Policy:
NP025 – PROFESSIONAL BOUNDARIES

(ESTABLISHING AND MAINTAINING BOUNDARIES – MAINTAINING APPROPRIATE, PROFESSIONAL, THERAPEUTIC RELATIONSHIPS WITH SERVICE USERS, PATIENTS AND CARERS)

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Policy Owner	Safeguarding Lead
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Summary of policy

This policy is related to establishing and maintaining professional, therapeutic relationships with service users, patients, and carers. The policy relates to boundaries between staff, service users and carers.

Target audience	All staff including students and volunteers

Keywords	Relationships, Boundaries

Storage & Version Control

This version 2.0 is stored and available through the SHSC internet/intranet.
This version supersedes the previous version dated January 2015. Any copies of the previous policy held separately should be destroyed and replaced with this version

Version Control and Amendment Log

Version No.	Type of Change	Date	Description of change(s)
0.1	New draft policy created	2015	New policy commissioned by EDG on approval of a Case for Need.
1.0	Approval and issue	2015	Amendments made during consultation, prior to ratification.
2.0	Updated	2019	Version 2.0 – This policy relates to establishing and maintaining therapeutic relationships with service users/patients/carers
		30.08.2019	Version 2.0 which supersedes the previous version dated January 2015.
3.0	Review / approve / issue	09/2023	Detailed rewrite undertaken – v3 new template and new guidance drafted. Broad consultation undertaken and amendments made. Review undertaken to update the policy to comply with best practice and any new regulatory requirements. Comparison to current policy and guidance noted – e.g. Re gifts – see appendix. e.g. Re allegations against staff policy. New leaflet/s to be ratified once policy is ratified.
3.1	Review on expiry of policy	09/2025	SHSC to request a review in 2025.
4.0	Review / approval / issue	MM/YYYY	Full review completed as per schedule

Contents

1. Introduction

This policy is to outline the expectations and requirements for the boundary in a professional relationship between SHSC staff members (including students and volunteers) with service users, patients, and their carers.

1.1 This policy provides guidance to staff on what constitutes safe and appropriate practice in the building of positive, professional, and therapeutic relationships with service users and carers.

1.2 The professional relationship between a member of staff and a service user or carer must be based on the assessed needs of the service user or carer and the skills and knowledge of the member of staff engaged to help meet those needs.

1.3 It is essential that while you may develop a close working professional relationship with service users you must never allow that to cloud your professional judgement. The professional relationship keeps a professional boundary where the service user is supported by a therapeutic professional relationship and does not slip into a relationship that you would have with a friend or family member.

1.4 Should a service user be known to you in any capacity, or if you are involved in a pre-existing friendship, or relationship with a service user, carer, or family member, you must discuss this with your line manager to ensure that you receive appropriate supervision advice and support.

1.5 All staff must seek the advice through supervision with their line manager if they have a pre-existing knowledge of a service user, or any concerns or issues about any relationships with service users or carers.

1.6 Staff have a duty as part of their role to protect service users from exploitation, abuse, and harm.

1.7 Staff must follow policy and

- Respect the dignity, privacy, safety, and well-being of service users.
- Not take advantage of their position for their own purposes.
- Not take advantage of service users' vulnerability or enable others to do so in any aspect of care and treatment.

2. Scope

2.1 This is a Trust wide policy and is supported by other Trust policies and the relevant Codes of Professional Conduct from Professional Bodies such as the Nursing and Midwifery Council, General Medical Council and Health and Care Professions Council.

2.2 This policy applies to all staff in all roles. It relates to all staff without exception, including Estates, Finance, Housekeeping Administration, Managers and Clinical staff (it also includes people seconded to work in the trust, apprentices, trainees, students and volunteers) and all service users and carers.

2.3 There is a legal framework to follow – for example, the Sexual Offences Act, 2003, the ill treatment and wilful neglect offences in the Criminal Justice Act, 2015; and the national and local Safeguarding framework.

3. Purpose

3.1 This policy is intended to guide staff to help maintain a professional and boundaried relationship with all service users they work with and those receiving services elsewhere in the Trust, to ensure staff are aware of potential difficulties and where to get help and support should any difficulties arise.

3.2 The Trust has a responsibility to protect service users and carers from being manipulated and abused by staff, and staff should ensure that they consider their practice in line with the Safeguarding Adults policy of the Trust, and the relevant codes of professional conduct, where they apply to certain staff groups. The Allegations against Staff policy will be followed if relevant in managing concerns raised in this policy.

3.3 The Trust also has a duty towards its staff, who may sometimes be influenced by service users. This policy provides guidance within it and its links to other Trust polices to highlight the roles and responsibilities of staff and where they may gain support and protection.

4. Definitions

4.1 Within this document “the Trust” is SHSC.

4.2 Within this document, ‘service users’ should be understood to also include patients and carers.

4.3 Within this document staff should be understood to be any person working for SHSC and includes permanent, temporary, Bank and agency staff and volunteers and students/trainees.

4.4 Within the working relationship the same laws apply in relation to assault, theft, fraud, and other offences as in the wider world. This includes the Sexual Offences Act, 2003 which clearly states that any care worker in a ‘relationship of care’ including those providing direct care, or face to face contact, including administration, transport, and reception staff; could be liable to prosecution should they engage in any form of sexual activity with a service user of SHSC Trust.

4.5 The Mental Capacity Act (2005) introduced two further criminal offences: ill treatment or wilful neglect of a person who lacks capacity to make relevant decisions (section 20-25 & section 44) and is relevant in this policy.

5. Duties

5.1 The Trust has a duty of care towards all our service users, who by the nature of their needs will often be deemed as ‘vulnerable’.

5.2 Staff must recognise this vulnerability and protect service users from exploitation and abuse; staff must:

- Respect the dignity, privacy, safety, and well-being of service users.
- Not take advantage of their position for their own purposes.
- Not take advantage of service users' or enable others to do so.

5.3 All staff need to be aware that failing to comply with these standards may result in formal disciplinary action, which may include dismissal, in line with the Trust's Code of Conduct, and could be prosecuted under the Law, including the Sexual Offences Act, 2003.

5.4 Staff must raise any concerns about the professional conduct and practice of their colleagues with their supervisor and line manager. Actions must be planned, recorded and completed as required.

5.5 Staff should be aware that if service users and carers have experienced abuse in the past, they may have vulnerabilities and may find it difficult to understand the nature of the working relationship with staff and professional boundaries. Staff must be aware of this and offer support and appropriate advice, reference should be made to SHSC Standards for Sexual Safety Supervision. This is in line with the trauma informed approach to working and understanding service users' presentation and needs, and how these may link to previous trauma.

5.6 Managers are responsible for supporting staff in discussing any issues in relation to this policy and agreeing support and management structures including completion of necessary reports, statements etc. Managers are responsible for ensuring the provision of support and supervision as necessary to staff, service users and carers.

6. Procedure

6.1 What to do if you know a service user? Pre-existing relationships

6.1.1 It is quite possible that at some point someone you know or are related to will be referred to your team or workplace for a care assessment or service. This knowledge of a service user may include a neighbour, someone you see regularly in your community, at a local school, a friend, family member, someone you have dated, people you have an online relationship with, someone you have had a relationship with, or any other way that you have met and know someone. It is your responsibility to inform your manager of the relationship, if relevant to any service user. It is important in all situations, and especially so that you are not directly involved in their assessment or provision of care. Otherwise, you may be perceived to be in a position leading to a conflict of loyalties and a conflict of personal - professional boundaries.

6.1.2 It is difficult to provide an effective service to someone you already know – it requires a shift in the friendship/relationship and in the balance of power to allow you to ask relevant personal questions or to provide intimate care. You need to be able to step aside from your usual role.

6.1.3 There is a risk that your response would not be the most appropriate for their current circumstances. The service user may not wish to share important information with you, because they may not want to do so in your role as a friend or relative and find it difficult to separate that from your professional role.

6.1.4 The service user may try to use your relationship to get a 'better' service, or you may feel an obligation to do so, putting additional emotional pressure on you and setting up unrealistic expectations.

6.1.5 Once you inform your manager of the situation, your manager will agree with you a course of action which will include putting systems in place where you would not be involved with the service users care and treatment. (Please see Flow diagram 1 below).

6.2 Developing relationships.

6.2.1 When people work closely together with shared aims and objectives, often on a one-to-one basis, there is the potential for a work-based, professional relationship to develop into something more personal. A warm, friendly, strong, and honest professional relationship may be argued to make for a more successful outcome, but it is your responsibility to ensure that the professional relationship always remains on a boundaried, professional basis. You should ensure that you fully document all your interactions with the service user and ensure that you discuss any practice and professional issues within your supervision and with your manager.

6.2.2 It is necessary to maintain objectivity to make appropriate care assessments and judgements, and to offer appropriate advice. If your objectivity is compromised, you must discuss this in your supervision and arrange to transfer the work to a colleague if necessary. Concerns about a specific issue or interaction should be discussed immediately with your line manager and an agreed plan of action should be agreed if necessary.

6.2.3 The expectation for all Trust staff is like that for all professionals; it is presumed that you will carry out your designated task in a professional manner, with a degree of objectivity which enables you to make fair assessments and appropriate decisions for the people for whose benefit you are working.

6.2.4 It is never acceptable to start to develop a friendship, an intimate, romantic, or sexual relationship with a service user for whom you or SHSC have any professional responsibility. Regardless of how you may see the relationship, it may place the service user at risk of exploitation. Relationships may result in staff abusing their authority and they will be subject to disciplinary procedures or criminal law proceedings, for example, under the Sexual Offences Act, 2003.

6.3 Confidentiality

6.3.1 You must be clear about the policies and procedures relating to securing and sharing information, including the Confidentiality Policy, Information Sharing Protocol, GDPR and Mobile Communication Devise Policy and ensure that you give no personal information about a service user to an unauthorised person.

6.3.2 You must not attempt to access records for anyone for whom you do not have professional responsibility. Please refer to the Data Protection and GDPR Act and Trust Policy.

6.3.3 You should not routinely share personal information about yourself or your family with service users, unless for a clearly defined purpose in relation to the service user's situation – for example, a personal experience of a service being offered, or in line with a clinical modality.

(For example, the welcome pack that a psychotherapy service sends to clients once they have been accepted for therapy states that they may request to see a clinician of the same/similar sexual orientation to them, and we will do our best to accommodate this request. If someone asks for this and then sees a therapist from the LGBTQ+ community, then they know something personal about the therapist. Any further disclosures will continue to be carefully considered in advance, and advice will be sought in supervision.)

6.3.4 In small communities it may be more difficult to maintain confidentiality, and you will need to be aware of and manage the risks. Please discuss with your line manager and clinical supervisor the advantages and consider any potential risks prior to sharing information - for example, sharing information about your religion, sexuality, location of residence, may be reassuring for a service user but could enable a service user to find you outside of the Trust.

6.3.5 You should avoid giving service users a blanket assurance that you will keep everything they tell you confidential. Apart from assessment information, for which consent to share is routinely sought, you may be given information about abuse (please refer to Safeguarding Adult and Safeguarding Children Policy) or a medical condition, or a criminal act. Once you have that information, you will have a duty to act on it, whether directly or by persuading them to share the information with someone who may be more appropriate to respond.

6.3.6 Please refer to the national guidance from SHSC, your professional code of practice/guidelines if applicable, General Data Protection Regulation (GDPR) and Data Protection Act, 2018.

6.4 Communication

6.4.1 For some service users, email may be their preferred way of communicating. For recording and retention purposes, emails must be treated as letters and stored within the service users care records.

6.4.2 Text messages can be a useful alternative to a Minicom for people with impaired hearing, but you should only use mobile phones provided for work purposes by the Trust and restrict texts to arrangements for meetings or similar topics, if possible, ensuring that the telephone number is not transmitted with the text message and ensure that the text messages are recorded in the clinical records.

6.4.3 You should not give personal mobile or home telephone numbers to service users. This blurs the distinction between personal and professional relationships and is open to abuse by either party.

6.4.4 Although both texts and emails lend themselves to a more informal style, you must ensure they are as clear, informative, and appropriate in tone as any other staff/service user communication.

6.4.5 You should record and report any abusive or offensive communication to your line manager and refer to the relevant Trust policy for dealing with this situation.

6.4.6 Any contact made to you by a person who has been a service user must be communicated to your manager and to the team who are currently involved in the service users care if they are still receiving a service from the Trust.

6.4.7 Make sure you address service users by the name/title they prefer and be aware of the effect of your style and tone of voice/communication.

6.4.8 Remember that service users have the right to see the records kept about them. Be clear about what is factual and what is opinion, be careful to identify which is which in your recording and note the grounds on which your opinion is based. (Records Management Policy and Data Protection Act, 2018)

6.5. Cultural and religious issues

6.5.1 You are expected to be aware of general issues which may affect your work with service users of other faiths or cultural backgrounds, and to inform yourself about issues which may be specific to individuals.

6.5.2 You are expected to work with service users in a culturally sensitive way, acknowledging and respecting differences; you may need to negotiate appropriate ways of delivering the services they need. Please seek guidance from your supervisor, or colleagues in the inclusion, equality, and diversity team. You may also learn from Information which may be available online – for example about cultural or religious requirements, gender, sexuality, and other cultural aspects which are important to service users.

6.6 Intimate personal care

6.6.1 Service users who need intimate personal care must feel as much at ease as possible in situations where they are at their most vulnerable. You must always respect their dignity, privacy, and safety, and try to combine competence with empathy.

6.6.2 If on the very rare occasion a service user tries to take advantage of intimate situations; it is best to remain calm and matter of fact about this, while pointing out that their behaviour is unacceptable. You should discuss their behaviour immediately with your line manager or the person in charge of the service area on that day to decide how best to address this and identify a consistent response with the particular individual. You will need to note in detail what has happened and how you responded and create a plan for future care. You may also seek support and may ask to be debriefed on the matter.

6.6.3 If it is necessary to offer intimate care to service users, perhaps bathing support, the situation should be explored with the service user – to assure that the service user is comfortable and understands the necessity. Staff should seek the

service user's preference in the gender of care giving staff aligned to their identity and trauma informed plan of care when providing intimate care to service users. On occasions limited choice may be unavoidable because of staffing and skill mix levels due to short term staffing shortages and the immediate needs of the service user. If the service user or staff member are not comfortable an alternative arrangement should be sought, a chaperone provided, or another person requested to join the team from another area as soon as possible to address the situation with privacy and dignity.

6.7 Admitting people to a service users' home.

6.7.1 Only those people having legitimate business with the service user should be admitted to the person's home or Trust service area, and then only with the service user's permission. This would include their friends and family, other care providers, trades people who have arranged to call, and properly identified meter-readers etc.

6.7.2 You must not invite your own friends or family members into a service user's home.

6.7.3 You should not enter the service user's property yourself without their full permission.

6.8 Visits and transport

6.8.1 Any professional visits should be discussed in supervision and with your line manager and recorded in the care records. You may only use your own vehicle to transport service users when this has been agreed as part of the care plan for a specific purpose and the appropriate insurance cover is in place. (For details, please refer to the Trust Transport Policy).

6.8.2 Any accompanied visits must be as agreed in the care plan. Going for a walk is possible and can be agreed and documented if required in supervision or as part of a care plan agreement.

6.8.3 You must not take service users to your own home, or to any place which has not been agreed, and never agree or arrange to meet them outside of your work role.

6.8.4 If a service user is admitted to hospital, you would be expected to visit them in relation to their on-going or amended care plan, but not as a visitor. This should be discussed in supervision and with your line manager and recorded in the care records.

6.8.5 When a service user dies it may sometimes be appropriate for a member of staff to attend their funeral, memorial service, or other ceremony. If it is someone you have known for a significant time, or who has received substantial support from you as key worker, you may wish to attend. This should be discussed in supervision with your line manager and checked with family members regarding before attendance at the funeral. A record of attendance should be recorded in the care records.

6.9 Additional work with service users

6.9.1 Care staff that visit service users in their homes may become aware of additional help required or desired which is not currently available or being provided. You must not undertake additional work in these circumstances, either on a voluntary or paid basis. This is primarily because it blurs the boundaries between the work the Trust has contracted to do and the additional work you may do, making an accurate assessment or review of need difficult. There may also be insurance issues in the case of an accident – particularly if there is not clarity about whether you were working in an official Trust or unofficial capacity at the time. If you are asked to take on additional tasks, you must discuss this in supervision with your manager.

6.9.2 If you regularly undertake additional tasks not included in the care plan, you may cause difficulties for staff that may cover in your absence or take over from you and raise unrealistic expectations on the part of the service user and carers.

6.9.3 If additional care requirements are evident this should be discussed as part of the service user's review of care and a referral made to other agencies and services as appropriate to meet the service user's/carer's needs.

6.10 Money, gifts, and bequests

6.10.1 You must not loan money to service users, or borrow money from them, nor must you arrange for or influence them to lend money to or borrow from any third parties, except for a legitimate service-related reason previously approved by your line manager. (See SHSC Ethical Standards in the NHS: Including Hospitality, Gifts, Research and Commercial Sponsorship)

6.10.2 If you are authorised to help service users manage their money you must always keep their money separate from your own, keep accurate records of transactions and follow the procedures laid down for this work. If you are finding this difficult, discuss this with your manager in supervision.

6.10.3 You must not sell goods or services to service users or buy from them. Nor must you arrange for the sale of goods to or purchase from third parties, except for a legitimate service-related reason previously approved and documented by your line manager.

6.10.4 To avoid any suspicion of influence you must not witness wills for service users.

6.10.5 If you are a named beneficiary in a service user's will, you must discuss this with your line manager, who will seek advice from Human Resources and advise you on the best course of action.

6.10.6 You must not normally accept gifts from service users. If a service user is insistent, you must discuss the matter with your manager. Please see Managing Conflicts of Interest in the NHS Policy (CG 001 V2 October 2020).pdf (shsc.nhs.uk) and notes in section 16 below taken from that Policy.

6.10.7 You should never give personal gifts to service users with whom you work. However, the ward or team may provide, for example, a Christmas gift to those in hospital. This is a gift from SHSC as an organisation.

6.11 Property

6.11.1 You should naturally treat service users' property with respect, but accidental damage may occasionally happen. You must report this to your line manager and refer to the Trust Incident reporting and investigation policy and financial policies.

6.11.2 Similarly, if any of your property is damaged in the course of your work you should report this, via an incident form to your manger.

6.11.3 If a service user has to leave their home unexpectedly with no obvious family/ neighbour/ friend to secure the property and ensure the safety of any valuables: This should be discussed with your line manager, and it may be necessary for 2 staff to complete this process of securing the service user's home. (Please also refer to the Trust Transport Policy)

6.12 Peer Support workers

6.12.1 Peer support workers may experience complex boundaries. Peer support workers (PSWs) all attend specific peer support worker competencies training including around boundaries. It is more common that PSWs meet people that they may have been service users alongside due to the nature of the role. They immediately let their manager and their team leadership know if this was the case and depending on the relationship would agree a plan to manage those issues. Occasionally PSWs may co-facilitate a group in which are some of the participants they have known from services, this relationship will be discussed in advance and reviewed in supervision.

7. Information to share with clients, patients, and service users

7.0 **Professional relationships with Service Users/ Clients/ Patients/ Relatives/ Carers** (see also the "SHSC Understanding professional boundaries Information leaflet" provided for service users and carers - Reproduced by kind permission of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. July 2022/ SHSC updated autumn 2023).

7.1 SHSC Employees must maintain appropriate professional boundaries in the relationships they have with patients, clients and service users or their family and carers and must not foster any personal relationships with them. Employees who are required to be registered with statutory bodies are bound by codes of conduct that require clear professional boundaries to be maintained. Unregistered support staff are bound by the Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England.

7.2 SHSC expects the same standards of all our employees whose work involves contact with patients, clients, and service users.

7.3 Employees must not use their position to cultivate a personal relationship with a patient, client, or service user.

7.4 Employees should not:

- Give or accept social invitations.
- Accept gifts.
- Ask for or accept a date to meet with a patient, client, or service user to engage in a personal social activity.
- Visit a patient, client, or service user's home unannounced and without an appointment, outside of the treatment plan or service normally provided, without prior consultation with the employees' manager. If an unannounced visit is clinically necessary, this should be documented.
- Engage in unnecessary communication, including asking questions of a personal nature that are not necessary for the service or care being provided.

7.5 These examples are for guidance only and are not intended to be exhaustive. The highest standards of personal conduct and integrity are expected to maintain the confidence of patients, clients, and service users in the professionalism of SHSC's employees.

7.6 Here are some signs that boundaries have been breached and behaviours are inappropriate:

- Contact or visits while off duty
- Sexualised or overfamiliar communication e.g., nicknames, kisses on texts
- Flirtatious behaviour e.g., lots of eye contact or repeatedly touching
- Sharing a lot of information about themselves or others and inappropriate/unwanted physical contact
- Unnecessary communication beyond that of a professional relationship e.g., phoning, texting and social media contact
- Keeping in touch even though they are no longer working with you as a service user.

Please remember a service user and particularly a vulnerable person may not see that there is anything wrong with the relationship or how it started. It's everyone's responsibility to safeguard our service users.

8. How to raise concerns and possible sources of support and escalation of concerns

Please see and if relevant follow: Allegations against Staff policy
Managing Allegations Against Staff Policy (NP 037 V2 May 2022).pdf (shsc.nhs.uk)

This includes the below details:

8.1 All staff are responsible for ensuring that any allegation against another member of staff is brought to the attention of their manager in order for it to be addressed through this policy. All staff, including volunteers and visiting celebrities, have a right and a duty to raise any safeguarding matter of concern that they may have about the delivery of care to patients and service users, even though this may involve raising concerns about the conduct of a colleague. They should therefore raise any such concerns with their line manager or an appropriate alternative manager.

8.2 Employees who are making an allegation against a colleague should be made aware of the Trust's policy: Speaking Up - Freedom To Speak Up - Raising Concerns (Whistleblowing) Policy (2018) and be offered support from the Freedom to Speak Up Guardian. Speaking Up - Freedom to Speak Up Raising Concerns (Whistleblowing) Policy (HR 015 V6 April 23) | JARVIS (shsc.nhs.uk)

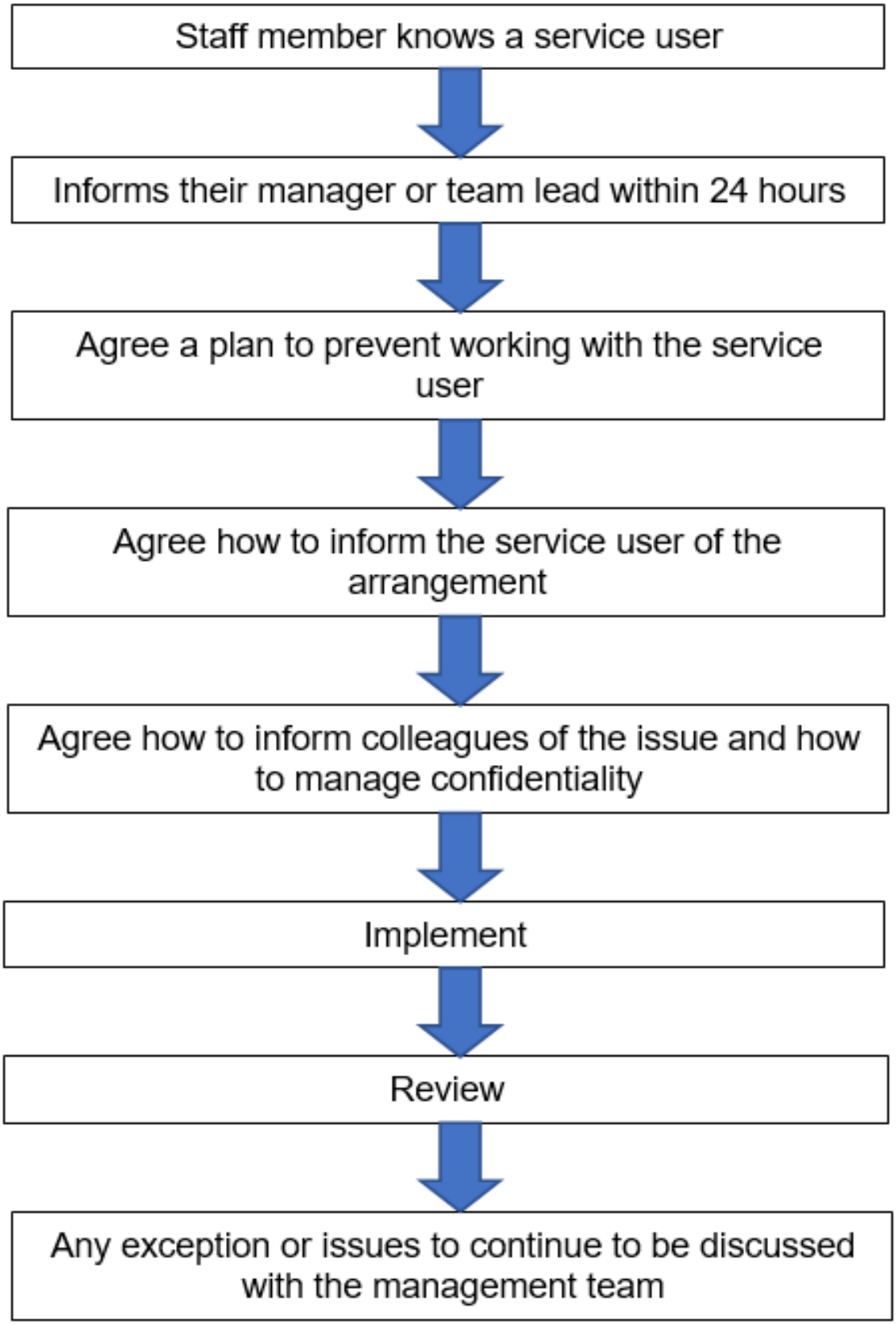
8.3 Staff must inform their line manager at the earliest opportunity if an allegation has been made against them whether this relates to their work within SHSC or outside of work for example sports coaching, social clubs, or caring responsibilities. The Line Manager should escalate to Head of Service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

8.4 Members of staff should be supportive of colleagues who report any untoward incidents or concerns and have a duty to co-operate with any investigation that may be carried out in response to an allegation against a colleague.

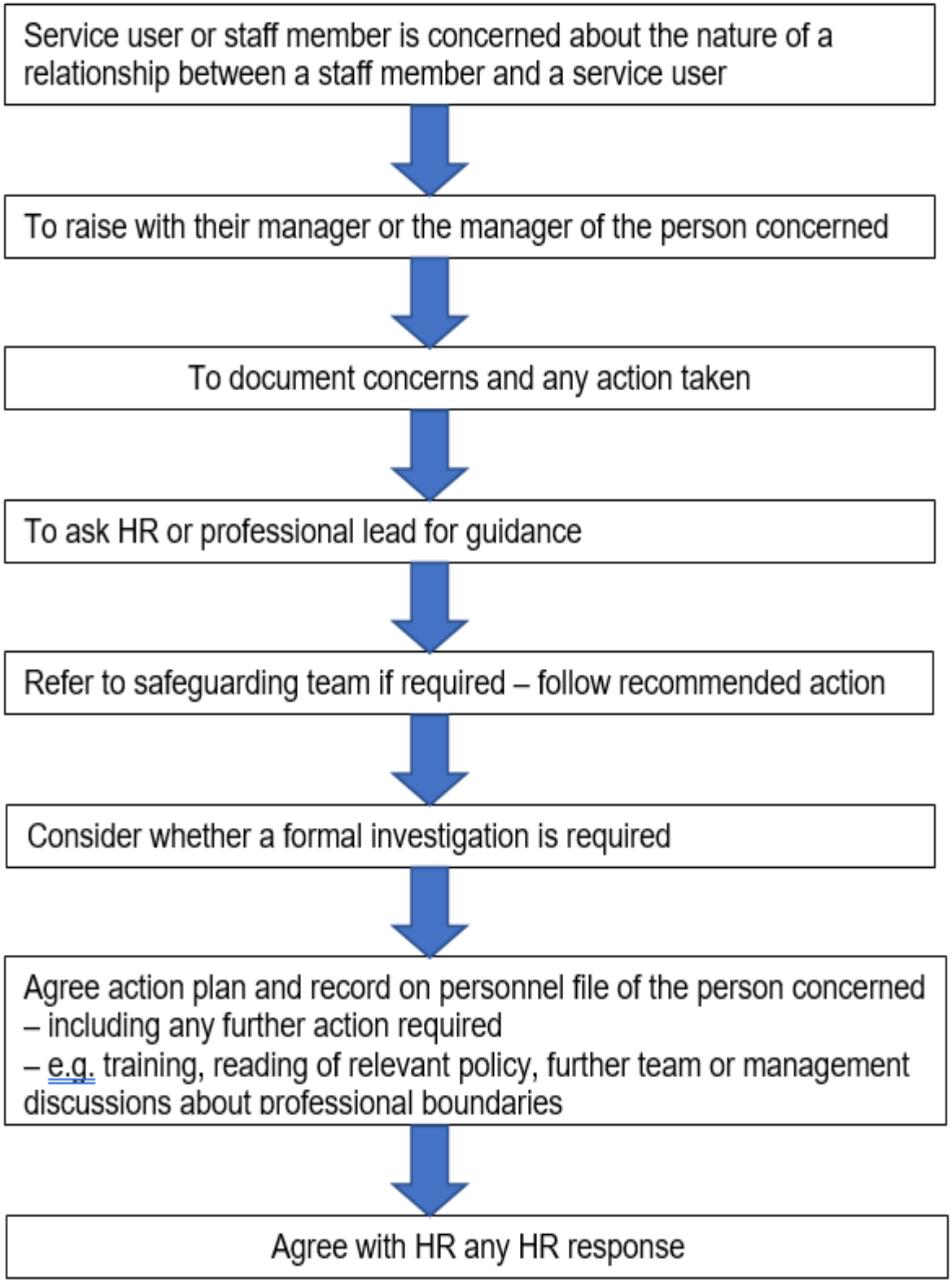
8.5 They should also: • Ensure their availability for investigation interviews when requested; • If allegations are made against them, give a clear and concise account of their version of events, supplying any supporting evidence where necessary. • If an allegation is made against a colleague and they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

8.6 Where relevant, the professional body code of conduct should be consulted and if required, information shared with the registrant and professional body.

Flow Diagram 1: How to manage an existing relationship with a service user



Flow Diagram 2: How to manage a concern about an unprofessional relationship with a service user - please see SHSC Allegations against Staff Policy.



9. Development, Consultation and Approval

9.1 The revised policy reviewed the HCPC and NMC codes of conduct as a basis for the new wording. The review of this policy included updating the language and some of the key aspects of the policy – including extending who is covered to all Trust staff. Links to legislation and links to Trust policies have been checked. The document was updated in brief and consulted on from April to July 2023.

9.2 The revised policy was shared for consultation and comment. This has been shared with colleagues, staff teams, the Rehabilitation and Specialist Services Directorate leadership team, colleagues in Human Resources, staff side, Chairs of the Staff Networks, Nursing leads, peer support workers and service user representation.

9.3 A range of changes and additions have been made following ideas shared by the colleagues who responded to the consultation. This updated the Policy further and added learning from recent Trust experiences, including HR processes.

9.4 Two Governance Groups have reviewed the revised policy: Clinical Quality and Safety Group - CQSG and JPG.

10. Audit, Monitoring and Review

Monitoring Compliance Template						
Minimum Requirement	Process for Monitoring	Responsible Individual/ group/committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
Review with patient safety and complaints teams, and with HR for a review of any related issues.	Review policy, update wording, Audit related incidents	Clinical Quality and Safety Group - CQ&SG	2025. Bi- Annual	Sue Barnitt and Dr Sara Whittaker	To sit with People Committee, HR and Patient Safety teams	Sue Barnitt and Dr Sara Whittaker

To review in 2 years due to the complex nature of the Policy and the importance of the boundary/practice. Target: September 2025.

10.1 It is expected that the issues covered in this guidance will be discussed in supervision, and any difficulties addressed at an early stage.

10.2 Complaints, incident data and analysis of any HR and disciplinary process will be used to identify any particular areas of difficulty.

10.3 Key elements of monitoring will be included in any Safeguarding Adult Audits and analysis on a yearly basis.

10.4 The policy will be reviewed in 2 years or earlier should changes be indicated by analysis of incident data or following the introduction of any national guidelines.

11. Implementation Plan

All policies should include an outline implementation plan (this will summarise sections above). It should include consideration of:

- Dissemination, storage, and archiving
- Training and development requirements and who will provide the training
- Any new job roles and responsibilities and how these will be implemented
- Resources needed
- Timescales
- Lead role and responsibilities for implementation
- Audit or monitoring of implementation planned

The implementation plan should be presented as an action plan and include clear actions, lead roles, resources needed and timescales. The Director of Corporate Governance team can provide advice on formats for action plans; however, an example layout for the plan is shown below:

Action / Task	Responsible Person	Deadline	Progress update
Upload new policy onto intranet and remove old version	Communications team	September 2023	
Make teams aware of new policy	Communications team	September 2023	
Develop and launch a leaflet for service users and one for colleagues	Communications team	December 2023	

11.1 Implementation plan NP025

Action / Task	Responsible Person	Deadline	Progress update
Ratified policy to be placed on the SHSC Intranet	Executive Director of Nursing and Professions	Within 2 weeks of policy being ratified September 2023	Policy to be on the intranet available for staff within 2 weeks of ratification
Ratified policy to be distributed to directorates for wider dissemination to all staff e.g. Make teams aware of new policy	Communications team	Policy to be sent to service directors within 3 weeks of policy being ratified with covering email explaining dissemination requirements September 2023	Policy to be disseminated to all Directorate leadership Teams (DLTs).
Ratified policy and supporting leaflet to be cascaded to teams to enable all staff to be aware of it.	Directorate leadership teams	Policy to be cascaded to all relevant teams within 2 weeks of receipt of the policy	Relevant teams within 1 month of ratification to be led by DLTs
Sexual Safety standards will be implemented on all in patient areas	Ward managers	Ward managers to continue with the implementation of the sexual safety standards.	To work with Ian Brown and colleagues on the wards.

Include the policy in the Trust Induction pack	Human resources team and induction programme.	Provide the policy to the Workforce development manager for inclusion in Trust Induction information.	

12. Dissemination, Storage and Archiving (Control)

This section should describe how the new policy will be disseminated. It says where the policy will be made available and to whom. This will normally be that the policy is available on the Trust's intranet and available to all staff.

It makes it plain that any previous versions must be deleted and describes the archiving and storage arrangements for the current and previous versions of the policy.

It says who is responsible for archiving and version control, and what they should do.

Version	Date added to intranet	Date added to internet	Date of inclusion in Connect	Any other promotion/ dissemination (include dates)
1.0	January 2015			
2.0	August 2019			
3.0	Tbc – September 2023	tbc	tbc	tbc
4.0				

Dissemination, storage, and archiving

12.1 This policy will be inserted on the Trust website, Jarvis, in the policies section and through a communications strategy, an 'All SHSC' email alert will be sent to all staff telling them of the new policy and where to find it.

12.2 Clinical and service directors are responsible for ensuring that all staff in their directorates are aware of new policies and know where to find them.

12.3 The Integrated Governance team will maintain an archive of previous versions of this policy, and make sure that the latest version is the one which is posted on the Trust intranet.

12.4 Where paper policy files or archives are maintained within teams or services it is the responsibility of the team manager to ensure that paper policy files are kept up to date and comprehensive, and that staff are made aware of new or revised policies. Older versions should be destroyed to avoid confusion.

13. Training and Other Resource Implications

13.1 The policy must include a consideration of any training and development requirements for its effective implementation. Where training needs are identified, these must be discussed with the Education, Training and Development Team and reflected in the Trust's Training Needs Analysis.

13.2 Other resource implications to consider include the cost of dissemination and any new job roles or functions which are not in current job descriptions or work plans.

13.3 Current training programme has been delivered by an external provider, and links between their training, slides, handouts and this policy are being followed up.

13.4 This policy will be communicated to all staff via directorate management teams and will be supported by availability on the Trust Intranet.

13.5 New staff will be advised of this policy via Jarvis, Trust and local induction upon commencement of their employment.

13.6 Training in professional boundaries will be relevant for managers, and for certain staff roles and grades in particular.

14. Links to Other Policies & Standards (Associated Documents)

"SHSC Understanding professional boundaries Information leaflet" provided for service users and carers - Reproduced by kind permission of Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. July 2022

Understanding professional boundari

Allegations against Staff policy
Managing Allegations Against Staff Policy (NP 037 V2 May 2022).pdf (shsc.nhs.uk)

Supervision Policy
Supervsion Policy (NP019 V4 July 23) .pdf (shsc.nhs.uk)

South Yorkshire Safeguarding Adult Procedures
Safeguarding Adults Policy (NP 40 V4 July 2023).pdf (shsc.nhs.uk)

SHSC Safeguarding Children Policy
Safeguarding Children Policy (NP 017 V6 April 2022).pdf (shsc.nhs.uk)

Speaking Up Policy
Speaking Up - Freedom to Speak Up Raising Concerns (Whistleblowing) Policy (HR 015 V6 April 23) | JARVIS (shsc.nhs.uk)

SHSC Confidentiality Code of Conduct
Confidentiality Code of Conduct (IMST 011 V5 Feb 2023).pdf (shsc.nhs.uk)

SHSC Human Resource Policies
Including Mandatory Training Policy (HR 036 V4 July 2022).pdf (shsc.nhs.uk)

SHSC Incident Reporting and Investigation Policy
Electronic Incident Reporting: A manager's guide to reviewing incidents | JARVIS (shsc.nhs.uk)

SHSC Standards for Sexual Safety
Sexual Safety Policy (CG 008 V2 April 2022).pdf (shsc.nhs.uk)
Under review

SHSC Ethical Standards in the NHS: Including Hospitality, Gifts, Research and Commercial Sponsorship
Managing Conflicts of Interest in the NHS Policy (CG 001 V2 October 2020).pdf (shsc.nhs.uk)

https://jarvis.shsc.nhs.uk/system/files/2021-04/Managing%20Conflicts%20of%20Interest%20in%20the%20NHS%20Policy%20%28CG%20001%20V2%20October%202020%29%20-%20Declaration%20of%20Hospitality%20Gifts%20Research%20Sponsorship%20Form.docx

This states: "**Gifts from other sources (e.g. patients, families, service users):**
• Gifts of cash and vouchers to individuals should always be declined.
• Staff should not ask for any gifts.
• Gifts valued at over £25 should be treated with caution and only be accepted on behalf of Sheffield Health and Social Care NHS Foundation Trust General Fund, which is a Charitable Fund, not in a personal capacity. Staff must seek the approval of their relevant Associate Director (for clinical services) or service Director (for corporate services) who in turn should seek the approval of the relevant Executive Director before accepting the gift to charitable funds. These should be declared by staff.
• Modest gifts accepted under a value of £25 do not need to be declared.
• A common-sense approach should be applied to the valuing of gifts (using an actual amount, if known, or an estimate that a reasonable person would make as to its value).
• Multiple gifts from the same source over a 12-month period should be treated in the same way as single gifts over £25 where the cumulative value exceeds £25.
• There may occasionally be circumstances where it would be inappropriate to decline gifts under the value of £50 where they are offered to teams or wards for the benefit of the whole team or ward e.g. chocolates, biscuits etc. or where diplomatic or cultural sensitivities would cause offence. In these circumstances approval of the gift must be sought from an appropriate senior manager. The gift must also be declared.
What should be declared:
• Staff name and their role with the organisation.
• A description of the nature and value of the gift, including its source.
• Date of receipt.
• Any other relevant information (e.g. circumstances surrounding the gift, action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy)."

Sheffield Safeguarding Children and Child Protection Procedures
Safeguarding children | JARVIS (shsc.nhs.uk)
https://www.sheffieldasp.org.uk/sasp/sasp/policy-and-procedures/south-yorkshire-adult
https://www.sheffieldasp.org.uk/sasp/sasp/policy-and-procedures

https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf

SHSCFT Human Resource Policies
People Directorate | JARVIS (shsc.nhs.uk)

SHSCFT Being Open and Duty of Candour Policy
Duty of Candour and Being Open Policy (MD 010 V5 Dec 2021) | JARVIS (shsc.nhs.uk)

15. Contact Details

Title	Name	Email
Heads of Psychological Professions	Dr Sara Whittaker	Sara.whittaker@shsc.nhs.uk
HR Advisors	HR Team	HRAdvisors@shsc.nhs.uk

Title	Name	Email
Executive Director of Nursing, Professions & Quality	Salli Midgley	Salli.midgley@shsc.nhs.uk
Chief Nurse	Kelly McKernan	Kelly.McKernan@shsc.nhs.uk
Safeguarding & MARAC Lead, Operational Lead for PREVENT	Hester Litten	Hester.Litten@shsc.nhs.uk
Safeguarding Nurse Advisor	Angela Whiteley	Angela.Whiteley@shsc.nhs.uk

Appendix A

Equality Impact Assessment Process and Record for Written Policies

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

NO – No further action is required – please sign and date the following statement.
I confirm that this policy does not impact on staff, patients, or the public.

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

YES, Go to **Stage 2**

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

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

SCREENING RECORD	Does any aspect of this policy or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this policy or changes to this policy?	Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?
Age	no changes made		The aim is to enhance safe, professional relationships.
Disability	no changes made		The aim is to enhance safe, professional relationships.
Gender Reassignment	no changes made		The aim is to enhance safe, professional relationships.

Pregnancy and Maternity	no changes made		
Race	no changes made		The aim is to enhance safe, professional relationships.
Religion or Belief	no changes made		The aim is to enhance safe, professional relationships.
Sex	no changes made		The aim is to enhance safe, professional relationships.
Sexual Orientation	no changes made		The aim is to enhance safe, professional relationships.
Marriage or Civil Partnership	no changes made		

Please delete as appropriate: - Policy Amended / Action Identified (See Implementation Plan) / no changes made.
The aim is to enhance safe, professional relationships.

Impact Assessment Completed by:
Name /Date Dr sara whittaker. 17.05.2023,

Supplementary Section A - Stage One Equality Impact Assessment Form

1. Have you identified any areas where implementation of this policy would impact upon any of the categories below? If so, please give details of the evidence you have for this? NO

Grounds / Are of impact	People / Issues to consider	Type of impact		Description of impact and reason / evidence
		Negative (it could disadvantage)	Positive (it could advantage	
Race	People from various racial groups (e.g., contained within the census)			no changes made
Gender	Male, Female, or transsexual/transgender. Also consider caring, parenting responsibilities, flexible working, and equal pay concerns		Language updated	no changes made
Disability	The Disability Discrimination Act 1995 defines disability as 'a physical or mental impairment which has a substantial and long-term effect on a person's ability to carry out normal day-to-day activities. This includes sensory impairment. Disabilities may be visible or non-visible			no changes made
Sexual Orientation	Lesbians, gay men, people who are bisexual			no changes made
Age	Children, young, old and middle-aged people			no changes made
Religion or belief	People, who have religious belief, are atheist or agnostic or have a philosophical belief that affects their view of the world. Consider faith categories individually and collectively when considering possible positive and negative impacts.			no changes made

2. If you have identified that there may be a negative impact for any of the groups above, please complete questions 2a-2e below.

☐ 2a. the negative impact identified is intended OR ☐ 2b. The negative impact identified not intended.

2c. the negative impact identified is legal OR 2d. The negative impact identified is illegal OR (see 2e)
(i.e., does it breach antidiscrimination legislation either directly or indirectly?)

2e. I don't know whether the negative impact identified is leg al or not.
(If unsure you must take legal advice to ascertain the legality of the policy)

3. What is the level of impact?

☐ HIGH - Complete a FULL Impact Assessment (see end of this form for details of how to do this)

☐ MEDIUM - Complete a FULL Impact Assessment (see end of this form for details of how to do this)

☒ LOW - Consider questions 4-6 below.

4. Can any low-level negative impacts be removed (if so, give details of which ones and how)

The aim is to enhance safe, professional relationships.

5. If you have not identified any negative impacts, can any of the positive impacts be improved? (If so, give details of which ones and how)

The policy and the updates to the policy aim to reduce any abuse, exploitation or risk to service users and carers, by strengthening the requirement of all Trust staff to maintain clear professional boundaries.

6. If there is no evidence that the policy promotes equality and equal opportunity or improves relations with any of the above groups, could the policy be developed or changed so that it does?

7. Having considered the assessment, is any specific action required - Please outline this using the pro forma action plan below
(The lead for the policy is responsible for putting mechanisms in place to ensure that the proposed action is undertaken)

Issue	Action proposed	Lead	Deadline
Training offer around Boundaries and relationships	To follow up with Sue Barnitt as to forward offer arrangements – currently with third sector provider	Sue Barnitt	October 2023
To share the leaflet for service users	Leaflet to be shared on Jarvis and with services to share with service users	Communications team and DLTs	December 2023

Appendix B

Review/New Policy Checklist

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

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