Essex Partnership University
NHS Foundation Trust

APPENDIX 4: RESPONDING TO DOMESTIC ABUSE and DOMESTIC INCIDENT REPORTS

PROCEDURE REFERENCE NUMBER	CLPG37
VERSION NUMBER	[3]
KEY CHANGES FROM PREVIOUS VERSION	Updated to include changes from the Domestic Abuse Act and new guidance issued
AUTHOR	Gill Parker, Project Lead for Safeguarding
CONSULTATION GROUPS	Safeguarding Team, Mental Health Act and Safeguarding Committee
IMPLEMENTATION DATE	
AMENDMENT DATE(S)	May 2023
LAST REVIEW DATE	May 2023
NEXT REVIEW DATE	May 2026
MENTAL HEALTH & SAFEGUARDING SUB-COMMITTEE APPROVAL:	2nd May 2023 [Chair's Action]
RATIFICATION BY POLICY OVERSIGHT AND RATIFICATION GROUP	9 May 2023
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PROCEDURE SUMMARY

This procedure provides guidance to staff when working with service users experiencing Domestic Abuse and explains the process of managing Domestic Incident reports from the Police.

The Trust monitors the implementation of and compliance with this procedure in the following ways:

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this procedure is Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

APPENDIX 4: RESPONDING TO DOMESTIC ABUSE and DOMESTIC INCIDENT REPORTS

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

APPENDIX 4: RESPONDING TO DOMESTIC ABUSE and DOMESTIC INCIDENT REPORTS

Assurance Statement

Equality and Diversity Statement

The Trust is committed to ensuring that equality, diversity, and inclusion is considered in our decisions, actions and processes. The Trust and all trust staff have a responsibility to ensure that they adhere to the Trust principles of equality, diversity, and inclusion in all activities. In drawing up this policy all aspects of equality, diversity, and inclusion have been considered to ensure that it does not disproportionately impact any individuals who have a protected characteristic as defined by the Equality Act 2010

1.0 INTRODUCTION

1.1 This procedure offers guidance on Domestic Abuse, which includes

- Coercive control
- Honour Based Abuse
- Forced Marriage

Staff should read this guidance alongside the Local Safeguarding Partnership Child Protection procedures for the area they are working in when managing a case where there are concerns for these forms of potential child abuse.

1.2 The Domestic Abuse Act 2021 defines domestic abuse as:
"When both parties are aged 16 or over and are personally connected to each other and the behaviour is abusive, if it consists of any of the following":

- Physical or sexual abuse
- Violent or threatening behaviour
- Controlling or coercive behaviour
- Economic abuse
- Psychological, emotional or other abuse

1.3 The offence of Coercive Control came into force in England and Wales in December 2015.

- Coercive behaviour, is an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim
- Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

1.4 All the outcomes for children can be adversely affected for a child living with domestic abuse - the impact is usually on every aspect of a child's life. The impact of domestic abuse on a child will vary according to the child's resilience factors and their ability to respond to their particular circumstances.

1.5 Prolonged and/ or regular exposure to domestic abuse can have a serious impact on children's safety and welfare, despite the best efforts of parents to protect them. An exploration of the possible impact on the unborn child shows the foetus is at risk of injury because violence towards women increases in both severity and frequency during pregnancy, and often involves punches or kicks directed at the women's abdomen.

1.6 Both men (1:7, 2020) and women (1:4, 2020) can be victims of domestic abuse though a greater proportion of women experience all forms of domestic abuse and are more likely to be seriously injured or killed (274, 2020) by a male. (96%) Reported in the same year 83 men were killed because of domestic homicide and in 53% of those cases, the perpetrator was a male. Women are more likely to experience repeat victimisation, be physically injured or killed because of domestic abuse and experience non-physical abuse including emotional and financial abuse than men.

1.7 In April 2011 Domestic Homicide Reviews (DHRs) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). A DHR review means a review of the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- A member of the same household as him/herself,

The purpose of a DHR will be to identifying the lessons to be learnt from the death and Trust Staff involved the service user will be required to discuss the case with the identified member of staff conducting an Individual Management Review. Further guidance on the procedure for DHR is available in the Trust Safeguarding Adult Procedure CLPG39 Appendix 3.

1.8 Domestic incident reports (see section 4) produced by the police are distributed to appropriate Community and Mental Healthcare teams in the Trust when an incident occurs involving a family or service user where children are likely to or known to be present. The Trust has different processes in place for responding to Domestic Incidents in accordance to the local police departments arrangements. Staff should follow the general process in section 4 but be aware of specific process for their areas of work. Staff should contact their Safeguarding Named clinician for advice if they are unclear or access the Safeguarding Intranet site

1.9 Staff should be able to recognise indicators of harm and child abuse and know how to respond to domestic abuse to safeguard children and the victim. When domestic abuse is identified staff should:

- Focus on the victim's safety and that of their children.
- Share relevant information and refer if required to relevant agencies e.g.GP, Social Care.
- Support and reassure the victim.

1.10 When talking to an individual about domestic abuse staff should never:

- Discuss the situation or potential risk when another person is present.
- Promise confidentiality if there are children in the family.
- Accept culture as an excuse for domestic abuse.
- Force the victim to make a disclosure.
- Encourage them to immediately leave the family home.

1.11 If a referral to social care is required staff should inform the parent, unless it is felt that this may cause additional risk of harm to the victim or a child. Where there is evidence of domestic abuse, the implications for any children in the household must be considered and a referral to Children's Social Care must be made where staff are aware of;

- A child's direct involvement with a domestic abuse incident or injury;
- A victim who is a woman and is pregnant. Pregnant women frequently experience punches and kicks directed at the abdomen, risking injury to both mother and foetus;
- Any child that is injured during episodes of violence or is witnessing the physical and emotional suffering of a parent.

1.12 Where an interpreter is required, never use a family member as in cases of honour based violence there is a high likelihood that this will increase the risk of serious harm to the victim and children.

1.13 Where there are no Safeguarding children concerns and the person requests that no further action should be taken regarding domestic abuse then staff must

- Decide if the person has capacity to make an unwise decision.
- Consider risks to others including other family members.
- Advise on support services available.

1.14 Victims of Domestic Abuse may remain with an abusive partner for many years whilst suffering abuse without considering leaving or sometimes not recognising that they are living within an abusive relationship. Staff must consider the welfare of any child or another adult where there are additional areas associated with domestic abuse, including those below.

2.0 PROCESS AND TYPES OF DOMESTIC ABUSE

2.1 Honour Bases Abuse

2.1.1 Honour based abuse is 'an incident or crime involving violence, threats of violence, intimidation, coercion or abuse (including psychological, physical, sexual, financial or emotional abuse) , which has or may been committed to protect or defend the honour of an individual, family and or community for alleged or perceived breaches of the family and/or community's code of behaviour'. (The National Police Chiefs Council, 2015)

2.1.2 Honour based violence and abuse can take many forms:

- threatening behaviour
- assault
- rape
- kidnap
- abduction
- forced abortion
- threats to kill
- false imprisonment committed due to so called 'honour'

2.1.3 The most extreme consequence of honour based violence is the death of a service user or family member in which they are killed for perceived immoral behaviour, which is deemed to have breached the honour code of a family or community, causing shame.

2.1.4 Staff should respond to concerns for honour based abuse in the same way they would for service users subject to domestic abuse by facilitating disclosure, developing individual safety plans, ensuring the child's safety by according them confidentiality in relation to the rest of the family and completing individual risk assessments.

2.1.5 A child who is at risk of honour based abuse is at significant risk of physical harm (including being murdered) and/or neglect, and may also suffer significant emotional harm through the threat of violence or witnessing violence directed towards a sibling or other family member.

2.1.6 The behaviours that are perceived to have been immoral and having breached the honour code can be:

- Inappropriate make-up or dress
- The existence of a boyfriend or a perceived unsuitable relationship (gay/lesbian relationship)
- Kissing or intimacy in a public place
- Rejecting a forced marriage
- Sexual activity outside of marriage
- Pregnancy outside of marriage
- Being a victim of rape Inter-faith relationships (or same faith, but different ethnicity)
- Leaving a spouse or seeking divorce.
- Alcohol and/or substance use/misuse

2.1.7 When receiving a disclosure from a child, staff need to recognise the seriousness/immediacy of the risk of harm as there may be only the one opportunity to intervene. A child reporting to staff that they have fears of honour based abuse in respect of themselves or a family member requires a lot of courage, and staff must respond appropriately by making a referral to Social Care or if imminent danger call the police. Specifically, under no circumstances should staff allow the child's family or social network to find out about the disclosure, so as not to put the child at further risk of harm. Members of the local community are not used for interpretation.

2.1.8 When recording the incident staff should make an accurate, detailed, clear account and include the date, child’s own words in quotation marks, document any injuries including body maps. The records should only be available to those directly involved in the person’s case to protect their confidentiality.

2.2 Forced Marriage

2.2.1 A forced marriage, as distinct from a consensual 'arranged' one, is a marriage conducted without the full informed consent of both parties and where capacity to consent and where duress is a factor. Duress is not justifiable on religious or cultural grounds.

2.2.2 In 2021 the government updated the definition of domestic abuse and consequently forced marriage now come under this definition. In June 2014, it became a criminal offence to force someone to marry. A child forced into marriage is at risk of significant harm from physical, sexual and emotional abuse.

2.2.3 Some forced marriages take place in the UK with no overseas element, while others involve a partner coming from overseas or a British national taken abroad. The reasons given by parents who force their children to marry include protecting their

children, building stronger families, strengthening family links, protecting family honour, retaining or acquiring wealth or appeasement.

2.2.4 The warning signs staff should be alert to include:

- Family history of an older sibling leaving the country suddenly without returning or marrying early.
- Anxiety, depression or emotionally withdrawn. This may present as self-harm or attempted suicide
- Absence from school or other regular activity.
- Fear of forthcoming visits to their country of origin.
- A child going missing/running away.
- A child being in conflict with their parents
- A child being accompanied to all appointments and settings
- A child talking about an upcoming family holiday they are worried about.
- Surveillance or restrictions by family members- house arrest.
- A child directly disclosing that they are worried s/he will be forced to marry.

2.2.5 Staff suspecting Forced Marriage should contact Social Care and the Trust Safeguarding Team immediately. They should not approach or discuss with the family. Staff should follow the same guidance as indicated for Honour Based abuse in relation to record keeping and seeing the child alone. Staff should assist with facilitating a disclosure, developing individual safety plans, and ensuring the child's safety by according them confidentiality in relation to the rest of the family, completing individual risk assessments.

2.3 Domestic Abuse Notifications (DAN)

2.3.1 There are separate domestic abuse standard operating procedures within Community Health Services that relate to the process for Domestic Abuse Notifications (DAN). The police send DAN electronically to Trust Safeguarding Teams via secure NHS mail account. Some are also sent to Children's Social Care.

2.3.2 A copy of the DAN will be distributed to the named professional within Universal Services who must ensure the information is assessed against the child or parent records and an action plan developed if required. A copy should be filed within the child or adults record where appropriate and in accordance to local protocol.

2.3.3 All DAN received involving pregnant women are sent to the relevant midwife or hospital as per the protocol for Information sharing in respect of domestic abuse involving a woman in the antenatal period.

2.3.4 Staff receiving DAN will discuss with other relevant staff in order to safeguard the unborn or other relevant children or adults. A discussion with GP and relevant mental health professional should take place to share information and establish if there are any additional concerns.

2.3.5 Community Health Practitioners will prioritise the actions they take based on

- The number of incidents.
- There is a current or previous child protection plan.
- The police have identified the incident risk as high or very high.
- The child is subject to a child in need plan.
- Pregnancy.
- Knowledge of the family and any previous concerns.

2.3.6 Some DAN's are notified to social care by the police however, staff should not assume that Social Care I have all information regarding the child or family. If a DAN is received for the criteria above then staff should contact Social Care to establish any action to be taken by all involved professionals.

2.3.7 Caseload holders must record all incidents using the appropriate forms (e.g. Chronology of Events /selective intervention template) used by teams. This must include the nature of the incident, the assessment of its impact on the child or young person and the resulting action plan.

2.3.8 Where a DAN is received and a school child attends a school out of area then the Safeguarding Team will forward the DAN to their counterpart team in the relevant area.

2.3.9 When a DAN is received and the parent/child is not registered with a GP then the relevant professional should be notified in the geographical area that the child/parent is resident.

2.3.10 The Safeguarding Children team will provide supervision on cases where the practitioner has concerns for the impact of the domestic abuse on the child or young person.

2.4 Domestic Abuse Stalking & Harassment (DASH) Risk Assessment & Multi Agency Risk Assessment Conference (MARAC)

2.4.1 Where staff have concerns regarding a victims safety following the receipt of a domestic abuse notification a DASH risk assessment tool can be used to help aid a discussion between staff and victim and assess the level of risk to victim and any others including children. The DASH risk assessment (Domestic Abuse, Stalking and Honour Based Violence Risk Identification, Assessment and Management Model) is primary tool used to determine the level of risk posed to an adult victim of domestic abuse. The DASH tool is available via the Local Safeguarding Partnership sites or with support from through the safeguarding team.

2.4.2 Where a DASH is completed and reaches the appropriate threshold or where professional judgement dictates, then a referral to the Multi Agency Risk Assessment Conference (MARAC) by the practitioner or with support from the Safeguarding Domestic Abuse Lead.

2.4.3 Multi-agency risk assessment conferences (MARAC) are multi-agency meetings with a primary focus on the safety of high-risk adult victims of domestic abuse. Local representatives attend MARAC meetings from organisations, which may be involved in supporting victims, or working with the perpetrator. MARAC's take place regularly across the Trust area chaired by the police.

2.4.4 The purpose of a MARAC is to share information about Very High Risk victims in order to prevent serious harm, develop a safety plan, put all possible support in place and lower the risk to children and victim as soon as possible. The key objective of a MARAC is to manage/reduce the risk of serious harm or death of the victims and increase the health, safety and wellbeing of both adult victims and children by:

- Sharing information to increase the safety, health and well-being of adult victims and their children
- Determining whether the alleged perpetrator poses a significant risk to particular individuals and to the general community

- Jointly constructing and implementing a risk management plan that provides professional support to all those at risk and that reduces the risk of harm
- Reducing repeat victimisation
- Improving agency accountability
- Improving support for staff involved in high-risk domestic abuse cases.

2.4.5 The Trust is represented at MARAC by senior practitioners known to the service user or if unable a report is sent in before the meeting. All staff attending MARAC should provide information to aid assessments and reduce risk. Staff should check with Children's Social Care that any child or unborn is known and if not a referral should be made. Most MARAC will have an Independent Domestic Violence Advocate (IDVA) who is able to act as a bridge between the victim and the MARAC meeting and act as the primary point of contact for the victim and offer support during any court proceedings.

2.5 Record Keeping

2.5.1 It is important that staff follow the Trust, and local team record keeping policy and procedure. All actions and reasons for not taking action should be recorded clearly. Staff should note that any Trust records containing information on domestic abuse may be used for:

- Criminal proceedings.
- Civil proceedings regarding contact arrangements between perpetrators and children.
- Domestic Homicide Reviews.
- Housing provision

3.0 PROCEDURE REFERENCES / ASSOCIATED DOCUMENTATION (EXTERNAL)

Domestic Abuse Act (2021)
Working Together to Safeguard Children (Department of Health, 2019)

4.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES (INTERNAL)

Safeguarding Adult Procedure CLPG39 Appendix 2: Domestic Homicide Reviews.
Standard Operational Procedure for Responding to Domestic Abuse

5.0 GLOSSARY

Term	Meaning
DAN	*Domestic Abuse Notifications*
DASH	*Domestic Abuse Stalking & Harassment*
DHR	*Domestic Homicide Review*
IDVA	*Independent Domestic Violence Advocate*
MARAC	*Multi Agency Risk Assessment Conference*

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Essex Partnership University
NHS Foundation Trust

APPENDIX 7: PROCEDURE FOR DOMESTIC ABUSE

PROCEDURE REFERENCE NUMBER	CLPG39 Appendix 7
VERSION NUMBER	[3]
KEY CHANGES FROM PREVIOUS VERSION	Updates to guidance from new legislative changes.
AUTHOR	Gill Parker, Project lead for Safeguarding
CONSULTATION GROUPS	Safeguarding Team, Mental Health Act and Safeguarding Committee and Alpha Vesta
IMPLEMENTATION DATE	
AMENDMENT DATE(S)	May 2023
LAST REVIEW DATE	My 2023
NEXT REVIEW DATE	May 2026
MENTAL HEALTH & SAFEGUARDING SUB-COMMITTEE APPROVAL:	2nd May 2023
RATIFICATION BY POLICY OVERSIGHT AND RATIFICATION GROUP	9 May 2023
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PROCEDURE SUMMARY

The Trust monitors the implementation of and compliance with this procedure in the following ways:		
Services	**Applicable**	**Comments**
Trustwide	✓	

The Director responsible for monitoring and reviewing this procedure is Executive Nurse

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Equality and Diversity Statement

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1.0 INTRODUCTION

1.1 Practitioners are in a key position to identify and help interrupt domestic abuse. They can do this by recognising the indicators of abuse, responding, signposting and referring for support or protection as needed. This procedural guidance will assist staff when working with service users and their families when there are concerns for domestic abuse, disclosure or has been identified.

1.2 Definition of Domestic Abuse

A new Statutory Definition of Domestic Abuse was introduced in the Domestic Abuse Act, 2021, and is defined as:-
'Abusive behaviour between two people who are both aged 16 or over and are 'personally connected' to each other'.

Behaviour is 'abusive' if it consists of any of the following:-

a) physical or sexual abuse
b) violent or threatening behaviour
c) controlling or coercive behaviour
d) economic abuse
e) psychological or emotional abuse

Two people are 'personally connected' to each other if any of the following applies:-
They are or have been:-

a) in an intimate personal relationship with each other;
b) married or civil partners to each other;
c) involved in an agreement to marry or enter into a civil partnership with one another;
d) formerly or currently in a parental relationship in relation to the same child;
e) relatives / family members

2.0 PROCESS AND STAFF RESPONSIBILITIES

2.1 Understanding

Staff need to understand how to respond to the needs of victims and dependent children and make referrals as appropriate, in line with this and other policies and procedures. Victims of domestic abuse may present as a result of trauma and staff should use an approach that builds confidence with their service users and families.

2.1.1 As in any consultation, it is important to assess the level of difficulty where the service user may have a learning disability, cognitive problem or understand a different language. Staff should agree and carry out the best method of communicating with the service user but this should never through be friends or relatives when domestic abuse is a concern.

2.1.2 Separating from a violent, controlling or abusive relationship can result in patterns of harassment and stalking. It can put the victim at a high risk of injury of even murder. Do not advise a service user who maybe a victim to separate from a relationship without signposting and/or referring for specialist support and/or protection.

2.2 Early identification

To tackle domestic abuse, it is essential that service users who are victims are identified and disclose their abuse as early as possible. As a health professional, you may be the first or only opportunity for the client to disclose they are a victim of abuse. You have a responsibility to:

- Understand the different types of domestic abuse and risk factors associated with them.
- Recognise key indicators of domestic abuse which may include patterns of coercive or controlling behaviour often associated with domestic abuse
- Facilitate disclosure in private without any third parties present.
- Be attentive and approachable using open dialogue.
- Sensitively question what you are seeing and hearing.
- Decide if the presentation of the client warrants concern.

2.3 Enquiries

2.3.1 Sensitive Enquiries- There are a whole range of indicators to alert health professionals that a service user may be experiencing domestic abuse. Some of these are quite subtle and it is important that professionals remain alert to the potential signs and respond appropriately.

2.3.2 Some victims of domestic abuse also drop hints in their interactions with health and care staff and their behaviours may also be telling. They rely on all professionals to listen, persist, and enquire about signs and cues. They need professionals to follow up conversations in private, record details of behaviours, feelings and injuries seen and reported.

2.3.3 Professionals should support victims of domestic abuse to take action suitable for their organisation's systems and local pathways. As far as possible, action should be taken in line with a patient's preferences and with the consent of the patient, including where they lack capacity or their capacity is otherwise impaired, such as by fear or coercion.

2.3.4 All practitioners have a professional responsibility: if you identify signs of domestic abuse or if things are not adding up, ask patients alone and in private, regardless of gender, sexuality or age about their experience of domestic or other abuse, sensitively.

2.3.5 Routine Enquiries- Good clinical practice will incorporate routine enquiries into domestic violence and abuse when working with maternal service users and adult mental health services. Assessments of clients using substance misuse services are also expected to consider domestic abuse as a routine part of good clinical practice, even where there are no indicators of such violence and abuse.

2.4 Indicators of Domestic Abuse

2.4.1 Changes in Behaviour or Demeanour:
Withdrawn
Disengaged
Memory problems
On red alert
Walking on eggshells
Conscious of time
Consistently checking their phone
Other changes in the way the client dresses or presents themselves

2.4.2 Emotional or Psychological Signs:
Tearful
Anxious
Emotional outbursts
Low confidence
Impatient

2.4.3 Physical Signs:
Physical signs and symptoms such as unexplained or frequent bruises or other injuries or regularly appearing to be in pain and taking lots of pain relief.
Attempting to disguise injury through clever use of make-up

2.4.4 Complex Coping Mechanisms:
Signs of substance misuse including alcohol misuse
Disordered eating habits
Dramatic weight loss or gain
Development of obsessive disorders
Reluctant to be assertive.

2.4.5 Fear or intrusive 'other person':
Partner, spouse, or other family member always attending appointments unnecessarily
The patient is submissive or afraid to speak in front of the 'other person' present.
The escort is aggressive, dominant or overly attentive, talking for the patient or refusing to leave the room.

2.4.6 Indicators of Financial or Economic Abuse:
Missing appointments because of a lack of funds to get there
Basic needs not being met, smelling or looking dishevelled and/or dirty.

Domestic Abuse means different things to different people. Some service users would never associate with that term 'domestic abuse' or perhaps being a 'victim' or 'perpetrator' of abuse however, victims and perpetrators are everywhere, in a variety of different guises. None of these indicators automatically proves domestic abuse, but even if the service user chooses not to disclose at this time, knowing that you are aware of the issues and are supportive builds trust and lays the foundations for them to choose to approach you or another practitioner later.

2.5 Managing Concerns and Disclosures

2.5.1 Privacy - Only ever raise the issue of domestic abuse with a service user when you are alone with them in private and, if necessary; ask the escort to wait elsewhere. Even if a service user is accompanied by a relative who is not their partner or

spouse, regardless of gender, staff must consider that this person could be related to the abuser or could be the abuser themselves.

2.5.2 Ask Direct Questions- Victims who have been abused say they were often glad when a health practitioner asked them about their relationships. Staff can explain that they are concerned (or, if it is routine enquiry you ask everyone), and respectfully ask direct questions, such as:

- Are you ok?
- You seem tired or anxious today… can I help?
- Remember I am here if you would like to talk about anything that is worrying you.
- I've noticed that you don't seem quite yourself today, is there anything else worrying you?
- Look out for their body language such as eyes looking towards the 'intrusive other person' or tensing.

Once they are alone:-

- Is there anyone close to you that you are frightened of?
- Has anyone close to you been unkind or hurt you?
- Do you feel safe when you are at home?
- Do you feel you can make decisions yourself?
- Is there anyone who is pressuring you to say or do anything that you don't want to?
- Is there anyone that you trust that I can call for you to come and collect you?

2.5.3 Using an Interpreter- Never use a relative or friend of the victim as an interpreter and always use a professional interpreter instead. Practitioners should ask patients whether they would like an interpreter of the same gender as them. When using an interpreter, always look at your patient and speak directly to them – not to the interpreter.

2.6 Multi-Agency Assessment:

Multiagency input is essential when working with service users experiencing domestic abuse. Other services, like social care, the police, probation, youth justice, substance misuse, and other health services, may have additional information about the perpetrator and other vulnerable people. Friends and family of a victim may be able to provide helpful information. Practitioners must take this into account and actively seek additional information from the multiagency network rather than expect the victim to accurately assess the risk of harm to themselves or others like children in their situation. The effect of abuse and violence can reduce a victim's ability to analyse situations clearly and come to appropriate decisions.

2.7 The Care Act (2014) - Safeguarding Duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or is at risk of, abuse or neglect and
- as a result of those care and support needs, is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

2.8 Assessing Risk in Domestic Abuse

If domestic abuse is identified, an assessment should be undertaken to evaluate the risk of further harm to the person and to any children in the household.

- Assess the client's immediate safety. For example, for an adult or person over 16 years old, determine whether it is safe to go home.

- Assessing the risks facing the abused person informs safeguarding action, safety-planning, referrals to specialist support services and aids any police investigation.

2.8.1 The Safe Lives Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment tool is a reliable method for an initial risk assessment (available on Input). There is also a DASH for use with young people or people with learning disabilities. It is a helpful clinical tool to assist victims in recognising what is happening to them, and to feel that their experiences are recognised and validated. You should not attempt to undertake the DASH without having attended training or reading the guidance and frequently asked questions to ensure you have the requisite competencies and confidence to undertake this assessment.

2.8.2 This structured, score-based approach helps identify high-risk cases where the victim may be at risk of significant harm from the perpetrator of abuse.

- A score of 14 or more should automatically be referred for a MARAC
- For lower scores, but where you have professional concerns about risk and safety of those impacted, you should add your professional judgement and concerns on the DASH and refer to MARAC for a multiagency assessment.
- If the case does not meet threshold for a MARAC, other safeguarding action or referrals into specialist support services should be considered and/or discussed with the patient.

2.8.3 Based on findings from domestic homicide reviews, the top seven high risk indicators are:

- Pregnancy of the Victim
- Patterns of Coercive control / Stalking / Harassment
- Separation / Child Contact Issues
- Sexual Abuse
- Escalation and Severity of Abuse
- Isolation of the Victim and Complex Coping Mechanisms in both the Victim and Perpetrator of Abuse.

2.9 MARAC (Multi-Agency Risk Assessment Conference)

A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

2.9.1 Wherever possible, consent should be given by the client to refer to MARAC however their consent is not essential in the following circumstances:-

- Where the adult victim lacks capacity.
- It is in the public interest and the public interest test is engaged with the high threshold risk
- there are 14 or more questions answered ‘yes’ or
- high risk indicators are present and there are safeguarding concerns around those impacted.

2.9.2 A MARAC referral will go to the police and, if the threshold is met for a MARAC, an Independent Domestic Violence Adviser (IDVA) will contact the victim discreetly, initially by telephone where available. Where the victim lacks capacity for the decision to refer, you may refer if it is their Best Interests.

2.10 Raising a Safeguarding Concern

2.10.1 Adults - Where the client is disclosing ongoing domestic abuse, or where past abuse represents a current or future risk, complete a Safeguarding Adult Concern Form – Setsaf1 with the adult's consent. Further guidance is available to assist staff with making a referral in the Safeguarding Adults Policy (CLP39). The practitioner must take into account what being safe means to an adult experiencing domestic abuse, and work with them to establish solutions.

2.10.2 If you think that an abused service user may lack capacity to make any decision related to or arising because of the suspected abuse, staff will need to complete a Mental Capacity Act assessment. It should be understood that 'making an unwise decision' is not the same as 'lacking capacity'. Domestic Abuse may be affecting a victim's ability to understand the risks around their current situation rather than them 'lacking capacity'. Referrals to specialist domestic abuse services should be considered and revisited regularly**.**

2.10.3 If the person lacks capacity to make a decision in relation to domestic abuse (which could be because of mental illness, cognitive impairment, or fear/coercion) staff will need to make a Best Interests decision about whether to proceed with raising a safeguarding concern. Under the Act, where the vulnerable adult has no family or friend who can speak on their behalf, or where such networks are suspected as potential abusers, you need to consider whether to refer for an independent mental capacity advocate. Advice can be sought from a clinical member of the safeguarding team.

2.10.4 Children - It is highly likely that domestic abuse will have a significant impact on any children in the family when working with a service user. In the new 'Domestic Abuse Act, 2021', children are cited as Victims of Domestic Abuse in their own right whereas previously they were seen as bystanders to the abuse and only impacted in that way. Staff will need to consider the impact on children in the home or family. With the service user/parent's consent (you don't need consent from both parents) make a referral using the appropriate local safeguarding partnership referral process.

2.10.5 Describe your concern and the risks you have identified or suspect in as much detail as possible. If the parent does not consent to a referral, staff will need to consider whether the child is currently experiencing or is at 'risk of significant harm'. If this is the case staff must inform the service user/parent you are making a referral, unless doing so would increase risks to the child. Staff can seek advice from a clinical member of the safeguarding team. Consideration needs to be given to what immediate actions need to be taken to support the victim and children involved, to increase their safety and encourage referrals into specialist domestic abuse services.

2.11 'So-called' Honour Based Abuse and Forced Marriage

So called' honour-based violence and abuse is a collection of practices used to control behaviour within families and other social groups in order to protect perceived cultural and religious beliefs and/or honour. Fatal violence can occur when perpetrators perceive that a relative has "shamed" the family and/or community by breaking that honour. Abuse occurring in this context is extremely high risk and should always be referred to MARAC as well as completing other safeguarding referrals.

2.11.1 Forced Marriage is where one or both parties do not or cannot give their informed consent to a marriage. This can be due to a cognitive impairment such as significant learning disabilities or if consent is thought to have been obtained under duress. Forced marriage is recognised in the UK as a form of violence against

women and men as well as domestic abuse and/or child abuse. Further guidance is available in the Safeguarding Children Procedures (CLPG37 Appendix 4)

2.12 Gathering and Recording Information

2.12.1 Recording Information- Staff should record sufficiently detailed, accurate and clear notes to show the concerns they have and indicate the harm that domestic abuse may have caused as well as concerns around future risk for the service user. Records can be used in:

- Criminal proceedings if a perpetrator faces charges
- Obtaining an injunction or court order against a perpetrator
- Immigration and deportation cases
- Housing provision
- Civil procedures in family courts to assess the risks associated with granting an abusive parent contact with children
- Safeguarding practice reviews, safeguarding adult reviews and domestic homicide reviews.

2.12.2 *"The solicitors said there just wasn't enough evidence on my health records. Nothing to suggest my ex was to blame for my injuries. I was so let down. I thought my doctor had written down everything I said."* (Department of Health, 2017). Staff should always keep a detailed record of what they have discussed with a service user – even if your suspicions of domestic abuse have not led to disclosure. The patient might disclose information in the future.

2.12.3 For confidentiality ensure that the service user's record can only be accessed by those directly involved in their care. Domestic abuse should never be recorded in hand-held notes, such as maternal notes. A patient's permission is not required for you to record a disclosure of domestic abuse or the findings of an examination. Make it clear to a person or child that, as a duty of care, you have a responsibility to keep a record of their disclosure and injuries.

2.12.4 Data protection regulations exempt information from being released as a result of an access request which "would be likely to cause serious harm to the physical or mental health or condition of the data subject or any other person". Even if an abuser was able to sustain a right of subject access, information provided by the victim about the abuse could still be withheld on the grounds that it would be likely to result in further abusive behaviour causing serious physical or mental harm to the victim.

2.12.5 When recording information, you should:

- Describe exactly what happened. For example, service user states "my husband kicked me twice in stomach" rather than "patient assaulted".
- Diagnostic codes for domestic abuse are included in electronic clinical records
- Use the service users own words (with quotation marks) rather than your own.
- Document injuries in as much detail as possible, using body maps to show injuries, and record whether an injury and a victim's explanation for it are consistent. For example, "patient has four small two-pence-sized bruises on her upper arm 2cm apart. Patient reported 'I fell down, I can't really remember what happened'"
- Where organisational policies allow staff can take images (signed and dated) as proof of injuries.
- Domestic abuse records should be seen in the context of the whole health record to get a clear understanding of repeat consultations for health problems connected to the abuse.

- On computerised records, ensure that nothing about domestic abuse is visible on the opening screen (which could be seen by a perpetrator).

2.12.6 What to include in notes:

Your notes on domestic abuse should include:

- Suspicion of domestic abuse which has led/not led to disclosure.
- Whether routine or sensitive enquiry has been undertaken and the response
- Relationship to alleged perpetrator, name of alleged perpetrator.
- If the victim is female, whether they are pregnant.
- The presence of children in the household and their ages.
- Nature of psychological and/or physical abuse and any injuries.
- Description of the types of domestic abuse occurring / any other abuse experienced and reference to specific incidents.
- Whether this is the first episode, or how long regular abuse has been going on
- Presence of increased risk factors.
- Results of completed Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment for the adult and a Domestic Violence Risk Identification Matrix. (DVRIM) or DASH assessments for each child, if relevant.
- Indication of information provided on local sources of help.
- Indication of action taken (for example, direct referrals).

2.13 Confidentiality and Sharing of Information

It is vital that information on domestic abuse is kept confidential to protect victims from escalating abuse, violence or even death. However, in some instances, failure to share information can put victims at risk. When sharing information about adult patients, breaking confidentiality has to be based on consent, unless there is a public interest or other legal justification such as 'risk of significant harm'.

2.13.1 Confidentiality: NHS Code of Practice (2003) sets out the standards required for confidentiality of patient information and consent. Staff can access further guidance from Trust guidance on Confidentiality and information sharing via Input. Staff need to be particularly careful in situations where confidentiality could accidentally be broken and cause harm, such as:

- In general practice, where health professionals might treat other members of a victim's family – including the perpetrator of the domestic abuse. The perpetrator may punish their victim for disclosing the abuse or use the GP surgery as a source of information to track down a victim who has moved away.
- If a child who has a background of domestic abuse spends time in hospital and the perpetrator of the domestic abuse visits the child, you should take care that records on display do not include a contact address or any other information that could help a perpetrator track down people he has abused.

2.13.2 Where consent cannot be obtained or is refused, or where sharing the relevant information is likely to prevent or interrupt a crime, professionals may lawfully share information if this can be justified in the public interest, such as:

- where there is serious risk of harm to the victim or risk to any children involved or somebody else
- to inform a risk assessment where the definition of 'harm' to a child includes impairment caused by seeing or hearing the abuse of another person
- when the courts request information about a specific case.

2.13.3 If you do pass on information without permission, you should be completely sure that your decision does not place somebody at risk of greater violence. Record your reasons to be able to justify your decision and subsequently, record confirmation that the information you passed on has been received and understood.

3.0 PROCEDURE REFERENCES / ASSOCIATED DOCUMENTATION (EXTERNAL)

Care Act (2014)
Confidentiality: NHS Code of Practice (2003)
Data Protection and Confidentiality Policy (CP59)
Domestic Abuse Act (2021)
Domestic Homicide Reviews Key Findings from Analysis of Domestic Homicide Reviews (Home Office, 2019)
Forced Marriage Guidance for Children Local Safeguarding Partnerships
Responding to domestic abuse: A resource for health professionals. (DoH, 2017)
Online Children's social care portal: https://www.essex.gov.uk/report-a-concern-about-a-child
COMPASS - domestic abuse services in Essex 0330 333 7 444 (Essex domestic abuse helpline) https://www.essexcompass.org.uk/
SETDAB - The Southend, Essex and Thurrock domestic abuse partnership website, https://setdab.org/
The Change Portfolio Essex Wide Perpetrator, Victim and Relationship Support Service - 01245 258680 - https://www.thechange-project.org/
National 24hr Domestic Abuse Helpline for Women – 0808 2000 247 - https://www.nationaldahelpline.org.uk/
Men's Advice Line - 0808 8010 327 - https://mensadviceline.org.uk/
Spotlight Report #SafeAndWell Safe and Well: Mental health and domestic abuse - May 2019 https://safelives.org.uk/spotlights/spotlight-7-mental-health-and-domestic-abuse
Forced Marriage Unit https://www.gov.uk/guidance/forced-marriage
Southend, Essex and Thurrock Safeguarding Guidelines May 2017
https://www.essexsab.org.uk/media/1895/doc-set-safeguarding-guidelines.pdf

4.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES (INTERNAL)

Safeguarding Adult Procedure (CLPG39)
Safeguarding Children Procedure- Responding to Domestic Abuse and Domestic Incident reports (CLPG37 Appendix 4)

5.0 GLOSSARY

Term	Meaning
DASH	*Domestic Abuse, Stalking and Honour Based Violence*
DVRIM	*Domestic Violence Risk Identification Matrix*
IDVA	*Independent Domestic Violence Adviser*
MARAC	*Multi-Agency Risk Assessment Conference*

END

Essex Partnership University
NHS Foundation Trust

APPENDIX 1: TRAINING FRAMEWORK FOR SAFEGUARDING CHILDREN

PROCEDURE REFERENCE NUMBER	CLPG37 Appendix 1
VERSION NUMBER	[3]
KEY CHANGES FROM PREVIOUS VERSION	Updated competencies from new Inter collegiate Frameworks
AUTHOR	Gill Parker, Project Lead for Safeguarding
CONSULTATION GROUPS	Trust Safeguarding team, Mental Health Act and Safeguarding Committee
IMPLEMENTATION DATE	
AMENDMENT DATE(S)	May 2023
LAST REVIEW DATE	May 2023
NEXT REVIEW DATE	May 2026
MENTAL HEALTH & SAFEGUARDING SUB-COMMITTEE APPROVAL:	2nd May 2023 [Chair's Action]
RATIFICATION BY POLICY OVERSIGHT AND RATIFICATION GROUP	9 May 2023
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PROCEDURE SUMMARY

The guidance outlines the training requirements that staff and the Trust has to deliver and attend to discharge its statutory responsibilities. In addition a training Framework has been developed as a stand-alone document for speedier amendments for competency additions or changes.

The Trust monitors the implementation of and compliance with this procedure in the following ways:

Services	Applicable	Comments
Trustwide	✓	

The Director responsible for monitoring and reviewing this procedure is Executive Director Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

TRAINING FRAMEWORK FOR SAFEGUARDING CHILDREN

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

TRAINING FRAMEWORK FOR SAFEGUARDING CHILDREN

Assurance Statement

Equality and Diversity Statement

The Trust is committed to ensuring that equality, diversity, and inclusion is considered in our decisions, actions and processes. The Trust and all trust staff have a responsibility to ensure that they adhere to the Trust principles of equality, diversity, and inclusion in all activities. In drawing up this policy all aspects of equality, diversity, and inclusion have been considered to ensure that it does not disproportionately impact any individuals who have a protected characteristic as defined by the Equality Act 2010

1.1 INTRODUCTION

1.1 All Health Trusts have a statutory duty to ensure every member of staff is competent and confident in carrying out their Safeguarding responsibilities appropriate to their role and remit. It is the duty of employers to ensure that those working for them clearly understand their contractual obligations within the employing organisation, and it is the responsibility of employers to facilitate access to training and education, which enable the organisation to fulfil its aims, objectives and statutory duties effectively and safely. This procedure outlines elements of the Safeguarding Training Framework available to staff, which applies to Children and Adults.

1.2 The framework introduces indicative minimum training requirements, which are competency based relating to an individual's role not their job title and apply to all staff delivering, or working in settings which provide healthcare. The competency based training aims to enable staff to perform a specific task, action or function successfully within their role.

1.3 All Trust staff, including non-clinical staff **must** consider the welfare of Children and Adults irrespective of whether they are primarily working with adults or with children and young people:

'*All staff working in healthcare services – including those who predominantly treat adults – should receive training to ensure they attain the competencies appropriate to their role and follow the relevant professional guidance'* (DoE, 2018)

"Safeguarding is everyone's responsibility. Each professional and organisation must do everything they can to ensure that children and adults at risk are protected from abuse, harm and neglect". (2018)

1.4 The Framework affords staff the opportunity to understand and have the necessary knowledge, skills, attitudes and values to carry out their responsibilities and be aware of safe practice within their work setting with regard to Safeguarding Children and Adults including Looked After Children (LAC) Prevent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. (DoLS) It incorporates a training programme, which meets

individual training requirements in accordance with specific competency needs within EPUT. These are predominantly within levels 1-4 of the framework and those required for membership of EPUT Board.

1.5 The Framework makes optimal use of the Local Safeguarding Partnership arrangements multi–agency training programmes to promote partnership working and the Trust ensures that a programme of in house training is in place for all staff including Doctors that supports the delivery of national and local developments. Locum and agency staff should have either undertaken Safeguarding training on appointment or have access to in house training.

1.6 Safeguarding training delivered to staff within EPUT is facilitated by trained safeguarding clinical team members that are knowledgeable about safeguarding processes for both Children and Adults. Training reflects understanding of the rights of children and adults and is inclusive of an active respect for diversity and a commitment to ensuring equality of opportunity:

- Training is informed by current research evidence, lessons from Local Partnership Safeguarding Practice Reviews formally known as Serious Case Reviews, local and national developments and initiatives.
- All training includes a statement of the learning outcomes specific to the appropriate level.
- The Safeguarding Children and Adult annual reports for the Trust Board includes a report on training.

2.0 PROCESS

2.1 The Trust Safeguarding Training Framework (2023) and the Induction, Mandatory and Essential Training Procedure (HRPG21) outlines the requirement that all EPUT staff must receive Safeguarding Adult and Children training every three years as per Table 1. New staff must access levels 1 & 2 face to face or on-line training as appropriate to their role during their induction period within three months of start date. Specific staff dependant on their role are also required to access:

- Looked after Children (LAC)
- Prevent
- MCA & DoLS training.

2.2 There are a number of different levels of training dependant on Trust staff role, specialism and contact with adults or children. All staff should receive an update on safeguarding annually. This does not require attendance at formal training sessions but can be via a team discussion, time to learn, case study, newsletter, shadowing a colleague etc.

2.3 Safeguarding training is accessible via the Trust Employee Staff Record (ESR) site, Local Safeguarding Partnership arrangements, and National Conferences etc. Training content should comply with the competencies set out within the Intercollegiate Documents and the competencies should be reviewed annually as part of staff appraisals.

2.4 The Workforce Development and Training Department will report monthly on compliance levels to the Trust Executive Team and the Trust Mental Health Act and Safeguarding Sub-Committee. Compliance for all training is set at 95% of the true total of staff. Monthly data reports via Trust trackers are available for operational managers and directors identifying which of their staff are up-to-date and when they are approaching update deadlines. Non-attendance of courses by

staff are recorded.

2.5 Regular mapping of roles and subsequent training level takes place therefore the list below can change in accordance with newly developed roles or the acquisition of different services. The Trust Safeguarding team work closely with the Workforce Development team to ensure effective systems are in place to notify and monitor training.

2.6 SAFEGUARDING TRAINING

2.6.1 Levels of Safeguarding Training include:

Level 1 **Safeguarding Children & Adults (Table 1, EPUT Safeguarding Training Framework)**
All staff including non-clinical managers and staff working in healthcare settings.

Level 2 **Safeguarding Children & Adults (Table 2, EPUT Safeguarding Training Framework)**
Incorporates Level 1. Minimum level required for nonclinical and clinical staff who, within their role, have contact (however small) with children and young people, parents/carers or adults who may pose a risk to children. For adult safeguarding this includes all practitioners who have regular contact with patients, their families or carers, or the public.

Level 3 **Safeguarding Adult Training (Table 4, EPUT Safeguarding Training Framework)**
'All clinical staff working predominantly with children, young people and parents who contribute toward assessing, planning and evaluating the needs of children and parenting capacity where there are safeguarding concerns' (2019)

Level 4 **Specialist Safeguarding Adult Training (Table 5, EPUT Safeguarding Training Framework)**
Named and Designated Safeguarding Team staff

Board **Safeguarding Children and Adults (Table 6, EPUT Safeguarding Training Framework)**
Chief Executive Officers, Trust and Health Board Executive and Non-executive Directors/Members.

2.6.2 Looked after Children Training

Level 1 **Incorporated in Level 1 Safeguarding Training (Table 1, EPUT Safeguarding Training Framework)**

All staff including non-clinical managers and staff working in healthcare settings.

Level 2 **Incorporated in Level 2 Safeguarding Training (Table 2, EPUT Safeguarding Training Framework)**
Minimum level for all non-clinical and clinical staff who, within their role, have contact (however small) with children, young people and/or parents/carers or adults who may pose

a risk to children.

Level 3 **Looked after Children Training (Table 3, EPUT Safeguarding Training Framework)**
All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the health needs of a looked after child/young person or care leaver.

Level 4 **Specialist Looked after Children Training (Table 4, EPUT Safeguarding Training Framework)**
Specialist medical, nursing and health professionals for looked after children and adoption, including named professionals and medical advisors for fostering and adoption in the EPUT team.

2.6.3 Prevent Training

Level 1 **Incorporated in Level 1 Safeguarding Training (Table 1, EPUT Safeguarding Training Framework)**
All staff working in healthcare settings, including non-clinical managers and staff.

Level 2 **Incorporated in Level 2 Safeguarding Training (Table 2, EPUT Safeguarding Training Framework)**
All clinical and non-clinical staff who have regular contact with patients, their families or carers, or the public.

Level 3 **Incorporated in Level 3 Safeguarding Training (Table 3/4, EPUT Safeguarding Training Framework)**
All clinical staff working with adults, children, young people and/or their parents or carers, who could potentially contribute to assessing, planning, intervening and/or evaluating the health needs of a service user.

Level 4 **Specialist Roles – Named Professionals (Table 5, EPUT Safeguarding Training Framework)**
Safeguarding and Prevent clinical Leads**.**

2.7 ACCESS TO TRAINING

2.7.1 The Trust Safeguarding Team in conjunction with the Workforce Development and Training Department will circulate details of all available training for staff through its on line sites and training bulletins.

2.7.2 Safeguarding training is mandatory and all staff will be able to use their training tracker to identify which level of training is appropriate for them. Staff must follow Trust processes to access training via the Induction, Mandatory and Essential Training Guidance HRPG21. The Safeguarding clinical team can be contacted by staff to discuss individual safeguarding training requirements and staff can access further information on training from their area Local Safeguarding Partnership websites.

2.7.3 Staff who would like to access training not on their tracker as a mandatory requirement are welcome to attend any course (where spaces are available) and should discuss with their manager and contact the training department

accordingly. Training available from other organisations may require staff to complete an additional application form but it is vital that the Trust study leave form is completed so that staff are registered on the Trust data system as having received training.

2.7.4 Additional supplementary Safeguarding training will be considered in line with Local Safeguarding Partnership arrangements Learning and Improvement strategies. These will include learning from Local Safeguarding Partnership Practice Reviews formally known as Serious Case Reviews (national & local) and any changes in legislation/statutory guidance and local audit/case reviews.
Operational line managers and individual staff should consider supplementary safeguarding training as part of Personal Development Programme.

2.7.5 On completion of training staff will be asked to complete an evaluation form in order to assess the quality and effectiveness of the training. Random sampling of staff will be contacted post training to assess the impact that training has had on practice and whether it has met the desired learning outcomes.

2.8 DATA COLLECTION AND REPORTING MECHANISMS

2.8.1 The Workforce, Training and Development department maintain data on:

- Those applying for and attending training.
- The numbers from particular staff groups that attend training.
- Those that don't attend booked training events

2.8.2 The Safeguarding Team collects attendance data on all training they have delivered and send the attendance lists to the Training Department for recording against staff records. Performance reports are developed and presented using this data internally and externally from the Trust.

2.8.3 Trust training reports will be shared with the Local Safeguarding Partnership arrangements where required and the Safeguarding Training Framework will be agreed by the Safeguarding team and Workforce Planning Group before being approved by the Mental Health Act & Safeguarding Sub-Committee.

3.0 PROCEDURE REFERENCES / ASSOCIATED DOCUMENTATION (EXTERNAL)

3.1 **Children**

Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2019)
Looked After Children: Roles and Competencies of Healthcare Staff (2020).
Working Together to Safeguard Children (DoE, 2018)
Local Safeguarding Children Partnership Procedures
Building Partnerships, Staying Safe (DoH, 2011)

3.2 **Adults**

The Health and Care Act (DoH, 2022)
Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)
Local Safeguarding Adult Partnership Procedures
The Mental Capacity Act Deprivation of Liberty Safeguards (2015)
Building Partnerships, Staying Safe (DoH, 2011)

4.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES (INTERNAL)

4.1 EPUT Safeguarding Training Framework (2023)
HRPG21 Induction, Mandatory and Essential Training Procedure

5.0 GLOSSARY

Term	Meaning
DoLS	*Deprivation of Liberty Safeguards*
ESR	*Employee Staff Record*
LAC	*Looked after Children*
MCA	*Mental Capacity Act*

END

Essex Partnership University
NHS Foundation Trust

APPENDIX 1: TRAINING FRAMEWORK FOR SAFEGUARDING ADULTS

PROCEDURE REFERENCE NUMBER	CLPG39 Appendix 1
VERSION NUMBER	[3]
KEY CHANGES FROM PREVIOUS VERSION	Updated Competency Frameworks as result of new guidance
AUTHOR	Gill Parker, Project Lead for Safeguarding
CONSULTATION GROUPS	Trust Safeguarding team, Mental Health Act and Safeguarding Committee
IMPLEMENTATION DATE	
AMENDMENT DATE(S)	May 2023
LAST REVIEW DATE	May 2023
NEXT REVIEW DATE	May 2026
MENTAL HEALTH & SAFEGUARDING SUB-COMMITTEE APPROVAL:	2nd May 2023 [Chair's Action]
RATIFICATION BY POLICY OVERSIGHT AND RATIFICATION GROUP	9 May 2023
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PROCEDURE SUMMARY
This guidance outlines the training requirements that staff and the Trust has to deliver and attend to discharge its statutory responsibilities. In addition a training Framework has been developed as a stand-alone document for speedier amendments for competency additions or changes.
The Trust monitors the implementation of and compliance with this procedure in the following ways:

Services	**Applicable**	**Comments**
Trustwide	✓	

The Director responsible for monitoring and reviewing this procedure is Executive Nurse

ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CLPG39 APPENDIX 1 TRAINING FRAMEWORK FOR SAFEGUARDING ADULTS

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ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

CLPG39 APPENDIX 1 TRAINING FRAMEWORK FOR SAFEGUARDING ADULTS

Assurance Statement

Equality and Diversity Statement

The Trust is committed to ensuring that equality, diversity, and inclusion is considered in our decisions, actions and processes. The Trust and all trust staff have a responsibility to ensure that they adhere to the Trust principles of equality, diversity, and inclusion in all activities. In drawing up this policy all aspects of equality, diversity, and inclusion have been considered to ensure that it does not disproportionately impact any individuals who have a protected characteristic as defined by the Equality Act 2010

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- All training includes a statement of the learning outcomes specific to the appropriate level.
- The Safeguarding Children and Adult annual reports for the Trust Board includes a report on training.

2.0 PROCESS

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Level 3 **Safeguarding Adult Training (Table 4, EPUT Safeguarding Training Framework)**
'All clinical staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns'

Level 4 **Specialist Safeguarding Adult Training (Table 5, EPUT Safeguarding Training Framework)**
Named and Designated Safeguarding Team staff

Board **Safeguarding Children and Adults (Table 6, EPUT Safeguarding Training Framework)**
Chief executive officers, trust and health board executive and non-executive directors/members.

2.6.2 Looked after Children Training

Level 1 **Incorporated in Level 1 Safeguarding Training (Table 1, EPUT Safeguarding Training Framework)**

All staff including non-clinical managers and staff working in healthcare settings.

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Minimum level for all non-clinical and clinical staff who, within their role, have contact (however small) with children, young people and/or parents/carers or adults who may pose a risk to children.

Level 3 **Looked after Children Training (Table 3, EPUT Safeguarding Training Framework)**
All clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the health needs of a looked after child/young person or care leaver.

Level 4 **Specialist Looked after Children Training (Table 4, EPUT Safeguarding Training Framework)**
Specialist medical, nursing and health professionals for looked after children and adoption, including named professionals and medical advisors for fostering and adoption in the EPUT team.

2.6.3 Prevent Training

Level 1 **Incorporated in Level 1 Safeguarding Training (Table 1, EPUT Safeguarding Training Framework)**
All staff working in healthcare settings, including non-clinical managers and staff.

Level 2 **Incorporated in Level 2 Safeguarding Training (Table 2, EPUT Safeguarding Training Framework)**
All clinical and non-clinical staff who have regular contact with patients, their families or carers, or the public.

Level 3 **Incorporated in Level 3 Safeguarding Training (Table 3/4, EPUT Safeguarding Training Framework)**
All clinical staff working with adults, children, young people and/or their parents or carers, who could potentially contribute to assessing, planning, intervening and/or evaluating the health needs of a service user.

Level 4 **Specialist Roles – Named Professionals (Table 5, EPUT Safeguarding Training Framework)**
Safeguarding and Prevent clinical Leads**.**

2.7 ACCESS TO TRAINING

2.7.1 The Trust Safeguarding Team in conjunction with the Workforce Development and Training Department will circulate details of all available training for staff through its on line sites and training bulletins.

2.7.2 Safeguarding training is mandatory and all staff will be able to use their training tracker to identify which level of training is appropriate for them. Staff must follow Trust processes to access training via the Induction, Mandatory and Essential Training Guidance HRPG21. The Safeguarding clinical team can be contacted by staff to discuss individual safeguarding training requirements and staff can access further information on training from their area Local Safeguarding Partnership websites.

2.7.3 Staff who would like to access training not on their tracker as a mandatory requirement are welcome to attend any course (where spaces are available) and should discuss with their manager and contact the training department accordingly. Training available from other organisations may require staff to complete an additional application form but it is vital that the Trust study leave form is completed so that staff are registered on the Trust data system as having received training.

2.7.4 Additional supplementary Safeguarding training will be considered in line with Local Safeguarding Partnership arrangements Learning and Improvement strategies. These will include learning from Local Safeguarding Partnership Practice Reviews formally known as Serious Case Reviews (national & local) and any changes in legislation/statutory guidance and local audit/case reviews. Operational line managers and individual staff should consider supplementary safeguarding training as part of Personal Development Programme.

2.7.5 On completion of training staff will be asked to complete an evaluation form in order to assess the quality and effectiveness of the training. Random sampling of staff will be contacted post training to assess the impact that training has had on practice and whether it has met the desired learning outcomes.

2.8 DATA COLLECTION AND REPORTING MECHANISMS

2.8.1 The Workforce, Training and Development department maintain data on:

- Those applying for and attending training.
- The numbers from particular staff groups that attend training.
- Those that don't attend booked training events

2.8.2 The Safeguarding Team collects attendance data on all training they have delivered and send the attendance lists to the Training Department for recording against staff records. Performance reports are developed and presented using this data internally and externally from the Trust.

2.8.3 Trust training reports will be shared with the Local Safeguarding Partnership arrangements where required and the Safeguarding Training Framework will be agreed by the Safeguarding team and Workforce Planning Group before being approved by the Mental Health Act & Safeguarding Sub-Committee.

3.0 PROCEDURE REFERENCES / ASSOCIATED DOCUMENTATION (EXTERNAL)

3.1 **Children**

Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2019)
Looked After Children: Roles and Competencies of Healthcare Staff (2020).
Working Together to Safeguard Children (DoE, 2018)
Local Safeguarding Children Partnership Procedures
Building Partnerships, Staying Safe (DoH, 2011)

3.2 **Adults**

The Health and Care Act (DoH, 2022)
Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)
Local Safeguarding Adult Partnership Procedures
The Mental Capacity Act Deprivation of Liberty Safeguards (2015)
Building Partnerships, Staying Safe (DoH, 2011)

4.0 REFERENCE TO OTHER TRUST POLICIES/PROCEDURES (INTERNAL)

4.1 EPUT Safeguarding Training Framework (2023)
HRPG21 Induction, Mandatory and Essential Training Procedure

5.0 GLOSSARY

Term	Meaning
DoLS	*Deprivation of Liberty Safeguards*
ESR	*Employee Staff Record*
LAC	*Looked after Children*
MCA	*Mental Capacity Act*

END