Kent and Medway
NHS and Social Care Partnership Trust

Low Secure Forensic Services

An Integrated Model of Staff Support: Responding to patient perpetrated violence

Procedure
V2.0

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V1.0	To be approved	19/08/17	To be approved by Low Secure Service Clinical Governance board	**Approved at Clinical Governance meeting of 14.09.17**
V2.0	Reviewed	08.12.20	Sarah Cooper	No change.

REFERENCES, RELATED DOCUMENTS

All internal and external documents which relate in any way to this document	*Reference code of document*
Tarentfort Staff Support following incidents - Procedure	KMPT, October 2009
Police Involvement with mental health in-patients - Policy	KMPT, March 2015
Restorative Practice: Repairing harm – A response to patients who have caused harm - Procedure	KMPT, October 2016
Stress Management Policy	KMPT, May 2015
Staff Supervision Policy	KMPT, November 2016
Staff support Policy	KMPT, May 2015
Prevention and Management of Violence and Aggression and Rapid Tranquilisation Policy and Guidance	KMPT, 2017
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CONTENTS

1. INTRODUCTION

2. Patient perpetrated violence in forensic inpatient settings

2.1 Staff on inpatient settings haven been shown to be at most risk of violence and aggression in healthcare settings (Renwick, Stewart, Richardson, Lavelle, James, Hardy, Price, & Bowers, 2016). In the UK, the National Audit of Violence found that on acute inpatient settings 44% of clinical staff and 72% of nursing staff were threatened or made to feel unsafe at work; 46% of nursing staff reported physical assaults (Royal College of Psychiatrists, 2007). Bowers, Stewart, Papadopolous, Dack, Ross, Khanom, and Jeffery (2011) found rates of violence were greater in forensic inpatient services. Variation of violence within such settings exist and may be accounted for by staffing levels and education (Bowers Douzenis, Galeazzi, Forghieri, Tsopelas, Simpson, & Allan, 2005); as well as methodological problems in study design (Beech and Leather, 2006). Violence experienced by healthcare staff can take many different forms including, verbal abuse and threats (Jonker, Goosens, Steenhuts & Oud, 2008), physical assaults (Renwick et al, 2016) and sexual assaults (Flannery, LeVitre, Rego, & Walker, 2011).

3. Impact of patient perpetrated violence

3.1 Consequences to these events can include physical injury (Bowers et al, 2011) and/or psychological harm (Leeuwen and Harte, 2015). In a study of 150 forensic healthcare professionals working in medium secure units in the UK, Elliott and Daley (2012) found a substantial proportion of staff experienced elevated levels of psychological distress and occupational stress, with moderate levels of burnout, their relatively small sample size and low response rate may have impacted on results. Whilst the majority of staff are found to go on to make a full recovery (Jonker, et al, 2008; Rick, O'Regan, & Kinder, 2006) more severe responses to patient perpetrated violence has included post traumatic stress disorder (PTSD).

3.2 How staff cope with these experiences has stimulated much interest. High levels of staff support have consistently been linked to lower levels of occupation stress (Elliott and Daley, 2012) and reduced levels of emotional stress (Stewart and Terry, 2014). Effective clinical supervision and reflective practice are two ways in which meaningful staff support can be delivered (Coffey and Coleman, 2001). Stewart and Terry's (2014) systematic review found clinical supervision and psychosocial intervention training to be amongst the most effective strategies in reducing staff burn out, with the latter also improving attitudes and empathy towards patients for nurses, their study was limited by the small number of papers reviewed.

3.3 Staff training has also been found to be helpful in targeting some of the known 'at risk' staff groups (Flannery et al, 2011) and may include principles and practices of personal safety (Beech and Leather, 2006) and building personal resilience (Clarke, 2008). Training for unqualified staff has also been identified as a need (Clifford and Reid, 2016). Unfortunately, we have not reached a stage where positive effect can be generalised (Beech and Leather, 2006). Staff counselling has also led to positive psychological outcomes (McLeod, 2008; Xanthakis, 2009).

3.4 In addition to staff members being affected by patient perpetrated violence, implications on patient care were recognised by Arnetz and Arnetz (2001), who found patients' reported a lower quality of care from hospital staff who had experienced client violence. There are implications at a wider service level with financial costs in relation to increased absenteeism and high staff turnover (Wright 2005; Leeuwen & Harte, 2015) reduced productivity and low morale (Occupational Safety and Health Administration, 2015) including staff wanting to leave their job (O'Connell et al, 2000, as cited in Greenwood et al, 2012).

4. Models of staff support

4.1 Literature in the last decade has focused on developing models and guidance in how to safely and effectively support staff post violence. Clarke's (2008) model of dynamic adaption (MDA) provides detailed and systemic guidance in how to target interventions to minimise the stresses experienced in critical occupations. There is increasing recognition that early intervention is central to the prevention of long term disability (Privitera, 2010) and getting the 'right kind of support' is key in enabling staff to move on from the effects of patient perpetrated violence (Jussab and Murphy, 2015).

4.2 Much of the earlier support frameworks were built on Dyregrove's (1997) and Mitchell's (1983) models of psychological debriefing (PD); a process involving an intense emotional re-exposure to the incident. However, in the 90's and 00's it was suggested such approaches were ineffective, and may also have caused further harm (Raphael & Meldrum, 1995; Rose, Bisson, Churchill & Wessely, 2002). Controversy surrounding PD led to a review of the trauma response guidance and NICE (2005) advised instead, practical, emotional and social support. Advocates of PD have defended the approach, highlighting methodological flaws within studies critiquing it (Regal, 2007; Mitchell & Everly, 2003; Regal and Dyegrov, 2012) and demonstrate how the critical incident stress management (CISM) approach, of which PD forms a part, has been adopted and applied to many services in all but name, such as the British Royal Marines utilising a 'Trauma Risk Management' (TRIM) approach.

4.3 Rick, et al's (2006) 'Support Post Trauma' (SPoT) approach focuses more on practical support and information. Over a two year period, they generated data from 815 royal mail workers who had been exposed to potentially traumatic incidents in the UK. Those who attended SPoT meetings were more likely to experience increased reassurance about their symptoms, felt more knowledgeable with regard to where they could access further information and support, and felt more cared about than those who did not receive SPoT. In the United States and Canada the Assaulted Staff Action Program (ASAP) has been selected as best practice in supporting staff with symptoms of psychological distress (Flannery et al, 2011). The voluntary programme involves offering psychological first aid immediately after an incident, a follow up meeting, support groups and referrals to trauma specialists. Follow-up studies have indicated ASAP interventions led to resolution in trauma symptomology, with personal recovery and workplace functioning being restored; a randomised control trial to rule out spontaneous recovery, has not been completed owing to the ethical issues this would raise.

5. Rationale and aims of procedure

5.1 This procedure is designed to address the need for robust staff support following exposure to violence within the Low Secure Forensic Service. It builds on the previous procedure 'staff support following incidents' (KMPT, 2009) which was based on Rick, O'Regan & Kinder's (2006) SPoT approach. A study evaluating the former staff support model (Cooper & Inett, in preparation) and a review of the literature have led to the development of the model.

6. THE PROCEDURE

6.1 In recognition that verbal abuse can lead to negative psychological outcomes for staff, the definition of violence includes nonphysical behaviour; the National Collaborating Centre for Mental Health (2014, p.16) refer to violence and aggression as *"a range of behaviours or actions that can result in harm, hurt or injury to another person, regardless of whether the violence or aggression is behaviourally or verbally expressed, physical harm is sustained or the intention is clear"*. The criteria for an incident requiring support would include the following:

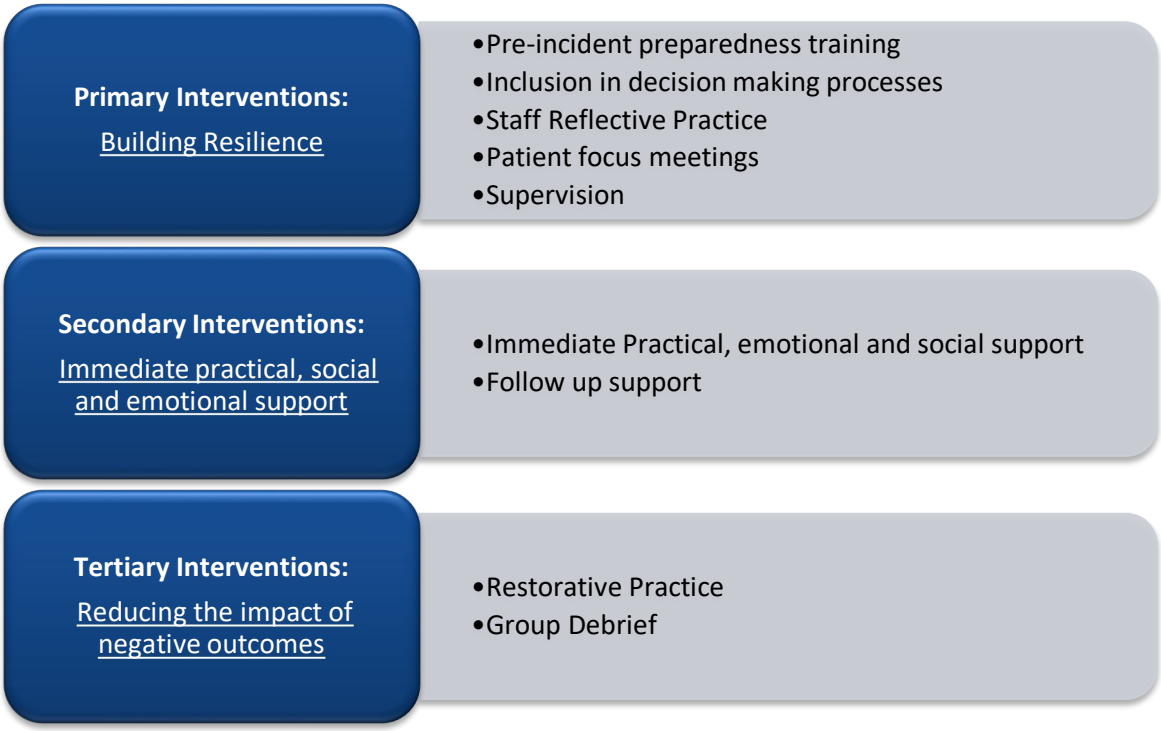
- Use of a weapon and physical assault
- Severe and ongoing threats of violence
- Racial abuse
- Personal verbal abuse and/or harassment
- A build up of minor incidents involving a particular staff member
- Sexual assault
- Early exposure to aggression for a new or inexperienced member of staff

6.2 The procedure also includes other incidents which may impact significantly on members of staff, for example;

- Suicide or death of a patient
- Involvement in a restraint
- Witnessing any event described above
- Any incident which would generate a SUI report
- Self referral from a staff member for support

6.3 The procedure described below adopts a model utilised by the Department of Health (2007, cited by Clarke, 2011) offering primary, secondary and tertiary interventions.

6.4 Figure 1: Integrated model of staff support



7. Primary Interventions, Building Resilience:

Aims to maximise staff well being by promoting good psychological health and minimise unhelpful outcomes.

7.1 Pre-incident preparedness training:

7.1.1 Mandatory training for all new starters. The training will be for all staff who have direct patient contact within the low secure forensic service, including all health care staff (qualified and non-qualified), administration and hospitality services.

7.1.2 Training will be delivered by the psychology department.

7.1.3 The training will include; psychoeducation about the kinds of stressors likely to encounter, common stress reactions, stress-management techniques, what support is available, where and how to access support.

7.1.4 Competence based Training: Working with offenders with complex mental health needs and developmental disorders: Communicating with, meeting and responding to their needs (including responding to aggression).

7.2 Inclusion in decision making processes:

7.2.1 An opportunity for nurses and health care workers to be involved with the decision making processes regarding the care and treatment of their patients.

7.2.2 Health care workers and nurses to attend their named patients ward rounds and Care Programme Approach Reviews.

7.2.3 Health care workers and nurses to provide fortnightly summaries of their named patients in ward round progress notes.

7.2.4 Wherever possible Clinical managers responsible for ensuring patients named nurses and key workers are booked to work on their patients ward round days and CPA's.

7.3 Staff Reflective Practice:

7.3.1 To be offered by trained members of the psychology department on a fortnightly basis.

7.3.2 Reflective practice sessions with be offered to each ward, and all members of the team who provide input to that ward will be invited.

7.3.3 A protected space where the team may have the opportunity to share in a non-judgemental environment, how the work impacts on their personal, psychical and psychological health and their relationships with colleagues.

7.3.4 To foster the gaining of mutual support, knowledge and insight from others, in a trusting, open and honest environment where confidentiality is paramount.

7.3.5 To develop effective multidisciplinary communication structures within the team that leads to a greater understanding and respect for the role of others.

7.3.6 To develop, through the group process, a consistent and cohesive team approach, whereby clear procedures and boundaries, when working with patients, are agreed and adhered to by the whole team.

7.3.7 To share concerns and uncertainties regarding work with patients and to explore, if appropriate, possible strategies when difficulties arise.

7.3.8 To allow clinicians to 'de-role' and to share their frustrations, feelings and vulnerability relating to difference of professional opinion, style, approach, etc., without being judged as failing in a professional capacity when using the group for this purpose.

(Thorndycraft & McCabe, 2008)

7.4 Patient focus meetings:

7.4.1 A regular programme of discussion meetings focused on individual patients. These meetings will be held as and when required and should be attended by a representative sample of the ward based team and as many members of the MDT as possible in order to share knowledge and experiences of working with patients in a supportive framework for all staff.

7.4.2 The meetings follow the Patient Information Profile structure with the aim of enhancing the involvement of each team member in the care planning process and a sense of active, valued involvement in each patient's care.

7.4.3 These meetings are co-ordinated by the clinical managers and the psychology department and invites are circulated throughout the entire staff group.

7.4.4 The meetings are planned to take place just after handover to allow as many ward staff to attend as is possible, payable as bank hours to staff members who attend when they are not on shift.

7.5 Supervision:

7.5.1 The formal provision, by approved supervisors, of a relationship-based education and training that is work-focussed and which manages, supports, develops and evaluates the work of colleagues (Milne, 2014).

7.5.2 The objectives of supervision are normative (e.g. case management and quality control issues); restorative (e.g. encouraging emotional experiencing and processing, to aid coping and recovery); formative (e.g. maintaining and facilitating the supervisees' competence, capability and general effectiveness).

7.5.3 Supervision will form part of the 'watchful waiting' approach, with supervisors assessing and monitoring any signs of distress in supervisees following incidents of patient perpetrated violence (either experienced directly or indirectly).

7.5.4 Each discipline will follow their code of practice in the implementation and delivery of supervision.

7.5.5 See also Staff Supervision policy.

8. Secondary Interventions, Immediate practical, social and emotional support:

Aims to assess early signs of distress, provide psychological distance and immediate support. Please see Figure 2, at the end of this section for a flow chart outlining the staff support process. (Please also refer to the staff support policy, KMPT, 2015 & Stress management Policy, KMPT, 2015).

8.1 Immediate practical, emotional and social support: The guidance provided here is to be offered as soon as the situation has been stabilised and safety has been resumed for all patients and staff. Those who have been harmed (or at risk of being harmed) should be removed from the situation immediately. Prior to offering the support described below it is expected staff would have followed relevant procedures with regard to relational security, de-escalation and restraint, individualised risk management plans to manage the situation (as detailed in each patients structured professional judgement tool), positive behaviour support plans and care plans. (Please also see Prevention and Management of Violence and Aggression and Rapid Tranquilisation Policy and Guidance, KMPT, 2017).

8.1.1 The immediate support described below will be offered by the NIC. Where the NIC has been harmed, immediate support will be offered by the ward manager. Where the ward manager is unavailable or has been harmed, support will be offered by a senior nurse from another ward and the on-call manager.

8.1.2 Where physical harm has occurred immediate medical attention to be offered, including support to Accident & Emergency.

8.1.3 Senior person responsible to acknowledge and validate experiences of those harmed. The staff harmed to be offered 10 to 15 minutes away from the ward (a longer period may be indicted in some circumstances). If necessary cover to be offered by other wards.

8.1.4 Where significant psychological or physical harm has occurred, the incident must be recorded onto relevant databases by the senior person responsible (DATIX, RIO, KASAF, incident forms), where the harm has caused minimal distress the staff member directly affected will be responsible for documenting the incident. Information can be copied and

pasted from RIO onto the incident forms to save time. The person harmed should be asked once for details of what happened, confirming the accounts written by the senior person responsible. Senior person responsible to ensure all documents/incident forms are sent to relevant parties.

8.1.5 Senior person responsible to hand information over to members of the MDT and during shift changes, preventing the person harmed from re-living the trauma.

8.1.6 Where the member of staff has gone home early or is at Accident and Emergency the senior person responsible to call them before the end of their shift, offering further validation of their experiences.

8.2 Follow up support (checking in) forming a watchful waiting approach:

8.2.1 The incident should be handed over to the wider MDT in the morning handover meeting on the next working day. The incident will be allocated to a member of the wider MDT to offer follow up support to the staff harmed. Where there is more than one staff member involved, there may be more than one allocated MDT member. The allocations will be logged and the record placed in the morning handover meeting file. On each day cases will be allocated to the following disciplines (unless there is reason for the case to be allocated to a particular person).

- Monday – Psychology
- Tuesday – Psychiatry
- Wednesday – Occupational Therapy
- Thursday – Social Work
- Friday – Nursing

8.2.2 Within 24 hours the allocated member of the wider MDT (including senior management) will check-in with the staff harmed and assess how they are. If the staff member is not on shift support can be offered by telephone or initial contact made via email. If the MDT member is unable to speak directly to the member of staff, a voicemail message or email will be left explaining the purpose of the call (see 7.2.4 below) and asking them to get in contact if they feel they need further support.

8.2.3 Only members of the wider MDT who have been trained in providing follow up support will be allocated cases. The training will be mandatory for all senior management, ward managers, senior nurses and members of the wider MDT. The Psychology department will be responsible for providing this training.

8.2.4 The role of the supporting member of staff is to;

- Validate experiences and explain the purpose of contact is to enquire after their wellbeing and to offer peer support. The MDT member will adopt an empathetic non-judgemental approach and offer general reassurance.
- Provide information about stress reactions (for example, be reassured that feeling anxious about the incident, being more irritable than normal, disturbed sleep, or being preoccupied with the incident is quite normal following a difficult incident, and that such feelings should alleviate with time).
- Provide information about coping with stress (for example, giving staff permission to take care of themselves, identifying people they can talk to, what they could do to relax, remind them not to take on too much, who to talk to if they need time off).
- Inform them of other support available, how to access this support and how they may be supported with this (staff care services (counselling); Occupational health team, health and safety team, the Trust Chaplaincy service, Legal services department, complaints department, promoting safer therapeutic services (PSTS) team, security management services) in accordance with the KMPT Staff Support Policy, 2015).
- Discussion of the details of the incident will be avoided during these conversations. This is in accordance with research and best practice guidelines

which suggest there is a risk of re-traumatising the person during *single session* debriefing. If they try to discuss incidents, they will be advised that now is not the best time to do so and that they should wait a few days and see how they feel then. There may be times a formal debriefing process is necessary, this will be assessed and delivered by a trained member of the psychology department (see debriefing below).

- The individual's line manager and/or supervisor should engage in a process of watchful waiting for any increase in signs of trauma for the following month.
- A follow up contact from the allocated MDT member to enquire about the need for any further support should also be arranged one month following the incident. There will be a prompt for the follow up support to be offered in the morning handover file.
- Should the member of staff be displaying signs of PTSD longer than one month post incident, they should be referred to the staff care services, where they will be supported to access counselling.

8.2.5 Police involvement: The Trust is committed to supporting staff to report any incidents of harassment and assault, including physical, racial and sexual abuse perpetrated by patients, to the police for further investigation. The victim of any such assault should be made aware of this course of action through the follow up support, and supported to file a report should they wish to by their manager.

- It is the decision of the individual harmed whether they want to inform the police. It is their responsibility to inform the police by dialling 101.
- If the victim of the crime is too distressed to make the call but has decided they want to pursue police action, their line manager will provide support in contacting the police.
- Where the case has progressed to the Courts, the member of staff will be given time off from work to attend.
- The line manager of the member of staff harmed will provide regular check in's to see how the member of staff is coping with the progress of the case, providing appropriate support where necessary.

9. Tertiary Interventions: Reducing the impact of negative outcomes:

Aim to manage symptoms of distress and support staff to work through traumatic and difficult experiences.

9.1 Restorative Practice:

9.1.1 Restorative practice has been shown to reduce harm, build relationships and facilitate helpful dialogues. It offers victims of harm a process in which they can reach a sense of closure and reassert some control over their situation. It allows the harmer to reflect more greatly on their behaviour and relearn how they might behave in the future.

9.1.2 Where harm has been caused and ruptures emerge in therapeutic relationships, restorative practice will aim to repair the harm caused.

9.1.3 Both the patient and member of staff must be willing participants for a restorative intervention to be considered.

9.1.4 A restorative intervention must be delivered by a trained facilitator, which will aim to repair the harm caused.

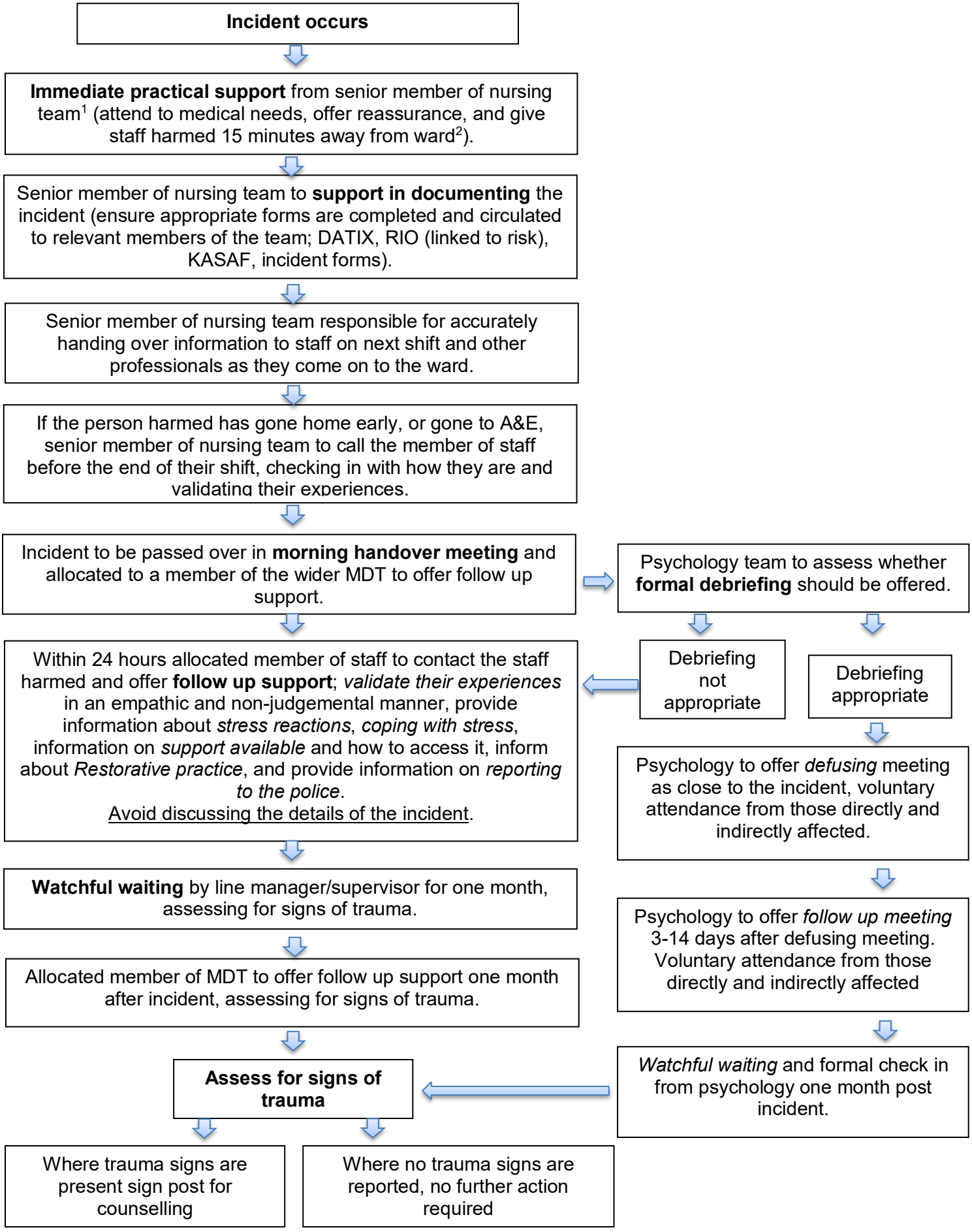
9.1.5 Please refer to the 'Restorative Practice: Repairing harm' procedure (KMPT, 2016) for guidance on the implementation of this intervention.

9.2 Group Debrief:

9.2.1 In some circumstances it may be appropriate to offer a more formal debriefing approach. This is an opportunity for staff to come together for support and discussion. Debriefing is not a fix, nor will it prevent trauma reactions. It should be offered to the whole staff team (including those directly and indirectly involved, including witnesses) and is attended on a voluntary basis. The need for this intervention will be assessed and then delivered by trained members of the psychology department. Where possible the intervention will be delivered by two trained debriefers.

- *Part 1: Defusing:* As close to the incident, offer support to all affected staff, providing facts about the incident, and psychoeducation on stress, normalise and validate experiences, practical support on how to access support and how to move forward (including how shifts will be covered etc.). Signpost to relevant resources/departments where appropriate.
- *Part 2: Follow up meeting:* 3 -14 days after first group meeting. A chance to review and go over some of the material covered in the first group. Communicate progress of cases and consider signposting. To be offered by the same debriefers.
- *Part 3: Watchful waiting and formal check in with staff:* Offered one month after the incident. All staff encouraged to look out for one another and alert management to any signs of distress. Signposting where indicated.

10. Figure 2: A flowchart in responding to patient perpetrated violence



[1] Where a NIC or ward manager has been hurt, support and cover to be provided by ward manager or NIC from another ward.

[2] Time away from ward to be assessed by senior nurse, a longer period may be required, staff from other wards to provide cover.

EQUALITY IMPACT ASSESSMENT

The Equality Act 2010 places a statutory duty on public bodies to have *due regard in the* exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes.

HUMAN RIGHTS

The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with. If you think your policy/strategy could potentially breach the right of an individual contact the legal team.

MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

Try to use the following table to show how implementation of the procedure/ guideline/ protocol will be monitored This section may also include details of review – although not necessary to repeat a date if that is on the front page Remember – if a process is documented it must also include how it will be monitored

What will be monitored	How will it be monitored	Who will monitor	Frequency	evidence to demonstrate monitoring	Action to be taken in event of non compliance
MDT members allocated to offer staff support	Log of allocations to be kept		Annually	Log of allocations held	Review of systems in place. Meetings with professionals involved and line management.
Debriefing sessions	Log of debriefing sessions	Psychology team	Annually	Log of sessions held	
Numbers of staff reflective practice sessions & patient focused meetings	Log of sessions to be kept	Psychology team	Annually	Log of sessions held	
Completion of pre-preparedness training	List of attendees	Psychology team and management	Annually	Training Attendee list	
Restorative Practice interventions	Restorative Practice database	Sarah Cooper	Annually	Referral database and supervision records	
Supervision records	Log of supervisions	Admin	Monthly	Log of supervision	

APPENDIX A EQUALITY ASSESSMENT SCREENING

General Information	
Name/s of function: (*State whether service, policy, project etc.)*	Procedure
Directorate:	Forensic and Specialist Services
Function Owner:	Sarah Cooper
Date of screening:	19.08.2017
Is this a proposed, new or existing function?	EXISTING FUNCTION (To replace Tarentfort Centre staff support following incidents procedure)

Aims of function and monitoring arrangements

What are the overall aim/s or purpose**?** *Include outline of objectives and function aims* of the policy, procedure, practice or service.

This procedure is designed to address the need for robust staff support following exposure to harmful events within the Low Secure Forensic Service Centre. It builds on the previous procedure 'staff support following incidents' (KMPT, 2009). A study evaluating the former staff support model (Cooper & Inett, in preparation) and a review of the literature has led to the development of the new procedure.

Do you monitor the policy, procedure or practice in relation to any of the following?

☒Complaints ☐ Eligibility criteria ☐ KPI's ☐ Service Uptake

☒User Satisfaction ☐ Equality characteristics Other: Research and Audit

Which protected groups of people will be affected by the policy, procedure or practice? E.g. particular service users, staff, patients etc. Please tick the box if any of the following protected groups will be affected? Provide brief details about the nature of impact. Use, anecdotal qualitative or quantitative in-house information identified above both local and any regional and national research findings, surveys, reports, research interviews, minutes from focus groups, anecdotal evidence stated in organisational documents, other forms of engagement activities, pilot activity evaluations etc. If there are gaps in evidence state what you will do to close them.

Age YES ☐ NO ☒ Detail nature of impact	Disability YES ☐ NO ☒ Detail nature of impact
Gender reassignment YES ☐ NO ☒ Detail nature of impact	Marriage and civil partnership YES ☐ NO ☒ Detail nature of impact
Pregnancy and maternity YES ☐ NO ☒ Detail nature of impact	Race YES ☐ NO ☒ Detail nature of impact
Religion and belief YES ☐ NO ☒ Detail nature of impact	Sex YES ☐ NO ☒ Detail nature of impact
Sexual orientation YES ☐ NO ☒ Detail nature of impact	Other Detail nature of impact

DETERMINING EQUALITY RELEVANCE OF THIS FUNCTION?

Does this function have Relevance to Equality & Human Rights? YES ☐ NO ☒ *Note: Public authorities need to consider all of their functions in order to determine which of them are relevant to the aims of the duty. Some functions will be relevant to most or all protected groups.*

PROPORTIONALITY - Based on the answers above what weighting would you ascribe to this function? LOW		
HIGH High relevance to equality, /likely to have adverse impact on protected groups	MEDIUM Medium relevance or Insufficient information/evidence to make a Judgement.	LOW Low relevance or Insufficient information/evidence to make a judgement.
State rating & reasons: *(Green or Low equality relevance of function means does not have to undergo full impact assessment because it has nothing to do with protected groups).* Function owner should conclude the process at this stage.		
If you ascribed function equality & human rights proportionality as Red or Amber – Please provide reasons.		
Is a Full Equality Impact Assessment required? YES ☐ NO ☒ *(If no, please DO NOT CONTINUE Just date and sign at the end of the form).*		
YES - If you have established that there may be some equality relevance adverse then proceed to the Full Equality Impact Assessment		
Additional comments:		
Date Screening was completed		
Screening Lead:	Signed:	Date:
Head of Department/Directorate:	Signed:	Date

(This should show the Screening done by the Policy Owner prior to this stage)

If it is felt the policy requires a full equality impact assessment this form can be found by clicking on the below link
http://staffzone.kmpt.nhs.uk/Downloads/staffzone/policies/EqIA%20Full%20Assesment.doc