Blackpool Teaching Hospitals
NHS Foundation Trust

Placing a Risk of Violence Warning Marker on Electronic and Paper Records

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Version Control Sheet

This must be completed and form part of the document appendices each time the document is updated and approved

Date dd/mm/yy	Version	Author	Reason for changes
09/07/19	2	Karen Sanderson, Local Security Management Specialist	General review

Consultation / Acknowledgements with Stakeholders

Name	Designation	Date Response Received
	Health Informatics Governance Divisional Board	16/05/2019
	Health Informatics Divisional Board	16/05/2019
Colin Norris	Health and Safety Officer	02/11/2018
Tracy Crumbleholme	Assistant Director of Nursing (Quality)	
Lisa Horkin	Associate Director Nursing Unscheduled Care	

Consultation / Acknowledgements with Stakeholders		
Name	**Designation**	**Date Response Received**
Carole McCann	Associate Director Nursing Community Midwifery and Health	
Jo Lickiss	Associate Director of Nursing Scheduled Care	
Nicola Parry	Associate Director of Nursing Midwifery	
Steven Bloor	Head of Information	
Marie Thompson	Director of Nursing	
Dawn Goodall	Solicitor/Head of Claims	
Hayley Atkinson	Information Governance Manager	
Karen Hawkins	Health Records Service Manager	12/07/2019

CONTENTS

1 Introduction / Purpose

Blackpool Teaching Hospitals NHS Foundation Trust has a duty of care under health and safety legislation, and accountable as employers for assessing the risks of violence to their employees and, if necessary, putting in place control measures to protect them. This policy ensures that appropriate control measures are put in place to protect NHS staff in the implementation of a system of markers on electronic and/or paper records to help alert staff to individuals who pose or could pose a risk of violence. This also enables staff to take actions to reduce this risk.

Provide security warnings and handling advice to NHS staff to avoid or minimise the risk.

Helps reduce the number of violent incidents at the local level also assisting in creating a safe and secure environment for staff, patients and visitors.

1.1 Definitions

Unacceptable or inappropriate behaviour can be defined as any incident where a staff member feels, harassed, abused, threatened, bullied (not by a colleague), insulted in circumstances relating to their work or whilst they are at work.

The Health and Safety Executive (HSE) definition of work-related violence:

> '*Any incident, in which a person is abused, threatened or assaulted in circumstances relating to their work. This can include verbal abuse or threats as well as physical attacks*.

Violent Warning Marker (VWM): a visible electronic or paper marker applied to a care record to indicate a level of risk following an incident of violence associated with a particular service user or relative / next of kin.

Senior clinical lead / line or team manager – Is any person authorised to review and sign off any incident reports of Blackpool Teaching Hospitals NHS Foundation Trust.

Clinician – relates to any practicing health care professional who works with patients, this will also include other staff groups such as volunteers or engagement representatives under the umbrella of Blackpool Teaching Hospitals NHS Foundation Trust.

2 General Principles / Target Audience

This procedure applies to all staff directly or indirectly employed by Blackpool Teaching Hospitals NHS Foundation Trust including Bench staff, Students agency workers and independent contractors who carry out work within the Trust.

3 Definitions and Abbreviations

HSE	Health and Safety Executive
LSMS	Local Security Management Specialist
MRLM	Medical Records Library Manager
SMD	Security Management Director
VWM	Violent Warning Marker

4 Responsibilities (Ownership and Accountability)

4.1 Chief Executive

The implementation of this policy is the responsibility of the Chief Executive. The Chief Executive will appoint a Director at board level with voting rights and with responsibility for Security Management within the Trust.

The Chief Executive will ensure a Director is nominated as the Security Management Director (SMD) in line with the Secretary of State Directive for Security Management within the NHS.

4.2 Security Management Director (SMD)

The Director of Nursing has been assigned the role of Security Management Director SMD.

The (SMD) is responsible for ensuring the support of the Board is obtained for security management strategies and initiatives, and a scheme for placing risk of violence markers on patient records including the identification of those patients is in place.

4.3 Local Security Management Specialist (LSMS)

The Trust's Local Security Management Specialist's (LSMS) has statutory responsibility for assisting the SMD in the promotion and realisation of a pro-security culture throughout the Trust.

This includes:-

- Undertaking Investigating incidents of violence
- Gathering evidence from victims and witnesses
- Contributing to a risk assessment
- Making the recommendation and/or decision on the need for a violence marker to be assigned
- Ensuring that all relevant staff have access to the necessary information, particularly those working off-site, outside office hours and lone workers.

The role of the LSMS is not to establish whether the act was intentional or based on an underlying clinical condition, treatment or care, but to assist staff in managing future risks.

4.4 Assistant Director of Nursing (Quality)

The Assistant Director of Nursing and Quality will act as the representative of both the (SMD Panel) to provide advice and guidance on the risk assessment process undertaken before the decision is made whether to mark an individual's record. If the Assistant Director of Nursing and Quality feels a further escalation is required they will refer the alert through a panel process, (refer to 4.1.7)

4.5 Information Governance Manager

It is the duty of the Information Governance Manager to provide advice and guidance on the application of the Data Protection Act 2018 with regards to the vulnerable marker placed on the records

4.6 Senior Clinicians

Where applicable the Senior Clinician in charge of the patients care will be required to provide advice to the LSMS and Review Panel, where an individual's medical condition or medication may have contributed to an incident of violence or aggression. This includes identifying factors in relation to the patient's condition which may be a trigger for violence, and identifying prevention measures.

4.7 Review Panel

It is the responsibility of the Review Panel to reassess any decisions made with regard to the application of any temporary Violence Markers that have been placed on to a Patients record.

The panel members will consist of:

- Information Governance Manager (Chair)
- Governance Risk and Patient Safety Manager
- Local Security Management Specialist
- Mental Capacity Act Lead
- Head of Safeguarding or Representative
- Clinician, Doctor, Nurse relating to Patient
- Trust Solicitor

With the main focus to provide a safeguard to ensure that the decision-making process is objective, transparent and fair (Safeguarding issues will be reviewed by the panel on guidance from the Head of Safeguarding).

4.8 Departmental / line managers

Departmental Managers are responsible for ensuring all staff reporting incidents of violence are aware of the Policies and procedures in place regarding Placing a Risk of Violence Marker on the Electronic and Paper Records.

Managers when first made aware of any reports involving potentially violent individuals, following an incident involving one of their staff members and before the decision is made whether to mark an individual's record must

- Ensure that risk assessments are completed and appropriate systems are in place to protect the safety of individuals at risk
- Complete an Untoward incident report form following such an event ensuring that enough details are documented on the form to allow the LSMS and to make a decision with regard to placing a risk of violence markers on the electronic data base.

Departments must not keep a Violent Warning Marker / patient's database for their own records.

4.9 Staff

It is the responsibility of all staff to take reasonable care of their own safety, to familiarise themselves with all relevant policies and procedures, to attend all relevant training, to take preventative measures when they identify a potential risk of violence, and to report all incidents of physical and non-physical assault through the Trust incident reporting system

Where a VWM has been assigned, staff need to know what is expected of them. This includes being aware of the risks associated with the individual and the application of preventative measures.

Staff who do not have direct access to patient health records must be made aware of all relevant information held in a VWM.

5 Procedure

The management of disturbed and violent behaviour frequently can involve interventions to which an individual does not or cannot consent to. It is therefore essential that staff use interventions that are in accordance with best practice and the law.

Failure of the Trust or individuals to act in accordance with guidelines i.e. law, both criminal and professional, may not only be a failure to act in accordance with best interest but in some circumstances have legal consequences.

Any intervention used to manage violence, aggression and challenging behaviour must be a reasonable and proportionate response to the risk it seeks to address. Staff must also assess the need to contact the police and report all incidents in accordance with The Prevention and Management of Violence, Aggression and Abuse at Work CORP/PROC/123.

When an incident occurs and is reported through the incident reporting systems there will be a systematic response by the senior clinician / line manager or consultant which may involve the issuing of verbal warnings, the marking of a service users records, and also acceptable behaviour agreements i.e. the issuing of warning letters and also in exceptional instances the withholding of treatment where there continues to be a threat to staff.

An acceptable behaviour agreement and/or marker will be applied where the individual abusing the staff member is a patient, but will equally be applied where the individual is a service user's associate (e.g. friend, relative or guardian).

Incidents of assault which involve clinical and non-clinical elements will equally be assessed for the implementation of a marker or letter;

5.1 Criteria for a marker

5.1.1 Types of incident

Examples of the types of incidents that might warrant a VWM please refer to (Appendix 2) examples of the types of incidents that may warrant a VWM for examples.

The same principles apply whether placing a VWM on the records of a patient or a patient's associate (carer, relative, friend or animal/family pet).

5.1.2 Reporting and investigating

5.1.2.1 The Trust procedure for incident reporting (Untoward Incident Reporting Procedure CORP/PROC/101) must be followed by staff witnessing an incident of violence or aggression and must be investigated promptly by the line manager.

5.1.2.2 The decision about whether a record should be marked will be based on: (please refer to Appendix (3)).

- Incident report
- Investigation of the incident
- Consultation with the victim, their line manager, LSMS and any other relevant staff
- Any statements taken

5.1.2.3 Any decision to place a VWM on a patient record will be based on a specific incident / series of incidents and not personal opinion or hear say.

5.1.2.4 There may be occasions where a perceived severe or imminent risk to staff outweighs the need for an investigation to be completed.

In those circumstances, the LSMS and Assistant Director of Nursing (Quality) will decide if a VWM may be placed on an individual's record, pending the prompt completion of the investigation.

5.1.3 Risk assessment / Factors to consider

5.1.3.1 There are specific risk factors that will be considered when determining whether a Patients record should be marked, this will include the following:

- Nature of the incident
- Degree of violence used or threatened
- Any injuries sustained
- The level of risk that the individual poses
- Medical condition and medication of the individual at the time of the incident
- Alcohol or drugs related
- Animal related
- Weapons related
- Whether an urgent response is required
- Impact on staff and others
- Mental Health Illness
- Previous history

5.1.3.1 Any risk assessment regarding the marking of patient records will include these factors above, as well as additional information provided by the Trust Health and Safety Advisors or staff and union representatives.

5.1.3.1 Refer to the Trust's Risk Management Policy CORP/POL/547 for instruction on who in the Trust is responsible for completing the assessments and where they should be recorded.

5.1.3.1 (For further information please refer to Appendix 3 for a checklist which may assist in the assessment of risk).

5.2 Decision-making process

5.2.1. The LSMS and relevant manager will consider the evidence available and risk assess the requirement for a VWM to be placed on an individual's record.

All incidents of violence and aggression will be considered for a VWM.

Where this is considered necessary, a marker will be placed on the system as soon as practicable. Only the LSMS must place a VWM on a patient's record.

5.2.2 The decision to place a VWM on an individual's record will then be forwarded to the LSMS for consideration and approval, along with the evidence and risk assessment.

5.2.3 The Assistant Director of Nursing and (Quality) will liaise with the LSMS and consider:

- If the VWM placed on an individual's record, is still relevant and appropriate this may include taking advice from an appropriate senior clinician.
- Whether the VWM can be removed from an individual's record
- Whether to inform the individual of the VWM, however, this may be rejected because it may provoke a violent reaction, jeopardise the individual's health or cause unnecessary distress to close relatives
- Whether the information requires sharing with other organisations
- Decide on a review period, usually between 6-12 months
- Oversee the review of VWMs
- Manage complaints

5.2.4 If it is concluded that a VWM is inappropriate, the LSMS will:

- Remove the marker at the earliest opportunity
- If previously notified, inform the individual of the decision
- Keep the victim informed

5.2.5 The Assistant Director of Nursing (Quality) will hold meetings with the LSMS, based on the following:

- Number of referrals
- Availability of the panel members
- Existing meeting arrangements
- Urgency of marking records

5.3 Placing a VWM on patient records

5.3.1 Essential Information

5.3.2 The VWM will include: Appendix 4

- Who or what the VWM applies to
- A brief classification of the incident
- Date the VWM is effective from
- Whether the individual has been notified or should not be notified
- Essential advice for staff
- Date for review

5.3.3 Additional information may include:

- Brief description of the incident
- Information relating to an individual's medical condition, if relevant
- Advice that the individual should not be denied treatment or care
- Any security warnings
- Reference to a dangerous animal
- Photograph or CCTV Still

5.3.4 When a violent warning marker relates to a patient themselves it will appear on their record

5.3.5 When a VWM relates to a direct associate of a patient, e.g. a carer, relative or friend, and their record or identity is not available to the Trust, a VWM will be placed on the patient's record but it will clearly identify whom it concerns, in order not to stigmatise the patient unfairly.

5.3.6 The LSMS will contact the Health Records Service Manager (HRSM) to arrange for the alert marker to be recorded on the patient's electronic record and provide a copy of the VWM (Appendix 4) for inclusion into the paper Health Record Folder (to be filed in section 1). Notification will also be given by the LSMS to the HRSM to instigate removal.

The LSMS will place the VWM on the various electronic record systems within the community setting.

5.3.7 Where a VWM has been assigned it will be available to view on the:-

- Acute electronic record (visible within A&E department)
- Acute paper health record in section 1
- Community IPM / PCIS record

5.3.8 It is the responsibility of all staff and managers to act on the information contained on the VWM and take appropriate steps to mitigate the risk of violence to staff who may come into immediate contact with the individual. Staff should refer to the Trust Prevention and Management of Violent, Aggressive And Abusive Patients, Relatives Or Visitors (CORP/PROC/123) procedure for further information.

5.4 Notifying the individual

5.4.1 The LSMS will be responsible for notifying the individual in writing if appropriate, that a VWM has been placed on their record.

A letter will be sent to the individual when the panel have:

- Confirmed the decision to place a VWM on the individual's record and
- Decided that the individual should be notified

5.4.2 A template is shown in Appendix 5.

5.4.3 The individual will be made aware that the information associated with a VWM may be shared with other NHS bodies and other providers with whom we jointly provide services for the purposes of their health and safety.

5.5 Information sharing

5.5.1 Principles

5.5.1.1 It is permissible and legitimate to share information contained in a VWM with other providers or health bodies in circumstances where:

- There are identified risks of violence which may affect staff who come into contact with the patient, internally or externally
- The processing is fair and justified
- Disclosures should be proportionate and limited to relevant details

5.5.2 Process

5.5.2.1 The Assistant Director of Nursing (Quality) will consider whether any information should be shared, and to whom, as part of the review process.

5.5.2.2 A review of the risk will determine with whom the information should be shared on the basis that they may come into contact with the individual, e.g.

- Other NHS Trusts
- Ambulance Services
- GP Practices
- Social Services
- Police

5.6 Reviewing a VWM

5.6.1 Review dates for a VWM will generally be every 6-12 months from the original incident, although there may be specific considerations for individual cases.

5.6.2 The documents listed below will determine the outcome of whether a VWM will stay on or be removed from the persons record

- The severity of the original incident and the impact on the staff member
- Any continuing risk
- Any further incidents
- Any indication the incident is likely to be repeated
- Outcome of any further investigations
- Action by other agencies e.g. police or courts
- Any other developments since the original incident

5.6.3 The LSMS will be responsible for notifying the individual in writing that a decision has been made to remove the VWM.

A letter will be sent to the individual when the panel have:

- Confirmed the decision to remove a VWM on the individual's record and
- Decided that the individual should be notified

5.6.4 The criteria for not notifying the individual are the same as shown in para (4.2.3)

5.6.5 *A template is shown in Appendix 6*.

5.7 Notification

5.7.1 The patient will be informed by the LSMS, Consultant and/or Responsible Clinician, if the VWM is removed from the patient's record.

5.7.2 The individual must be notified as soon as possible of the decision to remove a VWM. (See Appendix 6 for a template letter notifying an individual that the marker is being removed).

5.7.3 If a decision is made that it would not be appropriate to notify the individual of the removal of the VWM because this would be of a substantial risk of further threatening behaviour the decision will be based on the same criteria and should be the same as when the VWM was first placed on the record following the incident (see section 3.3.3), **Decision not to notify**.

If the decision is made to retain the VWM on the record, the next review date will be 6 months from the date of the decision to keep the VWM on the record.

5.8 Handling complaints

5.8.1 All complaints about a decision made to place a VWM on a patients records and/or other must be referred through complaints process. (For further information please refer to the *Better Practice Guide to Complaint Handling CORP/PROC/633*).

6 References and Associated Documents

BTHFT - Procedure, 2017. *Health Record – Recording Alerts and Attention Warnings.* [Online]
Available at: http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-PROC-445.docx
[Accessed 22 7 2019].

BTHFT - Procedures, 2017. *Untoward Incident and Serious Incident Reporting.* [Online]
Available at: http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-PROC-101.docx
[Accessed 23 04 2019].

BTHFT, 2017. *Better Practice Guide to Complaint Handling.* [Online]
Available at: http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-PROC-633.docx
[Accessed 23 5 2019].

BTHFT, 2018. *The Prevention and Management of Violence, Aggression and Abuse at Work.* [Online]
Available at: http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-PROC-123.docx
[Accessed 30 04 2019].

BTHFT, 2019. *Risk Management Policy.* [Online]
Available at: http://fcsp.xfyldecoast.nhs.uk/trustdocuments/Documents/CORP-POL-547.docx
[Accessed 23 04 2019].

Crown, 2018. *Data Protection Act 2018.* [Online]
Available at: https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted
[Accessed 19 6 2019].

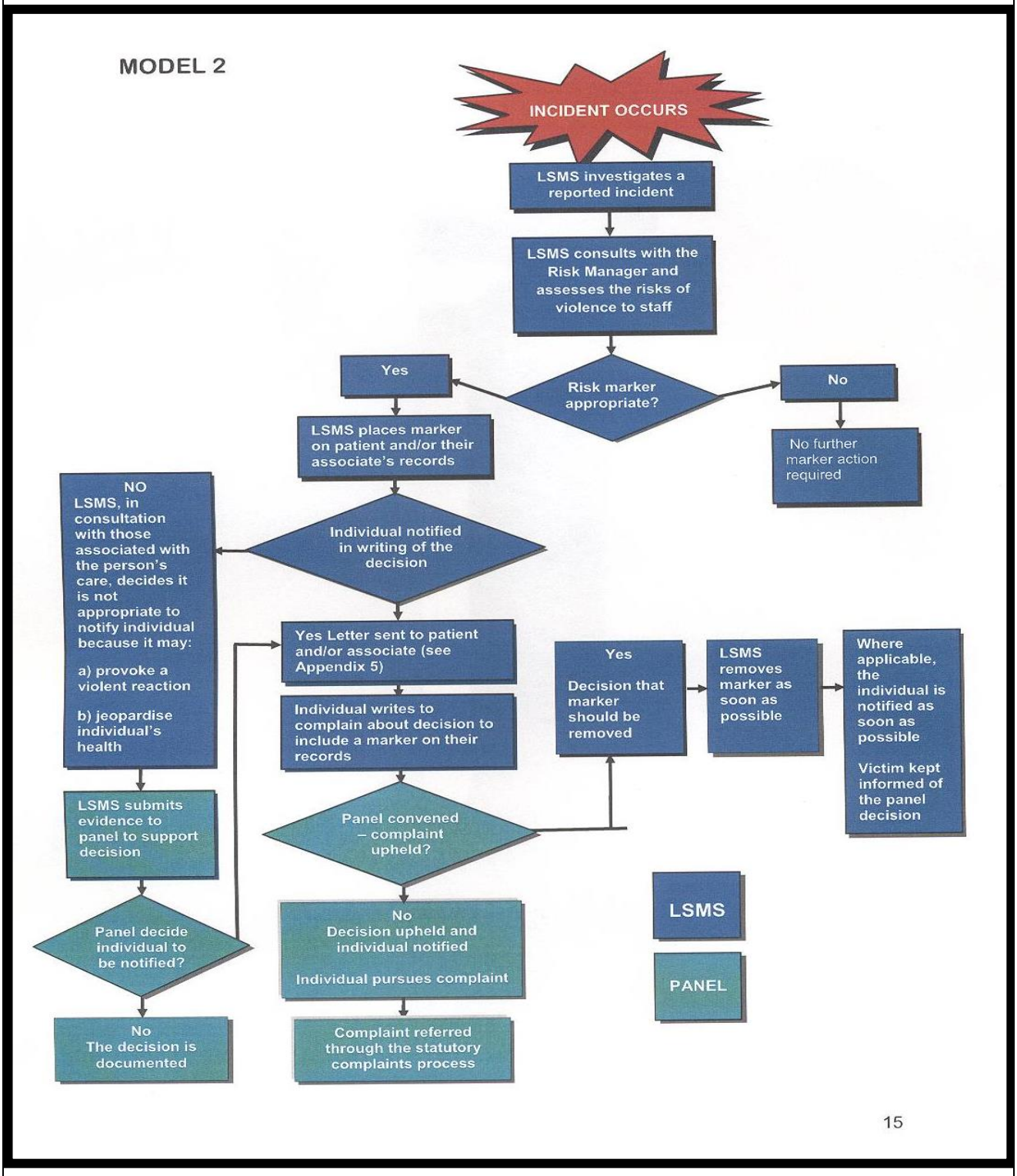
Gov.uk, 2018. *Data protection.* [Online]
Available at: https://www.gov.uk/data-protection
[Accessed 26 6 2019].

HSE, n.d. *Work-related violence.* [Online]
Available at: https://www.hse.gov.uk/violence/
[Accessed 26 6 2019].

ICO, n.d. [Online]
Available at: https://ico.org.uk/
[Accessed 26 6 2019].

Data Protection Good Practice Note - The use of violent warning markers',

Appendix 1: Decision-making process for issue of electronic marker

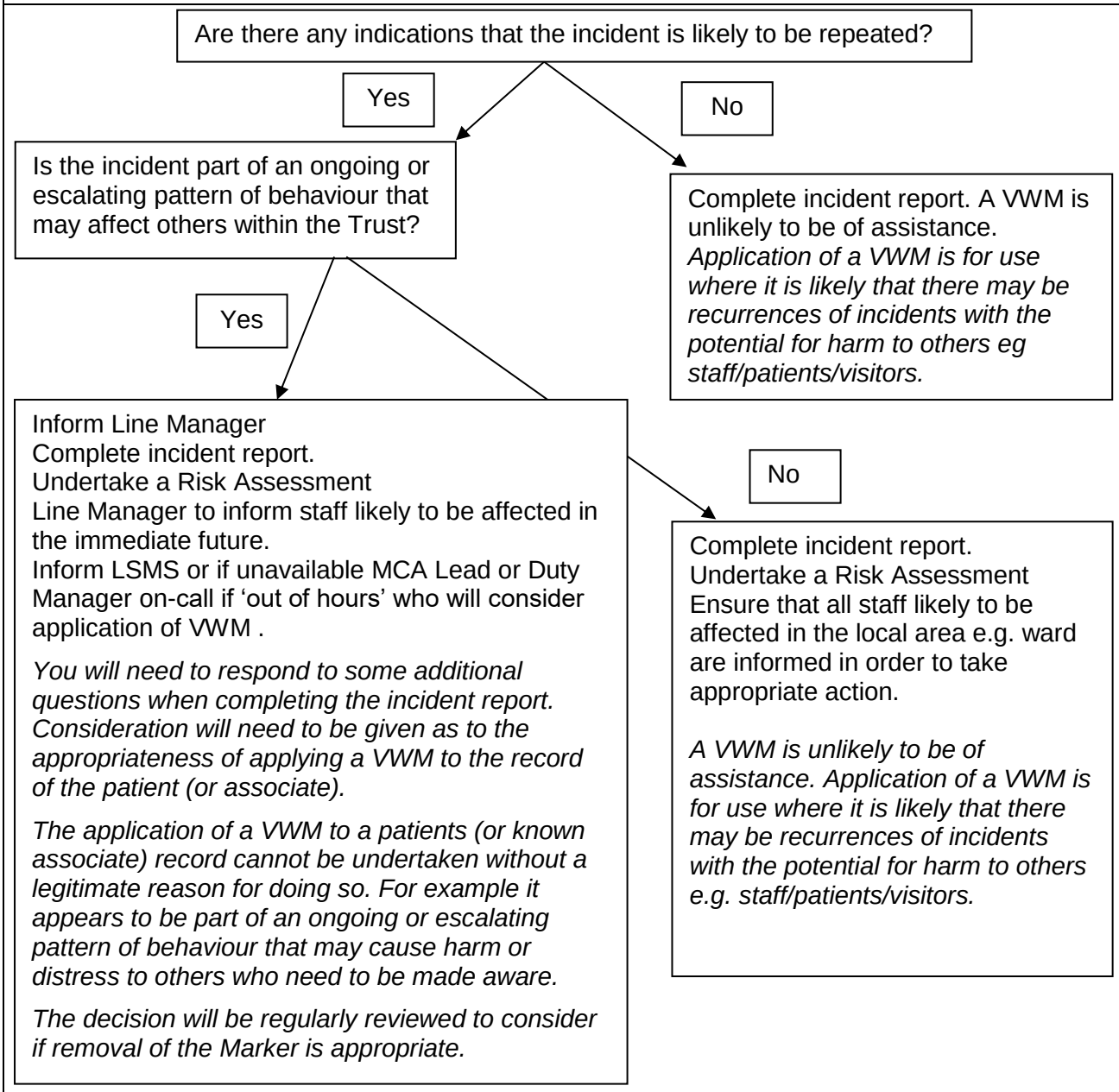


Appendix 2: Categories
It is not possible to list every category of incident which may warrant marking a person's records. Not only will the nature of the incident have to be considered but also the effect the incident has on all of those involved (staff, patients, relatives and visitors) and the likelihood of a further incident taking place. Staff should be familiar with the definitions below so that they know what types of incidents should be reported to their LSMS. The following definitions and categories are applicable when considering placing a VWM on records and each category should include appropriate handling information. Note: These lists are not exhaustive. Physical assault is defined as: 'The intentional application of force against the person without lawful justification resulting in physical injury or personal discomfort'.
Type of categorised physical assault
Physical assault (no physical injury suffered) ([1])
Physical assault (physical injury sustained)
Non-physical assault is defined as: 'The use of inappropriate words or behaviour causing distress and/or constituting harassment'.
Type of categorised non-physical assault
Offensive or obscene language, verbal abuse and swearing2
Brandishing weapons, or objects which could be used as weapons
Attempted assaults
Offensive gestures
Spitting
Threats
Intimidation
Harassment or stalking
Damage to buildings, equipment or vehicles which causes fear for personal safety
Offensive language or behaviour related to a person's race, gender, nationality, religion, disability, age or sexual orientation
Inappropriate sexual language or behaviour
Threatening to use dogs
N.B. some of the above examples of non-physical assault can be carried out by phone, letter or electronic means (e.g. e-mail, fax and text). (1) Spitting is included in the definition of a physical assault, in circumstances where the spittle hits the individual. (2) The use of swear words may warrant a VWM depending on the circumstances in which they are used. For some individuals, swear words may be used in everyday language, however a VWM should be considered where swear words are used to threaten or used aggressively.

Appendix 3: Process for placing a VWM checklist

Where there has been an occurrence of a violent or abusive incident this must be reported via the Trusts Incident reporting system.

The following flow chart must be used by the person managing the incident to help determine if appropriate actions have been taken and if there is a potential need to apply a Violence Warning Marker (VWM) to the record of a patient (or known associate).



A process for alerting staff to the possibility of violence, whether such actions are deliberate or take place as a result of a medical condition or as a response to treatment or medication. The application of a VWM to a patients (or known associate) record cannot be undertaken without a legitimate reason for doing so and the decision will be regularly reviewed to consider if removal of the Marker is appropriate.

Appendix 4: Sample proforma for risk of violence markers

http://fcsp.xfyldecoast.nhs.uk/H/HealthRecordsLibrary/Documents/Violence%20Warning%20Marker%20Proforma.docx

Appendix 5: Template for marker notification Letter

Blackpool Teaching Hospitals
NHS Foundation Trust

Dear (individual's name)

Notification of Violent Warning Marker (VRM) being placed on an NHS patient record

I am writing to you on behalf of Blackpool Teaching Hospitals NHS Foundation Trust where I am the Local Security Management Specialist. Part of my role is to protect NHS staff from abusive and violent behaviour and it is in connection with this that I am writing to you.

(Insert summary of behaviour complained of, include dates, effect on staff/services and any police / court action if known)

Behaviour such as this is unacceptable and will not be tolerated. Blackpool Teaching Hospitals NHS Foundation Trust is firmly of the view that all those who work in or provide services on behalf of the NHS have the right to do so without fear of violence, threats or abuse.

The NHS Constitution makes it clear that just as the NHS has a responsibility to NHS service users, so to do service users have a responsibility to treat staff with respect and in an appropriate way.

All employers have a legal obligation to inform staff of any potential risks to their health and safety. One of the ways this is done is by marking the records of individuals who have in the past behaved in a violent, threatening or abusive manner and therefore may pose a risk of similar behaviour in the future.

Such a marker may also be placed to warn of risks from those associated with service users (e.g. relatives, friends, animals, etc.). A copy of the Trust procedure on risk of Violent Markers is enclosed and/or can be obtained from [*insert details*].

I (*or the panel – insert panel name*) have carefully considered the reports of the behaviour referred to above and have decided that there is a risk of violence to NHS employees and therefore, recommend that a VWM be placed on your records.

This information may be shared with other NHS bodies and other providers we jointly provide services with (e.g. ambulance trusts, social services and NHS pharmacies etc.) for the purpose of their health and safety.

This decision will be reviewed in (6/12) months' time (*insert date if known*) and if your behaviour gives no further cause for concern the Violent Warning Marker will be removed from your records.

Any other provider we have shared this information with will be advised of our decision.

Appendix 5: Template for marker notification Letter

If you do not agree with the decision to place a VWM on your record, and wish to submit a complaint in relation to this matter, this should be submitted in writing to:

(*Insert complaints service/panel details. N.B. Even if a panel is being used details of complaints process should still be included*.)

Yours (sincerely/faithfully),

Insert name, job title and contact details

Appendix 6: Template for notification of the removal of a marker

Blackpool Teaching Hospitals
NHS Foundation Trust

Date

Dear (individual's name)

Notification of Violent Warning Marker (VWM) being removed from an NHS record

I am writing to you on behalf of Blackpool Teaching Hospitals NHS Foundation Trust where I am the Local Security Management Specialist. I wrote to you previously on (*date / reference*) concerning the placement of a VWM on your records after careful consideration of an incident...

(*Insert summary of behaviour complained of, include dates, effect on staff/services and any police/court action if known*)

This VWM was recently been reviewed after a period of 6/12 months.

After careful consideration, I (*or the panel – insert panel name*) have decided that there is no further cause for immediate concern.

(*State specific reasons for the decision, if any*.)

Therefore, the VWM has been removed from your records. Any other provider with whom we have shared this information will also be notified of our decision to remove the VWM.

However, you should be advised that any future incidents in which you are involved, and which indicate a risk to staff of physical or non-physical violence or abuse, may result in a VWM once again being placed onto your records.

Please be aware that behaviour such as this is unacceptable and will not be tolerated by the Blackpool Teaching Hospitals NHS Foundation Trust.

Blackpool Teaching Hospitals NHS Foundation Trust is firmly of the view that all those who work in or provide services to the NHS have the right to do so without fear of violence, threats or abuse.

The NHS Constitution makes it clear that just as the NHS has a responsibility to NHS service users, so service users have a responsibility to treat staff with respect and in an appropriate way.

A copy of the trust policy on Placing a VWM on patient's records is enclosed and/or can be obtained from [insert details].

Appendix 6: Template for notification of the removal of a marker
Yours (sincerely/faithfully),   Insert name, job title and contact details

Appendix 7: the Data Protection Act 2018

The Data Protection Act 2018 is the UK's implementation of the General Data Protection Regulation (GDPR).

Everyone responsible for using personal data has to follow strict rules called 'data protection principles'. They must make sure the information is:

- used fairly, lawfully and transparently
- used for specified, explicit purposes
- used in a way that is adequate, relevant and limited to only what is necessary
- accurate and, where necessary, kept up to date
- kept for no longer than is necessary
- handled in a way that ensures appropriate security, including protection against unlawful or unauthorised processing, access, loss, destruction or damage

There is stronger legal protection for more sensitive information, such as:

- race
- ethnic background
- political opinions
- religious beliefs
- trade union membership
- genetics
- biometrics (where used for identification)
- health
- sex life or orientation

There are separate safeguards for personal data relating to criminal convictions and offences.

Appendix 8: Equality Impact Assessment Form

Department	H&S/Security	**Service or Policy**		**Date Completed:**	24/12/2018

GROUPS TO BE CONSIDERED

Deprived communities, homeless, substance misusers, people who have a disability, learning disability, older people, children and families, young people, Lesbian Gay Bi-sexual or Transgender, minority ethnic communities, Gypsy/Roma/Travellers, women/men, parents, carers, staff, wider community, offenders.

EQUALITY PROTECTED CHARACTERISTICS TO BE CONSIDERED

Age, gender, disability, race, sexual orientation, gender identity (or reassignment), religion and belief, carers, Human Rights and social economic / deprivation.

QUESTION	**RESPONSE**		**IMPACT**	
	Issue	Action	Positive	Negative
What is the service, leaflet or policy development? What are its aims, who are the target audience?	See Purpose			
Does the service, leaflet or policy/ development impact on community safety • Crime • Community cohesion	No			
Is there any evidence that groups who should benefit do not? i.e. equal opportunity monitoring of service users and/or staff. If none/insufficient local or national data available consider what information you need.	No			
Does the service, leaflet or development/ policy have a negative impact on any geographical or sub group of the population?	No			
How does the service, leaflet or policy/ development promote equality and diversity?	No			
Does the service, leaflet or policy/ development explicitly include a commitment to equality and diversity and meeting needs? How does it demonstrate its impact?	No			
Does the Organisation or service workforce reflect the local population? Do we employ people from disadvantaged groups	No			
Will the service, leaflet or policy/ development i. Improve economic social conditions in deprived areas ii. Use brown field sites iii. Improve public spaces including creation of green spaces?	No			
Does the service, leaflet or policy/ development promote equity of lifelong learning?	No			
Does the service, leaflet or policy/ development encourage healthy lifestyles and reduce risks to health?	No			
Does the service, leaflet or policy/ development impact on transport? What are the implications of this?	No			
Does the service, leaflet or policy/development impact on housing, housing needs, homelessness, or a person's ability to remain at home?	No			
Are there any groups for whom this policy/ service/leaflet would have an impact? Is it an adverse/negative impact? Does it or could it (or is the perception that it could exclude disadvantaged or marginalised groups?	No			
Does the policy/development promote access to services and facilities for any group in particular?	No			

Appendix 8: Equality Impact Assessment Form

Does the service, leaflet or policy/development impact on the environment • During development • At implementation?	No			
ACTION:				
Please identify if you are now required to carry out a Full Equality Analysis		**Yes**	**No**	**(Please delete as appropriate)**
Name of Author: **Signature of Author:**	**Karen Sanderson**		**Date Signed:**	
Name of Lead Person: **Signature of Lead Person:**				
Name of Manager: **Signature of Manager**	Tracy Crumbleholme		**Date Signed:**	