisional Board
Divisional Board monitor actions
Division sign off after actions/ improvement in place or completed
Learning is shared
Investigating manager closes on InPhase
Feedback goes to original reporter

16. Endorsed by:

Name of Lead Clinician/Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date

17. Record of Changes

Changes approved in this document:			Date:	
Section Number	Amendment (***shown in bold italics)***	Deletion	Addition	Reason
Front Page	***Exec Lead***	Sue Pemberton	Joan Matthews	Role change

Supporting Staff Following Work Related Traumatic or Stressful Incidents

Policy and Procedure

For completion by Author			
Author(s) Name and Title:	Beth Williams-Lally, Head of People Transformation		
Scope:	Trust Wide	Classification:	Human Resources
Version Number:	4.0	Review Date:	07/03/2024
Replaces:	v3.2 Extended		
To be read in conjunction with the following documents:	Incident Reporting – including Investigation & Root Cause Analysis Procedures Policy Managing Attendance Policy Zero Tolerance Policy – The Prevention and Management of Violence & Aggression Stress Prevention & Management in the Workplace		
Document for public display:	Yes		
Executive Lead	Karen Nightingall, Chief People Officer		

For completion by Approving Committee			
Equality Impact Analysis Completed:		No	
Endorsement Completed:	Yes	Record of Changes	Yes
Authorised by:	People Delivery Group	Authorisation date:	07/02/2023

For completion by Document Control					
Unique ID No:	TW24(08)	Issue Status:	Approved	Issue Date:	11/07/2023
After this document is withdrawn from use it must be kept in archive for the lifetime of the Trust, plus 6 years.					
Archive:	Document Control		Date Added to Archive:		
Officer responsible for Archive:	IG and Document Control Facilitator				

Contents

Document Statement

Liverpool Heart and Chest Hospital recognises the importance of supporting staff through any potentially traumatic/stressful work related incidents, complaints or claims. This policy provides best practice guidance for managers when offering support to staff who have been involved in incidents, complaints or claims as well as ensuring that staff who face traumatic situations receive timely and appropriate support.

1. Roles and Responsibilities

Head of People Transformation
The Head of People Transformation is responsible for the development and implementation of this policy.

People Committee
The People Committee will monitor performance against this policy.

HR, Learning & Development Team
This group will be responsible for ratifying and reviewing the policy through delegated responsibility from the People Committee. The group will ensure appropriate management and staff side consultation when reviewing the policy and will monitor its applications and outcomes.

Health & Wellbeing Group
This group and wellbeing champions review and provide feedback on this policy to ensure it is fit for purpose and fit for the future.

Managers
Managers are responsible for applying the principles of the policy fairly, equitably and sensitively and ensuring all their team members are aware of the policy. Managers must contact the Human Resources Department if they require advice on the application of this policy

Employees
All Liverpool Heart & Chest employees are responsible for co-operating with the development and implementation of corporate policies as part of their normal duties and responsibilities.

2. Controlled Document Standards

This policy is designed to provide clear guidance on supporting staff following work related traumatic or stressful incidents.

This policy will enable managers to provide clear information as to how employees can access support when they experience work related trauma or stressful incidents.

This policy will ensure that all new and eligible employees to the Trust receive fair and consistent treatment.

3. Procedure

After a stressful or traumatic incident or event it is important that there should be an opportunity for a staff member to discuss the event with their manager as soon as possible after the event. The purpose of this debrief is to:

1. Discuss the event in order to support the member of staff
2. Discuss the need for further support for the member of staff
3. Examine the details of the event to assess if immediate action needs to be taken to protect patients or staff
4. To provide information and updates to the member of staff

When a staff member has been involved in a traumatic/stressful incident, claim or complaint, it is essential that they are offered support. The level of support required will depend on the individual involved and may include:

- Ensuring a staff member is given time to access internal/external support resources i.e. Employee Assistance Programme (EAP)
- Ensuring contact is maintained with the staff member throughout the entire process
- Ensuring staff are made aware of all the resources available to support them through the incident, claim or complaint.
- Consider liaising with professional contacts/Occupational Health/HR/Trade Union Representatives
- Consider providing information about local services that support Health & Social Care Staff (e.g. Cheshire & Merseyside Resilience Hub and sharing LHCH 'You Matter' resource toolkit)

Other sources of support include:

Managers

The manager may be able to provide support and advice directly or can support the staff member to contact one or more alternative support agencies. The manager can also facilitate any referral to Occupational Health if it is deemed appropriate.

Head of Department

There may be some circumstances when it is appropriate for the staff member to seek advice and support from the Head of Department, Divisional Head of Operations or equivalent. This may be appropriate when the Head of the Department, Divisional Head of Operations or equivalent is the lead on the issue in question or when the direct manager is personally involved in the incident, complaint or claim.

Occupational Health Service

The Occupational Health Service is able to provide advice and support when a referral is made to them. Occupational Health would also able to signpost staff to alternative sources of support if required.

Employee Assistance Programme

The Employee Assistance Programme (EAP) offered by the Trust is an independent and confidential service run by an external provider. The EAP details can be located on the Trust intranet site.

Patient Safety Lead

As an outcome of any investigation of an incident, complaint or claim, the Patient Safety Lead can provide advice and support in respect of task re-design, repeat risk avoidance.

Clinical Education Team

If training and/or development needs are identified as part of any investigation into an incident, claim or complaint, additional support will be available from the Clinical Education Team which the manager can access.

Witness Support

On occasion, staff may be called as a witness either internally, for disciplinary or grievance hearings, or externally, for professional conduct hearings, coroners court etc. Support and advice should initially be sought from the individual's manager, who can also advise on appropriate contacts such as Occupational Health or more specialist external support dependent on the circumstances. The Human Resources Department can also provide further advice regarding internal processes such as Disciplinary and Grievance procedures by explaining the process to potential witnesses. Individuals can also consider contacting their own trade unions and/or professional bodies for additional support.

Procedure for Accessing Support

When an individual has been involved in an incident, claim or complaint, it is the responsibility of the manager/ investigation manager to keep staff updated during the process and inform staff as soon as possible, of the outcome from any hearing to avoid any undue worry or stress.

It is the responsibility of the manager to assess what form of support may be required.

It is recognised that the type and source of support required may vary according to the individual circumstances therefore this assessment should be carried out in conjunction with the individual concerned and would take the form of an informal discussion to identify what support would be the most beneficial. As part of this process managers should consider:

- Providing Employee Assistance Programme (EAP) telephone number and email details
- Referral to Occupational Health
- Liaising with professional contacts/Trade Union Representatives
- Contacting the Clinical Education Team
- Consider providing information about local services that support Health & Social Care Staff (e.g. Cheshire & Merseyside Resilience Hub and sharing LHCH 'You Matter' resource toolkit).

During the informal discussion, consideration may need to be given as to whether the staff member is fit for work and/or whether any temporary adaptations to the role are required whilst in work. If it is identified that the individual may not be fit, or may need temporary adaptations, an Occupational Health referral should be made. Managers should also contact the Human Resources Department for guidance if needed. If the individual is going to be absent from work the Trust's Managing Attendance Policy should be followed.

The timeline for the duration of the support required will be dependent on the individual circumstances and therefore the manager should carry out regular reviews as part of an incident, claim or complaint in order to ensure the most effective support is being provided and for the most appropriate length of time.

The manager should keep a written record of all support offered to staff involved in incidents, claims or complaints along with any agreed actions taken and/or support given.

4. Policy Implementation Plan

This policy will be available on the Trust's intranet. Managers have a responsibility to ensure that applicants and new employees are aware of the policy and procedure.

5. Monitoring of Compliance

The effective implementation of this policy will be monitored by the HR and Education Group with delegated responsibility from the People Committee.

6. References

Health and Safety Executive and wellbeing organisations.

7. Appendices

None

8. Endorsed By:

Name of Lead Clinician / Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date
Beth Williams-Lally	Head of People Transformation	28 Sep ‘22

9. Record of Changes

Section No	Version No	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason
Main	V3.2	28 September 2022	▪ Included Health & Wellbeing Group and wellbeing champions under roles and responsibilities as they are new focus groups dedicated to employee wellbeing. ▪ Included reference to Cheshire & Merseyside Resilience Hub and 'You Matter' toolkit as additional support resources.			
Procedure for Accessing Support	V3.2	18 October 2022	▪ Included, 'it is the responsibility of the manager/ investigation manager to keep staff updated during the process and inform staff as soon as possible, of the outcome from any hearing to avoid any undue worry or stress.			