Policy:

NP 037 MANAGING ALLEGATIONS AGAINST STAFF POLICY (Allegations of abuse made against an employee, agency worker, volunteer or unpaid worker, student or bank worker)

Executive Director Lead	Executive Director or Nursing, Professions, and Quality
Policy Owner	Head of Safeguarding
Policy Author	Head of Safeguarding, Head of Nursing and Expert by Experience

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Summary of policy
The policy outlines the roles and responsibilities of all staff should an allegation of abuse be made against an employee, agency worker, volunteer, student or bank worker. It sets clear standards and subsequent actions that must be taken following such an allegation to ensure that our service users are safeguarded and staff are supported.

Target audience	All SHSC staff

Keywords	Allegations, Safeguarding, Local Authority Designated Officer (LADO), Designated Adult Safeguarding Manager (DASM)

Storage & Version Control
Version 3 of this policy is stored and available through the SHSC intranet/internet. This version of the policy supersedes the previous version (2). Any copies of the previous policy held separately should be destroyed and replaced with this version.

Version Control and Amendment Log (Example)

Version No.	Type of Change	Date	Description of change(s)
0.1	New draft policy created	14/04/2021	Director of Quality identified need for separate policy
1.0	Draft Issue and amendments	21/04/2021	Amendments made as per comments
1.1	2nd Draft issue and amendments	26/04/2021	Reviewed amendments to Appendices and transfer to SHSC template
1.2	3rd Draft with appendices and flow charts	9/5/2021	Flow charts and electronic links embedded and appendices added.
1.3	4th Draft with amendments from Corporate Safeguarding Team	17/5/2021	Amendments incorporated.
1.4	5th Draft with amendments following 2-week consultation	1/6/2021	Flowcharts merged due to duplication
1.5	6th Draft	3/6/2021	Formatting of policy
1.6	7th Draft		Amendment to Flow Chart
1.7	8th Draft with amendments after PGG		Discussion with HR. Amendments to wording in Scope 2.2
2.0	Reviewed after 3 months following approval at PGG in November 2021	18/5/2022	1.2.4 Decision to suspend or inform other agencies Caldicott Principles added as Appendices 6.3.4 examples of outside work activities 7.1.4 section on Safe Haven 7.2.10 Inclusion of Union rep at this stage. 7.2.11 clarity on when DBS will be notified. 8.3storage of vexatious/unfounded allegation will be agreed with staff member

3.0	Reviewed and amended	29/04/2024	1.1 Statement on zero tolerance in line with Trust values and behaviours. 6.3.5 Support for reporters of untoward incidents or concerns. 7.1.2 statement added noting safety of our service users is paramount. 7.1.4 Paragraph added regarding historic allegations. 7.2.1 Clarification on process added. 7.2.8 Clarification on Roles and Responsibilities added. 7.2.12 notification of possible further meetings following initial concern meeting. 7.8.3 Section added on allegations against non-substantive staff. Appendix 9 Initial Concerns Huddle Template added. Review completed in consultation with an Expert by Experience.

Contents

1 Introduction

1.1 Trust Safeguarding Statement

The Trust is committed to safeguarding and promoting the welfare of children, young people and adults at risk of abuse or neglect. It is also committed to creating a climate in which allegations or concerns can be raised without fear or recrimination to the reporter. All staff have a duty to be alert to potential vulnerabilities in children and adults, and to know what to do if they have concerns. The Trust will ensure that staff are provided with the resources and skills needed to implement the safeguarding policies and dealing with safeguarding concerns raised against staff.

No one should feel unsafe within our services, staff and service users alike, and SHSC has adopted a zero tolerance of any kind of unacceptable behaviour, bullying or harassment in line with our values and behaviours.

1.2 Information for all Staff

1.2.1 This policy applies to those allegations where there is reason to believe a child or adult is at risk of harm. However, it also applies to allegations which might indicate the alleged source of harm is unsuitable to work with adults or children in their present position or if the allegation is substantiated, in any future capacity.

1.2.2 This policy facilitates appropriate and coordinated responses to allegations made against Trust employees and workers, both temporary and substantive and includes those engaged by the Trust in a non-remunerative capacity, students and volunteers.

1.2.3 The Trust has adopted the same principles and procedures regardless of the age of the alleged victim. To ensure the Trust is a safer organisation whose service users and cares patients are safeguarded and have their welfare promoted. It is important to ensure even apparently less serious allegations or concerns are followed up and scrutinised.

1.2.4 Some allegations are so serious an immediate referral to the police and/or social care for investigation may be warranted for example an allegation of sexual assault or person has visible injury. This decision may need to be taken promptly by a senior manager or Director or a joint decision following meeting with Head of Service, Head of Nursing, Deputy Director of Nursing and Head of Safeguarding. Other situations are less serious and may not warrant this level of response and may be dealt with in accordance with the disciplinary procedures.

1.2.5 The , Executive Director of Nursing, Professions and Quality, and Head of Safeguarding, will be informed as soon as possible about any allegations made against members of Trust staff. The Medical Director will be advised in relation to allegations involving medical staff or student. The Executive Director of Nursing, Professions and Quality will inform the Chief Executive as required.

Commented [KDP1]: I have changed this bit as we don't update the CEO etc following all AAS?

This policy should be read in conjunction with SHSC Safeguarding Adults and Safeguarding Children, Professional Boundaries Policy and Unacceptable Behaviours

Policy.

2 Scope

This policy applies to all members of Trust staff regardless of their current role or place of work. The term “members of Trust staff” is used within this policy and refers to staff as follows:

- Employed by Sheffield Health and Social Care Trust
- Seconded or attached from other agencies e.g., Approved Mental Health Professionals (AMHPs);
- Bank, locum or agency staff.
- Volunteers or unpaid workers
- Students;
- Contracted with or commissioned by Sheffield Health and Social care Trust to provide services e.g., Medical staff.
- Service user, carer, elected, appointed and public representatives, and non-executive board members who take part in Trust committees and working groups.

It also applies whether the allegations arise in connection with:

- The employee’s own work
- The employee’s own children / adult family members
- Other children / adults living within the family
- Other children /adults living outside the family
- Whether the concern is current or historical

2.2 This policy will be used and applied to all members of Trust staff who are alleged to have:

- Behaved in a way which has harmed, or may have harmed or may be a risk to a child or an adult at risk; or
- possibly committed a criminal offence against, or related to, a child or an adult at risk; or
- perpetrated behaviours which breach the law or Trust policies and places the child or adult at significant risk of harm
- abused their position of authority or trust.

2.3 This policy will be applied when the Trust becomes aware of an allegation or concern about a member of Trust staff who, outside of their Trust workplace, may present a risk to service users. For example, an allegation of domestic violence or abuse, anti-social behaviour, substance misuse or fraud. Consideration will also need to be given when the actions, behaviours or attitude of a member of Trust staff brings the organisation into disrepute or potentially compromises their professional code of conduct and/or conditions of registration.

2.4 If the Trust becomes aware of an allegation or concern about an individual who is not employed by the Trust but who is employed under the same statutory framework (i.e. GP practice, children or adult social care services, etc) the Trust would inform the employer in order that they can instigate their own internal investigations. If the concerns were in relation to children we would also inform the Local Authority Designated Officer (LADO).

2.5 If there is reasonable cause for the Trust to consider that the actions or omissions of a member of its staff may impact on the health or welfare of any child or another adult this policy will apply.

See Appendix 7 for 8 Caldicott Principles

3 Purpose

3.1 This policy will provide a fair and transparent framework for managing safeguarding allegations against staff without prejudice or implication of guilt. This policy does not apply where concerns are in relation to professional conduct only and HR policies and procedures should be applied. In the event that an allegation is raised which relates to a Sheffield Health and Social Care Trust Executive or Non- Executive Director, another NHS organisation will be invited to facilitate an independent investigation.

4 Definitions

Abuse and Neglect	Abuse and neglect are forms of maltreatment of a child. Someone may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting; by those known to them or, more rarely, by a stranger. A child may be abused by an adult or adults, or by another child or children. The primary responsibility for protection all children from abuse lie with their parents and carers. Categories of abuse often overlap and an abused child frequently suffers more than one form of abuse. Therefore everyone who works or has contact with children or pregnant women should be able to recognise and know how to act upon evidence that the health or development of a child (or an unborn baby) is being or may be impaired, especially when suffering or at risk of suffering significant harm.
Adult	A person aged 18 years or over
Adult at Risk	An adult who has needs for care and support and is experiencing or at risk of abuse, neglect and as a result of their care or support needs is unable to protect themselves from either risk of or experience of abuse or neglect.
Child	As defined by the Children Act 1989 as anyone under the age of 18 years of age.
Harm	Under Section 31(9) of the Children Act 1989 as amended by the Adoption and Children Act 2002 the following terms are defined: • 'Harm' means ill-treatment or the impairment of health or development (including, for example, impairment suffered from seeing or hearing the ill-treatment of another); • 'Development' means physical, intellectual, emotional, social or behavioural development; • 'Health' means physical or mental health; and • 'Ill-treatment' includes sexual abuse and forms of ill-treatment which are not physical.
Parent	Usually a birth parent holds parental responsibility but there are exceptions. The following can hold parental responsibility; • birth mother (unless displaced because the child is adopted; • birth father (if married to the birth mother at time of birth); • birth father named on the birth certificate (after 1 December 2003); birth father or step parent with a parental responsibility
Safeguarding Managers	Safeguarding Managers professionals or managers (usually in a social work or community mental health team suitably qualified and experienced who have received Safeguarding Adults training. They are responsible for completing S42 enquiries or supporting other staff with sufficient experience to carry out such an enquiry, in response to an allegation of abuse.
Staff	All employees, both contracted and substantive, bank, agency, students and volunteers.

DASM (Designated Adults Safeguarding Manager)	The role of the DASM (Designated Adults Safeguarding Manager) was introduced in the Care Act 2014. The Department of Health soon removed the role as Local Authorities (LA) identified that the DASM role was duplicated in existing functions. Many LA's no longer have a DASM, however Sheffield City Council continues to use this title and it is part of the role of the Head of Safeguarding in the LA. This policy will therefore the term DASM.
LADO (Local Authority Designated Officer)	The LADO is responsible for overseeing individual cases of allegations concerning children and providing advice and guidance to employers and voluntary organisations.
PiPoT (Person in a Position of Trust)	A 'person in a position of trust' refers to any individual who works with adults or children in either a paid or voluntary capacity.

5 Detail of the policy

5.2 For all staff to understand their role and responsibilities in relation to the safeguarding of adults and children experiencing, or at risk of, harm or abuse;

5.3 All staff to understand the necessity to conduct themselves in a manner commensurate with being a fit and proper person whilst holding a position of trust in their employment.

5.4 All staff to understand the consequences of acting in a manner which is found to have caused ill treatment or neglect to an adult or child in their care with regard to:

- Mental Health Act 1983, section 127;
- Mental Capacity Act 2005, section 44;
- Criminal Justice and Courts Act 2015, sections 20-25;
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20 – Duty of Candour.
- Human Rights Act 1998

5.5 To ensure that allegations are dealt with consistently, thoroughly and in a timely manner. The process outlined will ensure appropriate, pragmatic and proportionate responses are made in partnership with other agencies taking account the risk, history and context of each situation.

6 Duties

Named Professional Roles

6.1.1 **Local Authority Designated Officer (LADO)** – The LADO is responsible for overseeing individual cases of allegations concerning children and providing advice and guidance to employers and voluntary organisations. They will ensure that decisions are made as objectively as possible and monitor the progress of cases to ensure that they are dealt with as quickly as possible in a consistent, thorough and fair process. Any allegation or concern about the conduct or behaviour of a Person in a Position of Trust (PiPoT) who works with children and/or young people must be referred to the Local Authority Designated Officer (LADO). This will enable the management of the three strands of the allegation's management process (potential safeguarding concerns, criminal investigation, and disciplinary procedures). All allegations and information should go to The Executive Director of Nursing and/or Director of Quality in the first instance before a referral is made to the LADO *Referrals must be made to the LADO when information suggests that an adult who has contact with children as part of their employment or voluntary work may have:*

•behaved in a way that has harmed a child or may have harmed a child
•possibly committed a criminal offence against or related to a child; or
•behaved in a way that indicates s/he is unsuitable to work with children

6.1.2 **Executive Director of Nursing, Professions and Quality -** retains the strategic lead for all allegations of abuse made against members of staff. This includes having responsibility for safeguarding across the Trust and Board Level responsibility for the requirements under Section 11 of the Children Act (2004) and the Care Support Statutory Guidance 2014. The Director of Nursing, Professions and Quality is responsible for ensuring that appropriate systems and processes are in place throughout the Trust for managing allegations and ensuring patient safety.

6.1.3 **The Deputy Director of Nursing and Quality** – The Deputy Director of Nursing and Quality holds the corporate lead on behalf of the Executive Director of Nursing, Professions and Quality for all allegations of abuse made against members of staff. The Deputy Director of Nursing and Quality will ensure any concerns are addressed with the LADO at an inter-agency level where this process is required in conjunction with the Head of Safeguarding.

6.1.4 **Director of People**– The Director of People is responsible for ensuring that human resources advice is given to the Executive Director of Nursing, Professions and Quality to support the appropriate investigation of all allegations of abuse made against members of staff. any concerns are addressed with the LADO at an inter-agency level where this process is required.

6.1.5 **Head of Safeguarding** – The Head of Safeguarding will provide advice and guidance within the Trust, liaising with other agencies as necessary. They should monitor the progress of cases to ensure they are dealt with consistently and in a timely manner, within a thorough and fair process. The Head of Safeguarding (or deputy) will ensure:
appropriate recording of initial concerns huddles to provide clear audit trails of decision making and recommendations in all processes relating to the management of the allegation and store these documents in a restricted electronic file.
• that a Point of Contact is identified at the initial concerns huddle to provide the employee with support and information of the allegation.
That a Point of Contact is identified for the victim/service user. The PoC should be chosen and agreed with victim/service user wherever possible.

6.1.6 **Named Doctor Safeguarding Children** – has Trust-wide responsibility under Section 11 of the Children Act (2004) and will coordinate the Trust medical response and involvement in all allegations made against staff in relation to children.

6.2 **Other Roles** (Working Together To Safeguard Children (2015) and Care Act 2014)

6.2.1 **Trust Board** – The Trust Board is responsible for ensuring that a culture of openness, trust, service improvement and sharing of learning is present within the organisation. It has overall responsibility for ensuring that the Trust's duties with regard to safeguarding patients and children and for ensuring the management of allegations and serious incidents are appropriately discharged, including ensuring compliance with this policy. The Board will receive assurance of this through the Quality Committee and the Safeguarding Committee.

6.2.2 **Executive Team** – The Executive Team is responsible for ensuring a culture of openness, trust service improvement and ensuring there is a mechanism for the sharing of learning within the Trust.

6.2.3 **Medical Director** – holds the professional lead for registered medical staff medical students and Physician Associates and will enact any necessary referrals to registering bodies as required following outcomes of investigations. The Medical Director will be advised at the outset of all allegations against members of Trust medical staff.

6.2.4 **General Managers** – are responsible for ensuring this policy is distributed and enacted within their service areas. All Trust managers are responsible for disseminating the policy within their area of responsibility and ensuring it is implemented by providing advice and support to staff and managers. They are responsible for ensuring that all allegations are managed in accordance with this policy.

6.3 All staff

6.3.1 All staff are responsible for ensuring that any allegation against another member of staff is brought to the immediate attention of their line manager for it to be addressed through this policy.

6.3.2 All staff, including volunteers and visiting celebrities have a right and a duty to raise any safeguarding matter of concern that they may have about the delivery of care to patients and service users, even though this may involve raising concerns about the conduct of a colleague. They should therefore raise any such concerns with their line manager or an appropriate alternative manager.

6.3.3 Employees who are making an allegation against a colleague should be made aware of the Trust Speaking Up - Freedom To Speak Up - Raising Concerns (Whistleblowing) Policy (2018) and be offered support from the Freedom to Speak Up Guardian https://jarvis.shsc.nhs.uk/documents/speaking-freedom-speak-raising-concerns-whistleblowing-policy-hr-015-v51-october-2018

6.3.4 Staff must inform their line manager at the earliest opportunity if an allegation has been made against them whether this relates to their work within SHSC or outside of work for example sports coaching, social clubs, or caring responsibilities. The Line Manager should enact this policy and escalate to Head of Service who should notify an HR Business Partner.

6.3.5 Members of staff should be supportive of colleagues who report any untoward incidents or concerns, without fear of repercussions or personal opinions of other staff members and have a duty to co-operate with any investigation that may be carried out in response to an allegation against a colleague. They should also:

- Ensure their availability for investigation interviews when requested;
- If allegations are made against them, give a clear and concise account of their version of events, supplying any supporting evidence where necessary.
- If an allegation is made against a colleague and they are invited to an investigation interview, give an honest and first-hand account of events, supplying supporting evidence where necessary; and
- Maintain confidentiality throughout the whole process.

6.3.6 All Trust staff are responsible for:

- Performing their duties in accordance with their contractual obligations, professional codes of conduct and the terms of their registration;
- Adhering to the professional boundaries of their role in order to ensure that their practice is safe;
- Exercising due care in the performance of their duties;
- Exercising their duty of care to others, e.g. safeguarding, raising concerns and whistle-blowing;
- Treating colleagues, patients, carers and visitors with respect ensuring their privacy and dignity;
- Being honest and trustworthy; and
- Being co-operative and acting reasonably;

6.4 External Agencies

6.4.1 For more complex allegations or concerns, and any involving children, there are a number of external agencies that must be involved in accordance with statutory guidance. Three key roles who could potentially be involved are the Local Authority Designated Officer (LADO), the Local Authority Safeguarding Manager, and the Police safeguarding unit. Detailed guidance and support, in the event of any of these agencies needing to be involved, would be provided to the Director of Quality and Head of Safeguarding.

7 Procedure

PROCEDURES FOR MANAGING ALLEGATIONS

7.1 Allegations against people in positions of trust (PiPoT)

The Care Act 2014, Care and Support Statutory Guidance Chapter 14. sets out in paragraphs 14.120 – 14.132 the management responsibilities regarding allegations against people in positions of trust.

7.1.1 An allegation against staff should be considered when there is an allegation or concern that an employee may have:

- Behaved in a way that has or may have harmed a child and /or adult.
- Possibly committed a criminal offence against, or related to a child / adults (including domestic violence)
- Behaved in a way that indicates that s/he is unsuitable to work with children / adults.
- Been subject to a MARAC (Multi-Agency Risk Assessment Conference) as a perpetrator or MAPPA (Multi-Agency Public Protection Arrangements) process; or referred for the same.

This should not be considered an exhaustive list and in cases of doubt, advice MUST be sought from the Trust Head of Safeguarding/Deputy Director of Nursing and Quality or Executive Director of Nursing, Professions and Quality. This may include allegations which occur outside of the work place but which may have an impact upon a child or adult's well-being or safety (reference professional code of conduct).

7.1.2 All allegations of abuse made against a member of staff are treated with a "zero tolerance" approach. This position is taken to afford the alleged victim, either child or adult the maximum level of protection possible. It is not to be considered an assumption of guilt on the part of the alleged member of staff. The Trust recognises that it also has a duty of care to its staff but will respond to such allegations by investigating the allegation in a thorough and transparent manner and liaising where appropriate with other statutory agencies. The safety of our service users is paramount and we will use all resources at our disposal to safeguard them.

7.1.3 Allegations may be contemporary in nature, historical or both. Even where concerns are clearly historical, allegations may have implications for the safety of children or adults at present and should be responded to in accordance with this policy.

7.1.4 The policy acknowledges that historic allegations or concerns may be raised after a period of crisis and it may not be until the person is recovering, that they identify or want to share their concerns. Service Users should be assured that historic allegations will be listened to, and appropriate action taken.

7.1.5 This policy should be read alongside the SHSC Confidentiality Code of Conduct Policy and adopts the same Safe Haven Procedures: In this context a safe haven is a location situated within the Trust Safeguarding Team where arrangements and procedures are in place to ensure person-identifiable information can be held, received and communicated securely.

7.2 Allegation management Process

7.2.1 All allegations of abuse should be reported through existing line management structures. If this method is compromised for whatever reason, alternative management oversight should be sought (please see section e. **Who should I raise my concern with?** Of the Speaking Up - Freedom To Speak Up - Raising Concerns (Whistleblowing) Policy (2018). https://jarvis.shsc.nhs.uk/all-about-me/freedom-speak It is important that all staff raise their concerns through their line management or FTSU Guardian as we have a duty to safeguard our service users. Your details will remain anonymous if you choose to raise a concern through the FTSU Guardian. Staff have a duty of care and must share information when a disclosure or allegation is made that impacts the safety of our service users. Not doing so would contradict our values and behaviours.

7.2.2 Once an allegation is received by a line manager, appropriate further reporting processes within the directorate will be implemented; **all allegations of abuse or neglect of a service user by a member of staff must be directly verbally reported to the General Manager and the Head of Safeguarding in the first instance, the Deputy Director of Nursing will be informed as soon as the verbal allegation is received by the Head of Safeguarding.** In their absence this should be the Exec Director of Nursing, Professions and Quality. **If the allegation relates to professional conduct only, HR policies and procedures should be followed. If there is any uncertainty, this policy should be followed to ensure safeguarding oversight.**

7.2.3 A safeguarding concern form should be completed and sent to the Safeguarding Team following the SOP for Making a Safeguarding Referral. The Service Manager, General Manager or Matron should be notified of completion of the Safeguarding Concern.

7.2.4 Out of hours, a phone call should be made to the Director on Call who will support the line manager with immediate risk management and notifications. **The safeguarding concern should be submitted as per SOP for Making a Safeguarding Referral as soon as possible.**

7.2.5 The General Manager will ensure that the Head of Service is briefed as soon as possible in addition to the most appropriate Professional Lead (Head of Nursing, Psychology Lead, Clinical Director or Lead AHP). The Head of Safeguarding will brief the Deputy Director of Nursing and Quality or in the absence of the DDoN, will brief the Executive Director of Nursing, Professions and Quality

7.2.6 The Deputy Director of Nursing and Quality will brief the Executive Director of Nursing, Professions and Quality within the working day for all allegations made against staff.

Commented [SM2]: In their absence it should be me.

Commented [KDP3]: Do we need to add something here around allegations of abuse that meet the threshold for safeguarding? This is often where the confusion lies, AAS or conduct/HR route?

Commented [HL4]: Who is the most appropriate person to identify here?

Commented [KDP5]: We don't currently do this, should we take it out or start briefing Caroline?

7.2.7 An Initial Concerns Huddle will be arranged with the following staff as a minimum:

* Deputy Director of Nursing and Quality or Exec Director of Nursing, Professions & Quality
* Head of Safeguarding or Deputy
* Head of Nursing, Professional Lead or Deputy
* HR Advisor
* Matron
* Ward Manager or Deputy
* Service or General Manager

Additional members may include:

* HR Business Partner or Deputy
* Head of Service
* For serious allegations pertaining to sexual matters the Executive Director of Nursing, Professions and Quality must be alerted and may wish to attend.

Commented [HL6]: Heads of Nursing usually attend. Heads of Service are advised of the meeting and attend as necessary.

7.2.8 The concerns meeting will agree immediate safeguards to ensure the safety of the public, safety of people in the care of SHSC and safety of the potential victim/person making the allegation and the alleged perpetrator. This may include notifications and discussion with the LADO and/or PiPoT Leads in the MASH. Consideration should also be given to the severity of the disclosure and if the police should be notified or if advice should be sought via the professional telephone line for South Yorkshire Police. Roles and responsibilities will be allocated in the concerns meeting, with clear notes using the Initial Concerns Huddle Template (Appendix 9) Documentation will be stored securely in the Restricted section of the Safeguarding folders on data store.

7.2.9 The meeting members will agree an initial point of contact for the service user/victim who should provide an immediate update of actions being taken. However, the victim/service users should be given opportunity to choose their point of contact wherever possible. The agreed PoC should be invited to any subsequent meetings.

7.2.10 The service user/victim should be given an apology and the meeting members should consider the principles set out in the Duty of Candour and Being Open Policy. This may include a formal letter of acknowledgement and apology from the Exec. Director of Nursing, Professions and Quality or Dept. Director of Nursing and Quality in their absence.

7.2.11 The concerns meeting will discuss the process for informing the employee of any allegations. In cases where there is police involvement their advice must always be sought prior to contact with the alleged employee.

7.2.12 Subsequent meetings may be held following fact finding which should include relevant staff involved in the persons care.

7.2.13 The responsibility for informing the employee following discussion with relevant professionals' rests with the line management structure, supported and advised by the Human Resources Department.

7.2.14 In discussion between the Human Resources and Line Management where appropriate a member of staff will be appointed to provide support to the staff member concerned and act as a point of contact. The staff member should also be offered support from a Trade Union representative. If this support is declined, this should be recorded within

the practitioner's record; this is the responsibility of the line manager.

7.2.15 The Deputy Director of Nursing and/or Head of Safeguarding will ensure that a record of the allegation is documented in the form of a chronology and that the record is updated and completed on an on-going basis with the progress and outcome of any allegation investigation. This record will be used to alert all relevant personnel as to the allegation, and subsequent actions. Disclosure and Barring Service (DBS) or any regulatory body will not be informed until the investigation is concluded.

Commented [SM7]: Can we have a section on managing the allegation with the service user pls, this is the bit we don't do well, so we need a duty of candor section, formal letter of acknowledgement from me or in my absence the DDON&Q to confirm that we have raised a safeguarding. Also something about who follows up with patient and family

7.3 Necessity to Suspend / Exclude from Duty

7.3.1 In some cases, it will not be appropriate for a member of staff to remain in their current post whilst an investigation is being undertaken. After discussion and review of the circumstances, as an alternative to suspension, non-patient facing duties or transfer to an alternative work area or setting should always be considered. Alternative placement should be agreed by those in attendance at the Initial Concerns Huddle, including HR representative, and relevant General Managers. Should the discussion conclude that the person requires suspension, this should be discussed with the Executive Director of Nursing, Professions (or other Exec. Director) by the DDoN.

7.3.2 The decision to suspend can only be taken by the Executive Director of Nursing, Professions (or other Exec. Director) and the decision will be made in accordance with SHSC Disciplinary Procedures.

7.3.3 All procedures in relation to suspension and internal investigative processes are detailed within the Trust's Disciplinary Policy
https://jarvis.shsc.nhs.uk/documents/disciplinary-policy-hr-001-v42-september-2017

7.3.4 Where the allegation involves the member of staff's family, consideration must be given to the safety of the family members. The person leading the investigation in collaboration with the staff member's line manager and the safeguarding team should decide if the police or other statutory services need alerting if a staff member is suspended from duty.
Please also see the Disciplinary, Capability, Ill health and Appeals for Medical Practitioners Policy
https://jarvis.shsc.nhs.uk/system/files/2021-04/Disciplinary%20Capability%20Ill%20Health%20and%20Appeals%20for%20Medical%20Practitioners%20Policy%20%28MD%20001%20November%202018%29.pdf

7.4 Timescales for Reporting Allegations

All allegations are to be reported immediately in line with this policy.

7.4.1 If the allegation is received out of normal working hours, a decision will be taken, proportionate to the potential risk, as to whether there is need to take immediate remedial action (including removal from duty). This decision will be taken by the Director on Call.

7.4.2 If an allegation occurs out of hours, notification to those listed in 7.3.1 should occur as soon as possible the following working day.

7.5 Multi-Agency Actions

7.5.1 Following either a referral to the LADO (children) or Adult Social Care (adults) a Social Care strategy meeting will be convened at the earliest opportunity in order to generate a plan for investigation and to ensure relevant safeguards, where necessary, are implemented.

7.5.2 Strategy meetings in relation to staff will be attended by a Named Professional from the safeguarding team, and / or Deputy Director of Nursing and Quality (or their nominated deputy), a senior Human Resources representative and where relevant; the Head of Service for the relevant Directorate.

7.6 Criminal Investigations

7.6.1 All police / criminal investigations take precedence over other internal / external lines of enquiry. Where a police investigation is underway, a member of the Corporate Safeguarding team will act as point of contact with the police to request guidance/permission if the internal investigation processes can proceed.

Consideration may be given to the person continued employment based on their availability to work during that process. Where a police investigation may be lengthy, a member of the Corporate Safeguarding Team will liaise with the police for updates and progression of the case to assist HR in their discussions.

7.6.2 In the event that the investigation or referral to the LADO/Adult Safeguarding Manager generates a formal criminal investigation by the police, all other investigative action on the part of the Trust (Safeguarding, Conduct, Complaints), will be suspended until direction is received from the officer in charge of the investigation.

7.7 Record Keeping

7.7.1 Where allegations lead to HR processes, a clear and comprehensive summary of the case should be kept on the employee's confidential personnel file and s/he provided with a copy. The record must include details of how the allegation was investigated, the decisions reached and the action taken.

7.7.2 These records should be kept at least until the person retires, or for ten years if longer.

7.7.3 A summary of the Initial Concerns meeting and any subsequent discussions will be held securely in the Restricted Section of the Safeguarding folder.

7.8 Allegations Involving Non-Substantive Staff

7.8.1 All allegations of abuse made in respect of non-substantive staff, i.e. agency and bank workers, students or contractors will be managed with due regard for this policy.

7.8.2 Appropriate referrals to Adult or Children's Social Care will be enacted within the timeframes stipulated. No delay will be caused by reason of hierarchical or line management dispute.

7.8.3 In all cases where allegations are made in respect of non-substantive staff, the appropriate manager will notify the Bank and Agency Office. The relevant agency should be notified and request they complete relevant enquiries with the staff member. Consideration should be given to cancelling any shifts whilst fact finding is ongoing.

7.8.4 Agreement will be reached between appropriate HR Business Partner/Advisor in each organisation as to where the primacy of an investigation relating to conduct will rest. As with all investigations, a police / criminal line of enquiry will take precedence above all others.

7.8.5 Flow charts to highlight the required process where an allegation against staff arises are contained in the Appendices.

8.0 UNFOUNDED AND FALSE ALLEGATIONS

8.1 In the case that an allegation is demonstrably false, the Deputy Director of Nursing and Quality and relevant General manager will agree an appropriate course of action in relation to this. This discussion will include the Head of Safeguarding.

8.2 If there is evidence that the allegation has been deliberately invented, a view from the police will be required in relation to appropriate action. Once this has been obtained, the Deputy Director of Nursing and Quality and relevant General manager will decide whether it is appropriate to proceed under the Trust policy in relation to conduct and the Trust's Disciplinary policy should be followed. If the allegation was made by a service user a decision will be made by the Multi-Disciplinary Team working with the service user as to how this will be recorded within their records.

8.3 In the case of unfounded allegations, in order to protect the employee, a clear and comprehensive summary of the case should be recorded in the summary of fact finding and kept in the Restricted section of the Safeguarding folders and on the employee's confidential personnel file, and s/he will be provided with feedback and support by their manager. The record must include details of how the allegation was investigated, the decisions reached, and the action taken. Under discussion with the staff member, it will be agreed whether to store the investigation in their personal file or within secure folders of the safeguarding team.

8 Development, Consultation and Approval

The process of developing this policy has been led by an Independent Safeguarding Consultant and the Interim Head of Safeguarding.

Policy has been reviewed by (people)

- Executive Director of Nursing, Professions and Quality
- Heads of Service
- Heads of Nursing
- General Managers

Circulated to members of:

- Safeguarding Assurance Committee
- Quality Assurance Committee

See also Review/New Policy Checklist

Authors have consulted information available from adass - Directors of Adult Social Services

and Local Authority regarding function of the DASM. The Policy was adapted from the Camden and Islington NHS Foundation Trust's policy.

Dates for consultation and review are as per version control.

9 Audit, Monitoring and Review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Annual Audit of all reported incidents using the Flowcharts as assurance.	Audit	Corporate Safeguarding Team	Annual	Safeguarding Assurance Committee	Corporate Safeguarding Team	Quality Assurance Committee
The Corporate Safeguarding Team will produce quarterly reports regarding number of allegations and current enquiries.	Report	Head of Safeguarding	Quarterly	Safeguarding Assurance Committee	Corporate Safeguarding Team	Quality Assurance Committee

10 Implementation Plan

Objective	Task	Executive/ Associate Director Responsibility	Timescale and Progress
Dissemination, storage and archiving	Post on Trust intranet (Jarvis)		Within 1 week of ratification
Communication of updated policy to all staff	Notification on Jarvis and weekly SHSC communication		Within 1 week of ratification
Cascading of information to all staff	Senior Operational Managers to share with Team/Ward managers to ensure all staff have access to latest version of this policy.	General Managers and SOM's	Within 1 month of dissemination
Training and development	Ensure up to date information is available at induction for all new staff	Corporate Safeguarding Team	Within 1 month of dissemination

11 Dissemination, Storage and Archiving (Control)

The Trust will ensure that the policy is circulated to all relevant staff using the Trust Jarvis pages and is promoted via the Safeguarding Assurance Committee. Dissemination will take place via:

- Staff Induction
- Safeguarding Training
- Trust Intranet (Jarvis)
- Learning Lessons Hub
- Strategic Development Group

12 Training and Other Resource Implications

12.1 In order to meet its obligations the Trust has made training of all staff in adult and child safeguarding mandatory at the required level, to be undertaken a minimum of three-yearly basis (dependent upon role and in line with the NHS Intercollegiate Guidance safeguarding competency pathway as set out by the intercollegiate document guidance):

- Basic training with respect to awareness that abuse can take place and the duty to report.
- Training on recognition of abuse and responsibilities with respect to both Trust and Multi-Agency procedures.

12.2 It is the Trust's expectation that all staff access safeguarding training in accordance with their roles and responsibilities. The training will include sections on the sharing of information and confidentiality in line with national and local protocols. Additional Trust training will also focus on record keeping; promoting the keeping of clear, accessible, comprehensive and contemporaneous records that are in line with national and local protocols.

12.3 The Trust's Electronic Staff Record maintains a record of all children and adult safeguarding training delivered, with reference to appropriate levels achieved.

12.4 The Trust accesses and contributes to the Local Safeguarding Board Partnership training pool, in delivery and receipt of advanced and / or specialist training.

12.5 Further detail in relation to available safeguarding training, levels and competencies can be found in the Safeguarding Training Strategy, which is available on the Trust Intranet.

13 Links to Other Policies, Standards (Associated Documents)

Sheffield Safeguarding Children and Child Protection Procedures

https://www.sheffieldasp.org.uk/sasp/sasp/policy-and-procedures/south-yorkshire-adult- safeguarding-procedures

https://www.sheffieldasp.org.uk/sasp/sasp/policy-and-procedures/pipot-procedure

https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf

SHSCFT Domestic Abuse Policy SHSCFT Human Resource Policies SHSCFT Consent Policy
SHSCFT Incident Reporting Policy SHSCFT Supervision Policy
SHSCFT Safeguarding Children Policy
SHSCFT Safeguarding Adults and Prevent Policy
SHSCFT Raising Concerns at Work (Whistle Blowing) Policy SHSCFT Access to Care Records Policy
SHSCFT PROFESSIONAL BOUNDARIES Policy
SHSCFT Being Open and Duty of Candour Policy SHSCFT Confidentiality and Information Sharing Policy

14 Contact Details

Title	*Name*	*Phone*	*Email*
Deputy Director of Nursing and Quality	Vanessa Garrity		Vanessa.Garrity@shsc.nhs.uk
Executive Director of Nursing, Professions and Quality	Salli Midgley		Salli.midgley@shsc.nhs.uk
Head of Safeguarding	Hester Litten		Hester.litten@shsc.nhs.uk
Safeguarding Team Administrator SHSC		271 6937	
Named Doctor for Safeguarding	Helen Crimlisk	275 0719	Helen.crimlisk@shsc.nhs.uk

Appendix 1

https://www.sheffieldasp.org.uk/sasp/sasp/policy-and-procedures/pipot-procedure

Sheffield Adult Safeguarding Partnership

Sheffield Adult Safeguarding Partnership

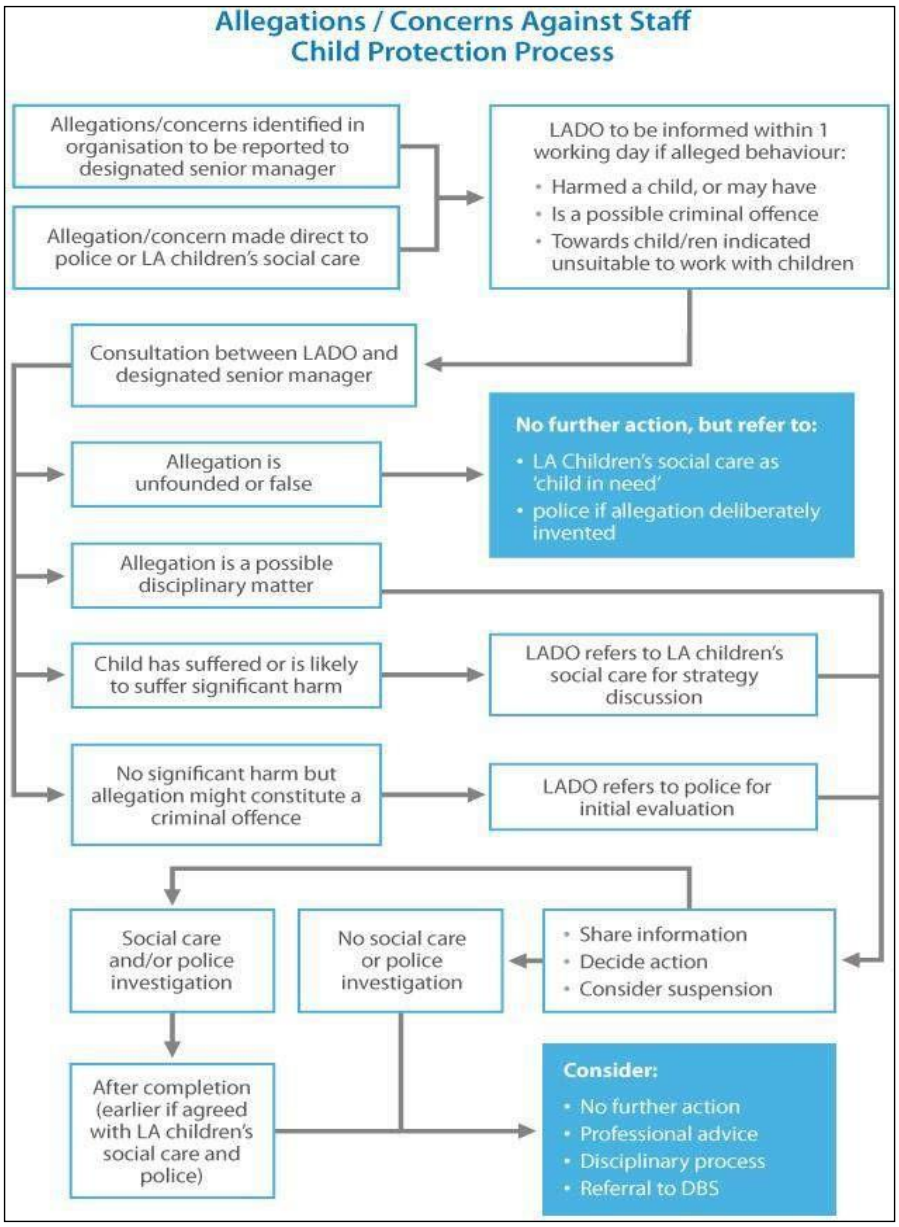
Managing Allegations Against People in a Position of Trust (PiPoT) Protocol

Document Control

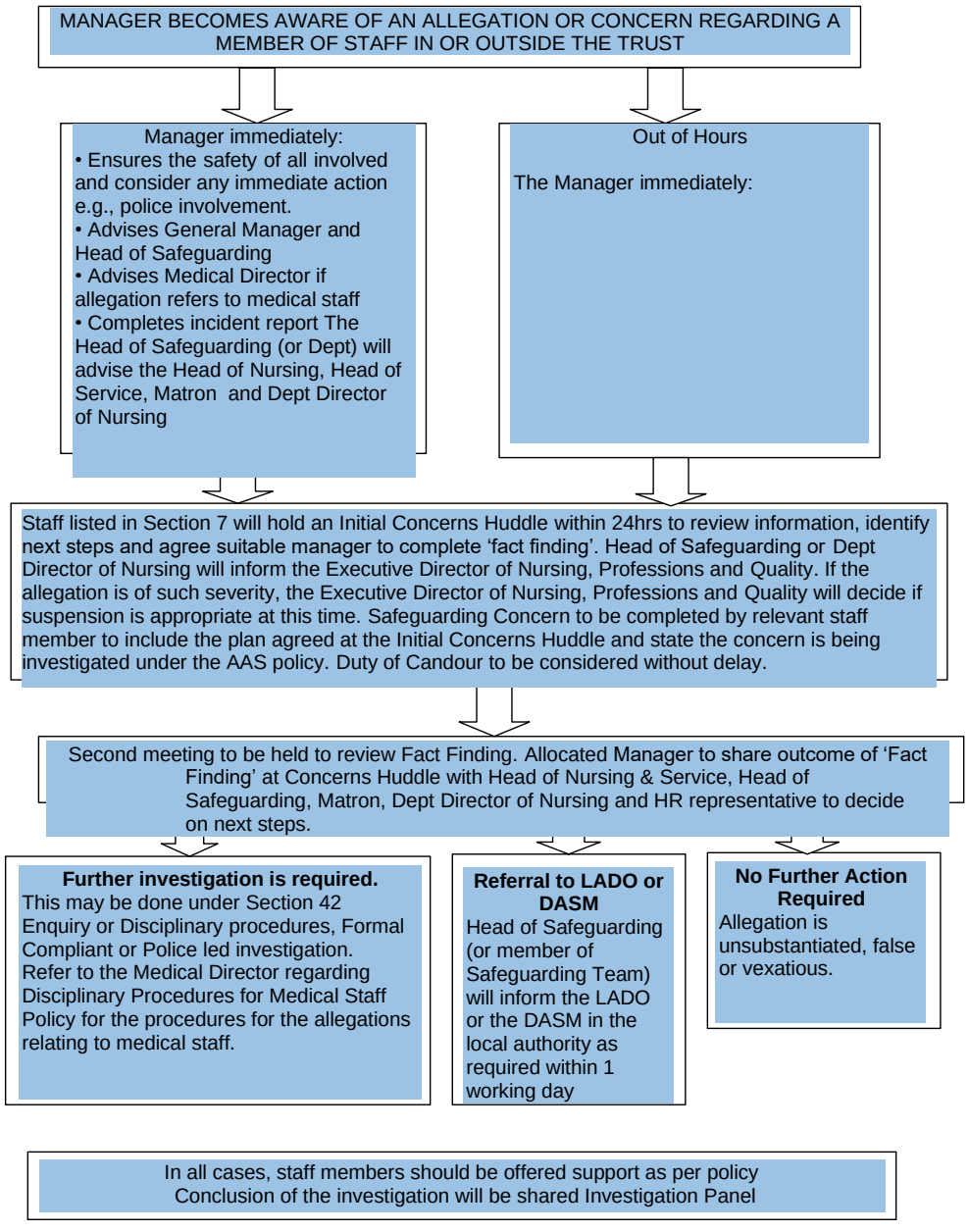
Author	Stuart James (Partnership Manager)	
Contributors	Jeanette Mundy	
Version	0.2	
Date of Production	23 February 2018	
Review Date	February 2019	
Responsibility for Review	SASP City Wide Best Practice Sub Group	
Primary Circulation List	Sheffield Safeguarding Adults Partnership	
Sign Off	Safeguarding Adults Board	
Date	Version	Comments
23rd February 2018	0.1	Draft for Operational Board for Comments.
16th March 2018	0.2	Final Version for sign off at Executive Board

1

Appendix 2


Allegations / Concerns Against Staff
Child Protection Process
Allegations/concerns identified in organisation to be reported to designated senior manager
Allegation/concern made direct to police or LA children's social care
LADO to be informed within 1 working day if alleged behaviour:
• Harmed a child, or may have
• Is a possible criminal offence
• Towards child/ren indicated unsuitable to work with children
Consultation between LADO and designated senior manager
Allegation is unfounded or false
No further action, but refer to:
• LA Children's social care as 'child in need'
• police if allegation deliberately invented
Allegation is a possible disciplinary matter
Child has suffered or is likely to suffer significant harm
LADO refers to LA children's social care for strategy discussion
No significant harm but allegation might constitute a criminal offence
LADO refers to police for initial evaluation
Social care and/or police investigation
No social care or police investigation
• Share information
• Decide action
• Consider suspension
After completion (earlier if agreed with LA children's social care and police)
Consider:
• No further action
• Professional advice
• Disciplinary process
• Referral to DBS

Appendix 3 Flowchart for the Management of Safeguarding Allegations in Relation to Adults and Children



Appendix 4

Care Act 2014 Care and Support Statutory Guidance Chapter 14

Responding to abuse and neglect in a regulated care setting

14.68 It is important that all partners are clear where responsibility lies where abuse or neglect is carried out by employees or in a regulated setting, such as a care home, hospital, or college. The first responsibility to act must be with the employing organisation as provider of the service. However, social workers or counsellors may need to be involved in order to support the adult to recover.

14.69 When an employer is aware of abuse or neglect in their organisation, then they are under a duty to correct this and protect the adult from harm as soon as possible and inform the local authority, CQC and CCG where the latter is the commissioner. Where a local authority has reasonable cause to suspect that an adult may be experiencing or at risk of abuse or neglect, then it is still under a duty to make (or cause to be made) whatever enquiries it thinks necessary to decide what if any action needs to be taken and by whom. The local authority may well be reassured by the employer's response so that no further action is required. However, a local authority would have to satisfy itself that an employer's response has been sufficient to deal with the safeguarding issue and, if not, to undertake any enquiry of its own and any appropriate follow up action (e.g. referral to CQC, professional regulators).

14.70 The employer should investigate any concern (and provide any additional support that the adult may need) unless there is compelling reason why it is inappropriate or unsafe to do this. For example, this could be a serious conflict of interest on the part of the employer, concerns having been raised about non-effective past enquiries or serious, multiple concerns, or a matter that requires investigation by the police.

14.71 An example of a conflict of interest where it is better for an external person to be appointed to investigate may be the case of a family-run business where institutional abuse is alleged, or where the manager or owner of the service is implicated. The circumstances where an external person would be required should be set out in the local multi-agency procedures. All those carrying out such enquiries should have received appropriate training.

14.72 There should be a clear understanding between partners at a local level when other agencies such as the local authority, CQC or CCG need to be notified or involved and what role they have. ADASS, CQC, LGA, NPCC (formerly ACPO) and NHS England have jointly produced a high level guide on these roles and responsibilities. The focus should be on promoting the wellbeing of those adults at risk.

14.73 Commissioners of care or other professionals should only use safeguarding procedures in a way that reflects the principles above not as a means of intimidating providers or families. Transparency, open-mindedness and timeliness are important features of fair and effective safeguarding enquiries. CQC and commissioners have alternative means of raising standards of service, including support for staff training, contract compliance and, in the case of CQC; enforcement powers may be used.

14.74 Commissioners should encourage an open culture around safeguarding, working in partnership with providers to ensure the best outcome for the adult. A disciplinary investigation, and potentially a hearing, may result in the employer taking informal or formal measures which may include dismissal and possibly referral to the Disclosure and Barring Service.

14.75 If someone is removed by being either dismissed or redeployed to a non-regulated activity, from their role providing regulated activity following a safeguarding incident, or a person leaves their role (resignation, retirement) to avoid a disciplinary hearing following a safeguarding incident and the employer/volunteer organisation feels they would have dismissed the person based on the information they hold, the regulated activity provider has a legal duty to refer to the Disclosure and Barring Service. If an agency or personnel supplier has provided the person, then the legal duty sits with that agency. In circumstances where these actions are not undertaken then the local authority can make such a referral.

Person alleged to be responsible for abuse or neglect

14.112 When a complaint or allegation has been made against a member of staff, including people employed by the adult, they should be made aware of their rights under employment legislation and any internal disciplinary procedures.

14.113 Where the person who is alleged to have carried out the abuse themselves has care and support needs and is unable to understand the significance of questions put to them or their replies, they should be assured of their right to the support of an 'appropriate' adult if they are questioned in relation to a suspected crime by the police under the Police and Criminal Evidence Act 1984 (PACE). Victims of crime and witnesses may also require the support of an 'appropriate' adult. Read government policy documents about helping victims of crime.

14.114 Under the MCA, people who lack capacity and are alleged to be responsible for abuse, are entitled to the help of an Independent Mental Capacity Advocate, to support and represent them in the enquiries that are taking place. This is separate from the decision whether or not to provide the victim of abuse with an independent advocate under the Care Act.

14.115 The Police and Crown Prosecution Service (CPS) should agree procedures with the local authority, care providers, housing providers, and the NHS/CCG to cover the following situations:

- action pending the outcome of the police and the employer's investigations
- action following a decision to prosecute an individual
- action following a decision not to prosecute
- action pending trial
- responses to both acquittal and conviction

14.116 Employers who are also providers or commissioners of care and support not only have a duty to the adult, but also a responsibility to take action in relation to the employee when allegations of abuse are made against them. Employers should ensure that their disciplinary procedures are compatible with the responsibility to protect adults at risk of abuse or neglect.

14.117 With regard to abuse, neglect and misconduct within a professional relationship, codes of professional conduct and/or employment contracts should be followed and should determine the action that can be taken. Robust employment practices, with checkable references and recent DBS checks are important. Reports of abuse, neglect and misconduct should be investigated and evidence collected.

14.118 Where appropriate, employers should report workers to the statutory and other bodies responsible for professional regulation such as the General Medical Council and the Nursing and Midwifery Council. If someone is removed from their role providing regulated activity following a safeguarding incident the regulated activity provider (or if the person has been provided by an agency or personnel supplier, the legal duty sits with them) has a legal duty to refer to the Disclosure and Barring Service. The legal duty to refer to the Disclosure and Barring Service also applies where a person leaves their role to avoid a disciplinary hearing following a safeguarding incident and the employer/volunteer organisation feels they would have dismissed the person based on the information they hold.

14.119 The standard of proof for prosecution is 'beyond reasonable doubt'. The standard of proof for internal disciplinary procedures and for discretionary barring consideration by the Disclosure and Barring Service (DBS) and the Vetting and Barring Board is usually the civil standard of 'on the balance of probabilities'. This means that when criminal procedures are concluded without action being taken this does not automatically mean that regulatory or disciplinary procedures should cease or not be considered. In any event there is a legal duty to make a safeguarding referral to DBS if a person is dismissed or removed from their role due to harm to a child or a vulnerable adult.

Allegations against people in positions of trust

14.120 The local authority's relevant partners, as set out in section 6(7) of the Care Act, and those providing universal care and support services, should have clear policies in line with those from the safeguarding adults board for dealing with allegations against people who work, in either a paid or unpaid capacity, with adults with care and support needs. Such policies should make a clear distinction between an allegation, a concern about the quality of care or practice or a complaint.

14.121 Safeguarding adults boards need to establish and agree a framework and process for how allegations against people working with adults with care and support needs (i.e. those in positions of trust) should be notified and responded to. Whilst the focus of safeguarding adults work is to safeguard one or more identified adults with care and support needs, there are occasions when incidents are reported that do not involve an adult at risk, but indicate, nevertheless, that a risk may be posed to adults at risk by a person in a position of trust.

14.122 Where such concerns are raised about someone who works with adults with care and support needs, it will be necessary for the employer (or student body or voluntary organisation) to assess any potential risk to adults with care and support needs who use their services, and, if necessary, to take action to safeguard those adults.

14.123 Examples of such concerns could include allegations that relate to a person who works with adults with care and support needs who has:

- behaved in a way that has harmed, or may have harmed an adult or child;
- possibly committed a criminal offence against, or related to, an adult or child;
- behaved towards an adult or child in a way that indicates they may pose a risk of harm to adults with care and support needs.

14.124 When a person's conduct towards an adult may impact on their suitability to work with or continue to work with children, this must be referred to the local authority's designated officer.

14.125 If a local authority is given information about such concerns they should give careful consideration to what information should be shared with employers (or student body or voluntary organisation) to enable risk assessment.

14.126 Employers, student bodies and voluntary organisations should have clear procedures in place setting out the process, including timescales, for investigation and what support and advice will be available to individuals against whom allegations have been made. Any allegation against people who work with adults should be reported immediately to a senior manager within the organisation. Employers, student bodies and voluntary organisations should have their own sources of advice (including legal advice) in place for dealing with such concerns.

14.127 If an organisation removes an individual (paid worker or unpaid volunteer) from work with an adult with care and support needs (or would have, had the person not left first) because the person poses a risk of harm to adults, the organisation must make a referral to the Disclosure and Barring Service. It is an offence to fail to make a referral without good reason.

14.128 Allegations against people who work with adults at risk must not be dealt with in isolation. Any corresponding action necessary to address the welfare of adults with care and support needs should be taken without delay and in a coordinated manner, to prevent the need for further safeguarding in future.

14.129 Local authorities should ensure that their safeguarding information and advice services are clear about the responsibilities of employers, student bodies and voluntary organisations, in such cases, and signpost them to their own procedures and legal advice appropriately. Information and advice services should also be equipped to advise on appropriate information sharing and the duty to cooperate under Section 6 of the Care Act.

14.130 Local authorities should ensure that there are appropriate arrangements in place to effectively liaise with the police and other agencies to monitor the progress of cases and ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.

14.131 Decisions on sharing information must be justifiable and proportionate, based on the potential or actual harm to adults or children at risk and the rationale for decision-making should always be recorded.

14.132 When sharing information about adults, children and young people at risk between agencies it should only be shared: - where relevant and necessary, not simply all the information held
- with the relevant people who need all or some of the information
- when there is a specific need for the information to be shared at that time

Appendix 5
Outcome Definitions

Advice/guidance	This applies where the person against whom the allegation/concern was made requires. advice/guidance/training in recognition of a need for a change of behaviour/approach.
Disciplinary Procedures	This would be where the Trust has considered the allegation under the terms of their own internal disciplinary investigation.
False	There is sufficient evidence to disprove the allegation.
Malicious	There is clear evidence to prove there has been a deliberate act to deceive and the allegation is entirely false.
No further action after initial consideration	Initial consideration means the discussion about whether the alleged incident constitutes an allegation within the scope of the LSCB's procedures, i.e. the initial discussion with the LADO, Social Care or the Police following which there may be no need for further action under the safeguarding procedures.
Substantiated	There is sufficient identifiable evidence to prove the allegation.
Suspension	In certain circumstances, it may be appropriate to suspend an employee where the alleged offence is of a nature such that continuing attendance at the premises of the Trust or continuation of the responsibilities of the employee is not appropriate in line with the Disciplinary Procedure. The circumstances, which may justify suspension, include the following:
Unfounded	There is no evidence or proper basis which supports the allegation being made. It might also indicate that the person making the allegation misinterpreted the incident or was mistaken about what they say. Alternatively they may have not have been aware of all the circumstances.
Unsubstantiated	This is not the same as a false allegation. It means that there is insufficient evidence to prove or disprove the allegation. The term, therefore, does not imply guilt or innocence.
Warning within disciplinary procedures	This applies where a case has been found and the person against whom the allegation/concern has been made is formally warned as part of the Trust's disciplinary procedures.

Dismissal from service	Following the SHSC Disciplinary policy and procedures, a panel may decide that on the balance of probability the allegation is substantiated and is of such a serious nature that a staff member is not suitable to remain in post and may be dismissed from their employment in SHSC.

Appendix 6

Sheffield Adult Safeguarding Partnership - (sheffieldasp.org.uk)

Sheffield Children Safeguarding Partnership Child Protection and Safeguarding Procedures Manual (proceduresonline.com)

Appendix 7

National Data Guardian
for health and social care

The Eight Caldicott Principles

Good information sharing is essential for providing safe and effective care. There are also important uses of information for purposes other than individual care, which contribute to the overall delivery of health and social care or serve wider public interests.
These principles apply to the use of confidential information within health and social care organisations and when such information is shared with other organisations and between individuals, both for individual care and for other purposes.
The principles are intended to apply to all data collected for the provision of health and social care services where patients and service users can be identified and would expect that it will be kept private. This may include for instance, details about symptoms, diagnosis, treatment, names and addresses.
In some instances, the principles should also be applied to the processing of staff information. They are primarily intended to guide organisations and their staff, but it should be remembered that patients, service users and/or their representatives should be included as active partners in the use of confidential information. Where a novel and/or difficult judgment or decision is required, it is advisable to involve a Caldicott Guardian.

Principle 1: Justify the purpose(s) for using confidential information

Every proposed use or transfer of confidential information should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed by an appropriate guardian.

Principle 2: Use confidential information only when it is necessary

Confidential information should not be included unless it is necessary for the specified purpose(s) for which the information is used or accessed. The need to identify individuals should be considered at each stage of satisfying the purpose(s) and alternatives used where possible.

Principle 3: Use the minimum necessary confidential information

Where use of confidential information is considered to be necessary,

each item of information must be justified so that only the minimum amount of confidential information is included as necessary for a given function.

Principle 4: Access to confidential information should be on a strict need-to-know basis Only those who need access to confidential information should have access to it, and then only to the items that they need to see. This may mean introducing access controls or splitting information flows where one flow is used for several purposes.

Principle 5: Everyone with access to confidential information should be aware of their responsibilities Action should be taken to ensure that all those handling confidential information understand their responsibilities and obligations to respect the confidentiality of patient and service users.

Principle 6: Comply with the law Every use of confidential information must be lawful. All those handling confidential information are responsible for ensuring that their use of and access to that information complies with legal requirements set out in statute and under the common law.

Principle 7: The duty to share information for individual care is as important as the duty to protect patient confidentiality Health and social care professionals should have the confidence to share confidential information in the best interests of patients and service users within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

Principle 8: Inform patients and service users about how their confidential information is used A range of steps should be taken to ensure no surprises for patients and service users, so they can have clear expectations about how and why their confidential information is used, and what choices they have about this. These steps will vary depending on the use: as a minimum, this should include providing accessible, relevant and appropriate information - in some cases, greater engagement will

be required.

Published December 2020

Appendix 9

Allegations Against Staff (AAS) Initial Concerns Huddle Template

Staff allegation:

Date of Initial Concerns Huddle:

Attendees:

Summary of Concerns

Things to consider: *Does the allegation relate to Crisis or OOH services? Consider safe contact for the service user and if a dedicated person can be identified to avoid duplication and reduce sharing of sensitive information. Ensure safeguarding concern is tagged as an 'Alert' to ensure colleagues are aware of a recent concern.*

Does the allegation need to be reported to the Police or consider using the SYP professionals line for advice.

Actions from meeting

Actions	Owner	Update

Equality Impact Assessment Process and Record for Written Policies

Stage 1 – Relevance - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? This should be considered as part of the Case of Need for new policies.

NO – No further action is required – please sign and date the following statement.

I confirm that this policy does not impact on staff, patients or the public.

I confirm that this policy does not impact on staff, patients or the public.

Name/Date: Hester Litten, 22/04/2024

Stage 2 Policy Screening and Drafting Policy - Public authorities are legally required to have 'due regard' to eliminating discrimination, advancing equal opportunity and fostering good relations in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance and Flow Chart.

Stage 3 – **Policy Revision** - Make amendments to the policy or identify any remedial action required and record any action planned in the policy implementation plan section

The Policy acknowledges that persons may make unfounded allegations based on a person's protected characteristics. The policy seeks to support staff from the point of initial allegation and ensure fact finding is a swift process to avoid any undue distress. The policy reminds staff of SHSC zero tolerance of any kind of unacceptable behaviour, bullying or harassment in line with our values and behaviours.

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	**No**		
Disability	**No**		
Gender Reassignment	**No**		
Pregnancy and Maternity	**No**		
Race	**No**		
Religion or Belief	**No**		

Sex	**No**		
Sexual Orientation	**No**		
Marriage or Civil Partnership	**No**	[redacted]	

Please delete as appropriate: - Policy Amended / Action Identified (see Implementation Plan) / no changes made.

Impact Assessment Completed by:
Hester Litten

Date 22/4/2024

Appendix B

Review/New Policy Checklist

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

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

20.	Is there a plan to i. review ii. audit compliance with the document?	Yes

21.	Is the review date identified, and is it appropriate and justifiable?	Yes