LONDON FIRE BRIGADE

London Fire Brigade Headquarters
169 Union Street London SE1 0LL
T 020 8555 1200
london-fire.gov.uk

Freedom of Information request: Reference number FOI2024/00138

Date of request: 20th January 2025

Request:

I would like to be provided with a copy of your Firefighters welfare policy Firefighters crisis and trauma policy Firefighters safeguarding policy Firefighters mental health policy Firefighters neurodiversity/adhd testing policy And Firefighters risk policy As a matter of urgency please. I would also like to be provided with suicide statistics of the brigade for the last 5-8 years. I believe a period of 8 working days will be sufficient time to collate all requested information. Thank you in advance.

Response:

Further to your request, please see below for the LFB policies that you have requested.

PN0915 recognising and coping with potentially traumatic events

PN1002 Mental health - promote, prevent and treat

PN0736 safeguarding adults at risk

PN1005 Supporting health and wellbeing policy

PN0553 Learning Support policy

With regards to your request for suicide statistics for the last 5-8 years, our HR department have advised that before August 2021, London Fire Brigade (LFB) did not record the cause of death for employees who died in service.

From August 2021, the LFB started to record the cause of death as detailed on the death certificate (when provided). Death certificates rarely state “suicide” as a cause of death, even when self-harm is involved. Since August 2021, there have been no deaths in service recorded as suicide. In addition, data on attempted suicide is not recorded.

Policy | Procedure

LONDON FIRE BRIGADE

Recognising and coping with potentially traumatic events

New policy number:	**915**
Old instruction number:	
Issue date:	**12 October 2017**
Reviewed as current:	**23 September 2022**
Owner:	**Assistant Director, Health and Safety**
Responsible work team:	**Counselling and Trauma Services**

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1 Introduction

1.1 This policy sets out the Brigade's arrangements to assist staff and managers in recognising and coping with potentially traumatic events and aid watch officers in deciding when and how to hold informal immediate watch debriefs following attendance at critical incidents (CI) or other potentially traumatic events (PTE). Watch officers can and will themselves be exposed to CIs or PTEs, therefore senior officers will need to be mindful of this and familiarise themselves with this policy, so that they are able to support watch officers.

1.2 This policy should be applied in line with the Brigade's values:

- Service – We put the public first.
- Courage – We step up to the challenge.
- Learning – We listen so that we can improve.
- Teamwork – We work together and include everyone.
- Equity – We treat everyone fairly according to their needs.
- Integrity – We act with honesty.

2 Post traumatic event

2.1 Individuals can react differently to critical incidents; some will find the incident traumatic and others may not. Any critical incident can be a potentially traumatic event for any individual. How a critical incident impacts on someone can be influenced by the individual's current stress levels, their personal resilience, any personal meaning the incident might evoke and cumulative previous exposure to critical incidents. Definition of 'trauma' trauma related stress can be experienced after exposure to any event considered to be outside of an individual's usual experience which causes physical, emotional or psychological harm.

2.2 A potentially traumatic event (PTE) is defined as:

- Threat of death or serious injury experienced by self or witnessed.
- Learning that events involved violent and/or accidental death or injury to family and/or close associates.
- Repeated or extreme exposure to details e.g. emergency services.

2.3 The Brigade's Counselling and Trauma Service (CTS) defines CIs as:

- Any incident where the OiC considers that CTS contact may be helpful e.g. flashovers, near misses, feelings of helplessness, many CIs attended in a short period. Anyone attending a CI who feels that it might have been potentially traumatic for the crew can raise this with the OiC and/or CTS.
- Two or more deaths of members of the public including RTCs.
- Death of a child or children.
- Death or serious injury to operational staff on duty.
- Terrorist activity, where life has been endangered or lost.
- Any serious RTA involving a Brigade appliance.
- Major/catastrophic incidents.
- Any incident where operational staff are trapped or missing.

2.4 In the course of normal duties, firefighters will occasionally respond to critical incidents (CIs) which they may find traumatic. There are a number of factors which determine whether an individual finds any one particular incident traumatic, these include:

- The meaning the incident may have for you e.g. a road traffic collision (RTC) involving a child of similar age to your own child.
- What else is going on in your life at the time e.g. is your stress level high?
- How resilient you are/have become e.g. do you have a good network of family and friends? Are you positive with a good sense of purpose?
- Is this one more in a series of CIs that you have attended.

2.5 Brigade attendance at a CI automatically triggers contact, usually a telephone call, from CTS. This is to check out how you are after the event and to give you useful information about trauma and keeping yourself safe from prolonged adverse psychological responses.

2.6 When attending a PTE the fight-flight-freeze response is triggered in everyone. This releases adrenalin and other stress hormones to assist the body to deal with the PTE. This is the body's survival mode. At such times less emphasis is placed on automatically recording precise and processed memories of the event. In the majority of cases these memories are processed naturally over the following week, with no further repercussions. During this time the individual may have some unsettling experiences such as feeling confused, exhausted, ruminating about the event, nightmares and disturbed sleep, flashbacks, feeling numb or upset (additional information in Appendix 3, Item 1).

2.7 Measures taken in the first 1-5 days following attendance at a PTE can promote normal processing, assist recovery and prevent the development of unhelpful trauma responses such as post traumatic stress disorder (PTSD - additional information in Appendix 3 item 2). These interventions can include:

- Informal manager's debrief held on station immediately on return from the potentially traumatic event.
- Contact from Counselling and Trauma Service 1-5 days following the potentially traumatic event (post critical incident contact -PCIC) when appropriate.
- Strategies employed by the individual to promote event processing (additional information in Appendix item 4).

3 Immediately after a critical incident

3.1 Most people tend to find that they feel 'not quite themselves' for a few days after attending a CI/PTE. Possible post CI reactions may include any of the following:

- Intense feelings: sadness, guilt, anger, shame, fear, disappointment.
- Physical symptoms: tiredness, poor sleep, nausea, headaches, neck and back aches, muscular tension, changes in habits e.g. eating, drinking.
- Psychological changes: poor concentration/motivation, nightmares, 'flashbacks', feeling 'on guard', rumination about the incident/other CIs attended.
- Behaviours: withdrawing, unable to express feelings, irritability, loss of sense of humour, impatience.

3.2 Usually, you will start to get back to normal in a period of 1-5 days following the CI. There are a number of things that you can do to help any symptoms subside, as you normally process the event. Helpful strategies in the days following a CI include:

- Check in and 'debrief' with your station officer, sub officer and leading firefighter immediately upon returning to your fire station after the CI.
- Follow familiar routines.
- Talk to supportive family/friends/colleagues.
- Exercise and eat healthily.

- Do activities/hobbies which bring you into the 'here and now'.
- Do distracting activities (computer games, crosswords, Sudoku).
- Monitor your intake of alcohol, nicotine, caffeine.
- Balance time alone with social time.
- Understand/accept that this is a normal process.

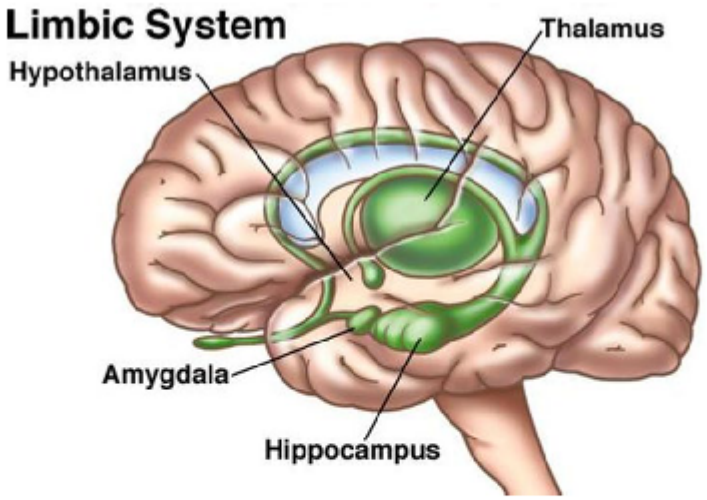
3.3 It is useful to monitor your reactions over time and consider seeking further help from a manager or from CTS if you are experiencing any of the following persistently for 2-3 weeks after the CI:

- Intense feelings, depression, exhaustion.
- Ruminative thoughts.
- Flashbacks.
- Poor sleep, nightmares.
- Difficulties focussing; accidents.
- You feel isolated.
- You cope by: constantly being busy, smoking/drinking, medication.

4 The neuroscience: why do we respond to trauma in this way

4.1 The limbic system is a part of the brain which regulates basic bodily functions such as breathing and blood flow; it controls our automatic survival instincts when we are faced with a PTE. At such a time it causes the release of stress hormones such as cortisol and adrenalin which get our bodies ready physiologically to fight, flight or freeze in order to stay safe.

4.2 Normally the recording, processing and storage of memories is the job of the hippocampus, an organ in the brain which makes sense of events in terms of date, time and narrative. This processing enables us to recall events at will.



4.3 However, when in flight/fight/freeze mode the hippocampus goes off line as the body has more important things to do than record memories such as preparing to run or fight. The job of recording events at these times is then taken over by another brain organ the amygdala, which is not so good at it. Snatches or fragments of the events get stored incorrectly in inappropriate parts

of the brain and the whole event doesn't get properly processed as a complete narrative and stored away in the brain's 'filing cabinets' in the cortex.

4.4 This incomplete processing of the event is the cause of post-trauma symptoms. 1-5 days after a PTE these will usually disappear; during this time the hippocampus comes back on line again and the incident fragments stored by the amygdala pop up (the cause of flashbacks and nightmares) and are then properly processed and filed.

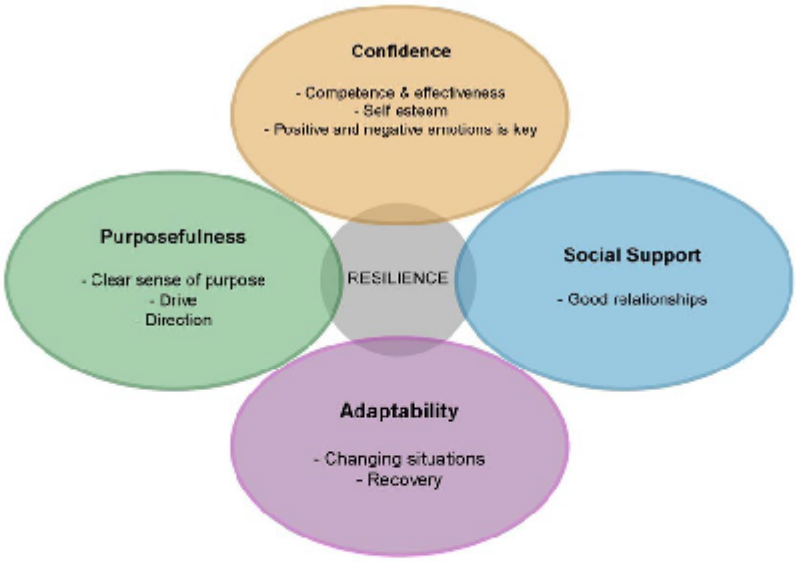
4.5 Very occasionally, normal post-trauma processing doesn't quite clear the symptoms; this can lead to the development of PTSD where the trauma related symptoms of intrusion (e.g. flashbacks, nightmares, rumination), avoidance (e.g. blocking thoughts with alcohol) hypervigilance (being on constant alert) and feeling emotionally numb persist for more than a month after the event.

4.6 Factors which protect against PTSD are good post-CI self-care and generally developing good psychological resilience.

5 Resilience and long term strategies

5.1 Psychological resilience allows us to adapt well following adversity, trauma, tragedy, threats, or significant sources of stress; it gives us the ability to 'bounce back'. Resilience is something that we can actively develop at any time and which will help to protect against developing prolonged adverse trauma responses after attending CIs.

5.2 Most of the many theories of personal resilience include having good social support networks in your life and developing the personal qualities of purposefulness, confidence and adaptability as illustrated in Robertson Cooper's model:



5.3 There are several positive steps that we can take in order to keep strengthening our resilience, these include:

- Make and maintain good relationships.
- Avoid seeing situations as insurmountable problems.

- Accept that some things are out of your control.
- Set realistic goals.
- Take decisive actions.
- Look for opportunities for personal growth.
- Nurture a positive view of yourself.
- Keep things in perspective.
- Maintain a hopeful/optimistic outlook.
- Take care of yourself: exercise, healthy lifestyle, relaxation (American Psychological Association).

6 Guidance for speaking to distressed family and friends

6.1 When dealing with PTE's it can be difficult to know what to say to those family and friends of casualties that have either died or suffered life changing injuries as a result of the incident. Below are suggested actions and language that may help in these situations.

6.2 When in attendance it is the responsibility of the London Ambulance Service (LAS) or Metropolitan Police Service (MPS) to speak to distressed family and friends, the following guidance is for brigade staff who may find themselves in a situation where either the LAS or MPS are not yet in attendance, or the destressed family member or friend has approached them. Only doctors, nurses or suitably trained ambulance clinicians can confirm that death has taken place, therefore the use of the words dead or died should be avoided unless the individual that is being spoken to has had this confirmed by someone suitably medically qualified to do so.

What to say

- Keep the language plain, concrete and unambiguous whilst remaining sensitive to the situation.
- Assume a certain formality in address.
- Try not to talk too quickly.
- Be prepared to repeat information if necessary.
- Monitor the impact of what you are saying and pace the information accordingly.
- Ensure that you only give up to date factual information.
- Allow time for the information to become absorbed.
- Try to avoid filling moments of silence, sometimes a presence alone can be supportive.
- Listen out for what the friend/family call the casualty, check out if you can use this name too.
- There are few consoling words that people will find helpful if the casualty is very seriously ill or has died. Its OK to say things like:
  - 'I'm really sorry this has happened'.
  - 'I cannot begin to imagine how you may be feeling at the moment'.

What not to say

- Avoid ambiguous words and phrases such as someone is 'lost' or has 'passed away'. It is better to use more concrete phrases that are less likely to lead to confusion or misunderstanding.
- Avoid using words/phrases such as 'the body', 'deceased', 'victim' or 'remains'. Use the casualty's name.
- Don't provide any information that you aren't 100% sure of; don't be afraid to say, "I don't know, but I will try to find out for you".
- Don't attempt to reassure them or lessen the blow with, for example:
  - 'Don't worry' or 'it could be worse'.

  - 'They died well'.
  - 'I understand how you feel'.
- Do not offer any false hope or try to talk the person out of their distress and grief. Try not to be led into saying things or making promises that may not be met.
- Unless initiated by the person concerned avoid physical contact as this may be intrusive and/or threatening.
- As a general rule, do not worry about saying very little; this is better than too much. Being present and able to tolerate the person's distress are often the most supportive aspects at this stage. Often unhelpful things are said in the vain hope of lessening the impact of the situation. It is much better to fully appreciate that you cannot make things better.

7 Guidance for speaking to distressed children

What to say/what to do

- Sit down with the child at eye level and say that you have something sad to tell them.
- Use language that the child will understand and be honest without giving unnecessary details.
- Use clear, concise, simple and concrete terms e.g. to explain the word 'dead'. For example, a child is more likely to understand the following statement: "Your parent is very ill at the moment, but we are trying to help them."
- Answer all questions honestly. It is okay to say to children "I don't know" when asked questions that seem impossible to answer.
- Provide reassurance that they are and will be kept safe.

What not to say/what not to do

- Avoid using phrases that are unclear or ambiguous such as: "…. has gone away" or "gone to a better/special place". The child will possibly wait for them to return, wish to visit them, or wonder why they were not invited to go.
- Do not assume the child has fully understood what you have just told them. Processing difficult information can take place for children over a longer period of time than for adults.

8 Manager's debrief

8.2 This should take place on station immediately following attendance at a critical incident or potentially traumatic incident.

8.3 Is an informal, routine, short meeting involving all attenders.

8.4 The purpose is to allow for mutual support in the watch, provide up to date information, give information about normal post critical incident responses and recovery, note if anyone is particularly struggling, advise of CTS contact when required and general services.

8.5 It is not a psychological debriefing which would only ever be done by someone trained in the psychological management of people exposed to traumatic events.

8.6 Staff who require a support call from CTS following an incident now have the new and improved option whereby managers notify CTS via the 'Incident' appointment generated within the LFB Diary. The manager's debrief is of the upmost importance to ensure that attending crews receive immediate support from managers and so managers can gauge the need for CTS calls.

8.7 Following the debrief, if staff or line managers feel that CTS support calls are required, they may use this new feature. Within the incident appointment, you will be able to 'select all' or select specific individuals to notify CTS that support calls are needed.

8.8 This will generate a pre-worded email, containing specific information relating to the incident and basic staff contact details. After receipt of the email then CTS shall make contact. The station commander will be informed via a notification in their LFB Diary work queue to ensure local management support at the earliest opportunity.

8.9 The LFB Diary feature should only be used to request a PCIC from CTS and is not to be used for any other CTS notification.

8.10 Manager's debrief guidance/template can be found in Appendix 1.

9 Role of Counselling and Trauma Service

9.1 The following procedure will be carried out by CTS when any of the bullet points in 2.3 have been met, staff are reminded of point one, "any incident where the OiC considers that CTS contact may be helpful e.g. flashovers, near misses, feelings of helplessness, many CIs attended in a short period. Anyone attending a CI who feels that it might have been potentially traumatic for the crew can raise this with the OiC and/or CTS" as it is important to realise the potential for trauma that the accumulative effect of attending several PTEs/CIs over time may have.

9.2 1-5 days after a potentially traumatic event staff counsellors from CTS will contact all attending firefighters, officers and where relevant control officers and fire investigators, following CTS's PCIC protocol (available on CTS hotwire page). This is called a critical incident/potentially traumatic incident call and is done automatically when a CTS CI criterion is met or if the OiC or a crew member contacts CTS and it is agreed to follow the PCIC protocol for that CI. Every effort is made to make telephone contact, between tours where relevant. Letters are sent out to individuals inviting them to telephone CTS when initial telephone contact has been unsuccessful.

9.3 The purpose of the critical incident/potentially traumatic incident call is:

- **Normalisation**: checking individual's experience of the incident and how they have been affected in subsequent days, putting this into the context of normal post CI responses. Identifying strategies they might use to aid recovery/event processing.
- **Psycho-education**: information is given about how people respond to trauma and typical normal recovery. What 'symptoms' to look out for and when to seek further help.
- **Risk assessment**: questions are asked based on a questionnaire which measures adverse trauma responses:
  - No psychological risk detected – no further CTS action.
  - Medium risk – follow up call scheduled for 1-2 weeks later.
  - High risk – appointment with a staff counsellor will be offered/suggested.
- **Watchful waiting**: monitoring to ensure that the individual is processing the incident and recovering normally. Adverse trauma responses are indicated if symptoms persist after a week or more.

9.4 If an adverse trauma response is detected, then counselling is offered using approved trauma treatment methods such as trauma-focussed cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR).

9.5 Summary of the Brigade's post critical incident and trauma prevention interventions can be found in Appendix 2.

10 Help and support

10.1 Please contact CTS on extension 35555 and by email to counselling@london-fire.gov.uk.

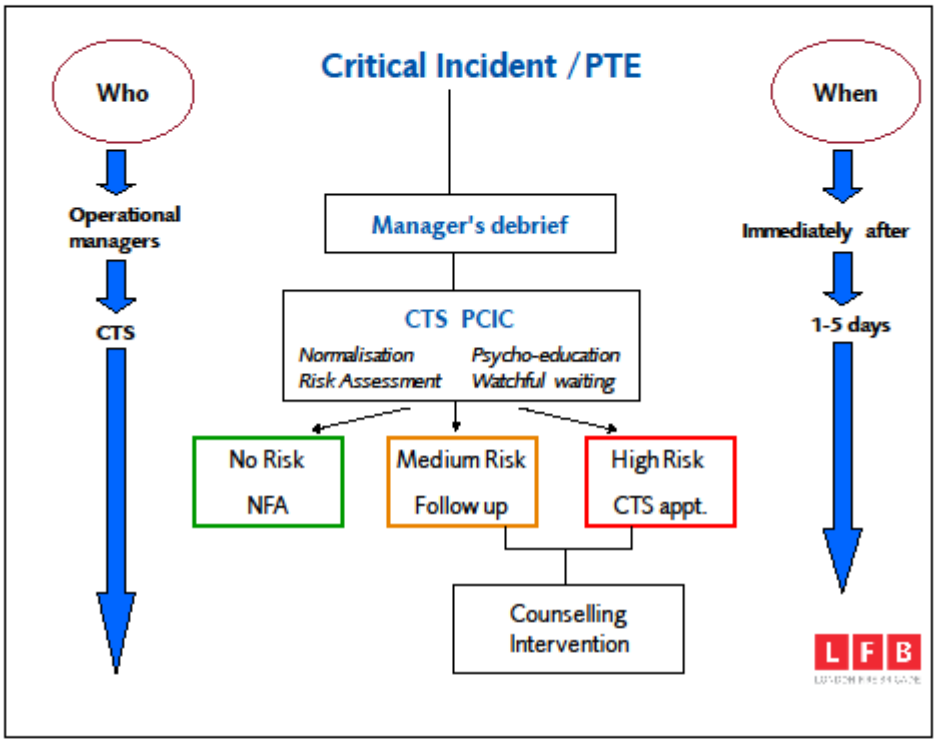
10.2 If you are in need of urgent assistance, please contact the CTS on-call service by calling Control (ext. 50208) and asking for the duty counsellor to be paged.

10.3 This policy may also be available on request in other alternative accessible formats as set out in Policy number 290 – Guidance note on translation and interpretation. Please contact Communications on extension 30753 and by email to communications.team@london-fire.gov.uk to discuss your needs and options.

Appendix 1 – Manager's debrief guidance/template:

Manager's debrief following Critical Incident / Potentially Traumatic Event	
Topic	**Tasks**
1. Physical wellbeing	Check for anyone with any immediate health or first aid needs.
	Everyone had time for rehydration, food and drink?
2. The incident	Provide a brief overview of the incident.
	Give everyone the opportunity to contribute to the narrative of the incident.
	Allow for people to 'let off steam' but try to contain and stabilise the meeting to reduce stress .
	Provide additional facts and updates, particularly regarding casualties, answer questions.
3. Impact of trauma	Explain how exposure to traumatic incidents can produce temporary symptoms and what they might experience (Appendix 3 item 1).
	Stress that the vast majority of people recover fully within a week and provide information of personal strategies that can assist with normal recovery (Appendix item 4).
4. Further assistance	Inform the watch that CTS will be telephoning them in next 1-5 days (if this fits the CI criteria for CTS contact; 2.5 above) or if you notify CTS that you would like the attenders to be called as the incident was potentially traumatic. Encourage engagement with this contact.
	Some staff may have different cultural/faith needs. Often if someone has a strong faith background, they will already have a faith leader who can provide additional support. Some however may just need short term guidance, and for that there is the Brigade Chaplain who can assist in accessing multi faith support.
	Ensure the watch have access to CTS leaflet/poster/contact details and remind them of the services available.
	Consider if any individuals appear to be immediately struggling with the incident; they may appear as very vocal, angry or quiet and withdrawn. Do they or the watch need a follow up meeting with you?
5. Ending	Reminder to monitor how they are and seek further help from CTS if symptoms persist after a week.
	Any further comments or questions.
	Encourage connection with their social support networks, self-care and talking to someone supportive if they need to.
Remember to check how you are, consider if you might need any additional support yourself.	

Appendix 2 – Summary of LFB's post critical incident and trauma prevention interventions



Appendix 3 – Additional information

[1] Symptoms which can occur after a CI/PTE (usually subside within 1-5 days)

- Feeling irritable and/or angry.
- Exhaustion.
- Poor concentration.
- Sleep difficulties.
- Avoiding places, people, thoughts and talking about the event.
- Intrusive rumination.
- Flashbacks of the incident.
- Hypervigilance, wary, watchful.
- Wanting to isolate, withdraw.
- Feeling upset.
- Disappointment.
- Feeling numb.
- Frightened.
- Confusion.
- Increased consumption of alcohol, nicotine, caffeine.
- Restlessness.

[2] Adverse trauma response, post traumatic stress disorder PTSD

PTSD is defined by some/all of these symptoms occurring 30 days or more after the PTE. It can persist for many years if not treated.

Reliving the event (as if in the 'here and now'):

Nightmares.

Flashbacks.

Intrusive rumination.

Avoiding situations that remind you of the incident:

Avoiding people or places that trigger incident memories.

Keeping very busy.

Avoiding/putting off seeking help.

Negative changes in beliefs and feelings:

Changes in the way you think about yourself or others.

Loss of trust in your safety in the world.

Difficulties in relationships.

Hypervigilant, 'keyed up':

Jittery always on alert.

Sleep difficulties.

Hard to concentrate.

Startle easily.

Document history

Assessments

An equality, sustainability or health, safety and welfare impact assessment and/or a risk assessment was last completed on:

EIA	30/04/24	SDIA	L – 24/08/23	HSWIA	04/09/23	RA	N/A

Audit trail

Listed below is a brief audit trail, detailing amendments made to this policy/procedure.

Page/para nos.	Brief description of change	Date
Throughout	Appendix 4 missing, updated version of the policy added.	16/10/2017
Page 1	Owner title and responsible work team details changed and changes to reflect the abolition of London Fire and Emergency Planning Authority, now replaced with London Fire Commissioner.	17/08/2018
Throughout	Counselling and Wellbeing updated to Counselling and Trauma Services.	14/11/2018
Throughout	Role to rank changes made to content.	15/10/2019
Throughout Page 9 Appendix 4	Deleting reference to co-responding incidents. Updating contact details for Counselling and Trauma Services. Deleted.	23/09/2022
Page 12	SDIA updated.	04/09/2023
Page 12	HSWIA updated.	08/09/2023
Page 2, para 1 Page 7, para 8 Page 8, para 10 Throughout	Introduction updated and Values added. New LFB Diary PCIC referral to CTS process added. Help and support added. Inclusive language updated.	29/04/2024
Page 12	Equality impact assessment date updated.	30/04/2024
Page 1	Responsible work team updated.	03/05/2024

Subject list

You can find this policy under the following subjects.

Stress	Trauma
Distress	

Freedom of Information Act exemptions

This policy/procedure has been securely marked due to:

Considered by: (responsible work team)	**FOIA exemption**	**Security marking classification**

Policy | Procedure

LONDON FIRE BRIGADE

Mental health: promote, prevent and treat

New policy number:	**1002**
Old instruction number:	
Issue date:	**7 November 2022**
Reviewed as current:	**24 April 2024**
Owner:	**Assistant Director Health and Safety**
Responsible work team:	**Wellbeing, Health and Fitness**

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1 Introduction

1.1 This policy sets out the Brigade's arrangements how it will **promote** good mental health, will seek to **prevent** poor mental health, and will **treat** (support) staff who experience mental health challenges during their employment.

1.2 The Brigade is committed to ensure that all individuals are treated fairly, with dignity and respect in their working environment, and therefore recognises that staff may need additional consideration, support, and adjustments during times of mental ill health.

1.3 To ensure that staff feel confident to be able to discuss their mental health and to ask for support/reasonable adjustments to their working practice, this policy has been developed to:

(a) **PROMOTE**

(i) Provide staff in our organisation with information to raise wider awareness and understanding of mental health.

(b) **PREVENT**

(i) Provide staff/managers with options that can be accessed to assist in helping prevent poor mental health taking hold.

(c) **TREAT**

(i) Outline what support is available to all staff who may experience episodes of poor mental health.

1.4 The Brigade's commitment to this responsibility is outlined in its internal publications; the Delivery Plan, Togetherness Strategy, People Services Strategy and Wellbeing Strategy and various policies, as well as being independently supported by the engagement with external stakeholders, the results of which include the Brigade being a signatory to the Time to Change* pledge promoted by the mental health charity MIND, and being accredited by the GLA's London Healthy Workplace Charter award to Excellence level (highest award)**.

* Signed by the Commissioner in February 2017 committing to challenge mental health stigma and promote positive wellbeing within the service.

**Awarded in April 2017 demonstrating that health and wellbeing are embedded in LFBs corporate culture and values.

2 What is mental health?

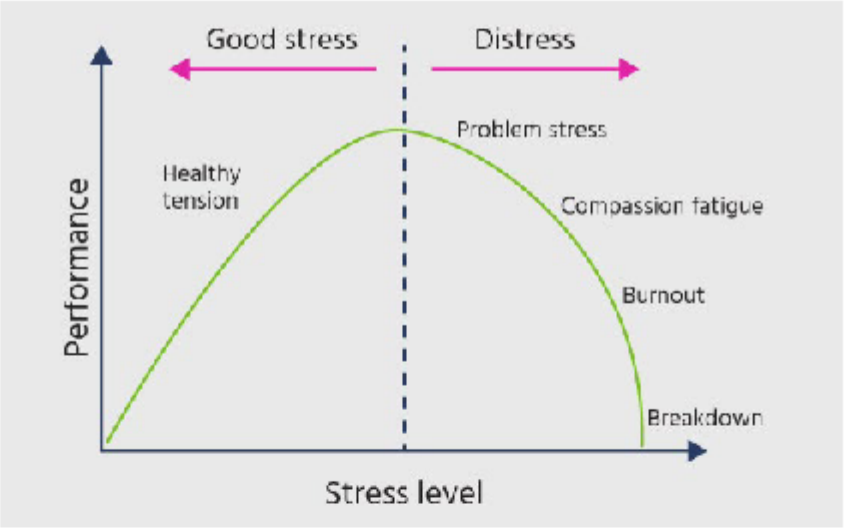
2.1 It is important to understand that everybody has mental health; best described as 'a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (World Health Organisation).

Mental health: From wellness to illness

2.2 Mental health should therefore not be thought of a solely static state, it fluctuates, so we are never always just mentally well or ill, people range from having excellent mental health to experiencing major mental health problems, illustrated as per below.

World Health Organisation - 2012

2.3 In a work context mental health is usually represented as per the diagram below.



MindEd 2021

2.4 Ensuring that staff do not move from 'Good stress' to 'Distress' is a primary aim of this policy.

3 London Fire Brigade and mental health

3.1 LFB believes that the PROMOTE, PREVENT and TREAT approach toward mental health wellbeing will provide staff/managers with a clear and referenced framework that they will be able to use to ensure that their own mental health wellbeing, and that of colleagues, is a constant consideration when undertaking their roles.

4 Promote

4.1 The Brigade believes that promoting mental health is integral to personal wellbeing, building effective working relationships and establishing a positive workplace culture. To promote mental wellbeing the Brigade will use:

Communication channels

4.2 Use its existing communication channels – **Hotwire**, **Shout**, Your LFB Update, Viva engage and staff briefings – to alert staff to mental health initiatives, services, and resource availability.

People and teams

4.3 Use dedicated staff and teams/groups to promote and engage with staff on matters relating to mental health.

(a) **Counselling and Trauma Service** (CTS) – the Brigades in house team will promote its professional counselling service provision to all staff using written materials, audio/visual resources, and face to face engagements. Information on CTS can be found on Hotwire. Direct contact can be made using counselling@london-fire.gov.uk.

(b) **Mental Health First Aid and Trauma Team Lead** – this officer will take responsibility for promoting, recruiting, and supporting the work of LFB Mental Health First Aiders (LFB MHFA) using written materials, audio/visual resources, and face to face engagements. Contact LFBMHFA@london.fire.gov.uk.

(c) **Wellbeing Team** – this team will promote and offer a wellbeing service provision to all staff focused not only on mental health, but also physical and workplace wellbeing using written materials, audio/visual resources, and face to face engagements. Contact wellbeingteam@london-fire.gov.uk.

(d) **Equality Support Groups (ESGs)** – these groups are essential to the delivery of the LFBs commitment to promoting equality, embracing diversity, and fostering inclusion and togetherness. They are all able to provide advice, guidance and sign posting support to staff about mental health wellbeing matters. A list of LFBs ESCs and contact details are available here.

(e) **LFB Mental Health First Aiders (LFB MHFA)** – LFB MHFAs will proactively engage with staff on a face to face basis and/or via Teams to account for any working from home status to begin conversations related to mental health. LFB MHFAs will be promoted via poster images, by the wearing of LFB MHFA pin badges and e-mail LFB MHFA sign off banners.

(f) **Trade union representatives** – trade union representatives will continue to engage with LFB to ensure that mental health wellbeing is a primary consideration in developing policies/guides/strategies, and when dealing with staff who may require additional performance support.

(g) **Wellbeing Dog** – the Wellbeing Dog handler and dog will visit LFB establishments and promote mental health wellbeing via face-to-face engagements and be available to talk on a one to one basis if requested by staff.

(h) **Safe to Speak Up** – this initiative allows all staff, and anyone working on LFB premises, to raise a concern and/or suggest improvements about any matter related to working for LFB, including mental health wellbeing, without fear of reprisals or consequences. Contact CCSafeToSpeakUp@london-fire.gov.uk.

Career/employment stages

4.4 The Brigade will use specific stages of a person's employment/career with LFB to reinforce and promote mental health wellbeing, including, but not limited to:

(a) Induction/onboarding to the organisation.

(b) Promotion(s).

(c) Change of role/responsibilities.

(d) Training/development programmes.

(e) Exiting the organisation.

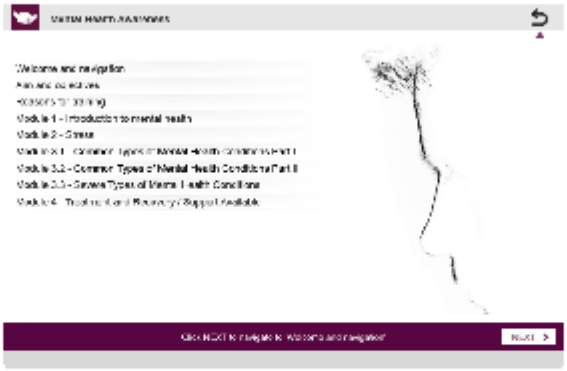
5 Prevent

5.1 The Brigade believes that preventing staff experiencing episodes of poor mental health is integral to personal wellbeing, building effective working relationships and establishing a positive workplace culture. To put measures in place to help prevent staff from experiencing poor mental health wellbeing the Brigade will:

Training

5.2 Ensure that training interventions are available for all staff in order that they better understand their own and others' mental health wellbeing, and the role they play as individuals/managers in recognising and actively engaging with colleagues who may be experiencing episodes of poor mental health.

(a) **Mental Health Awareness** – available on the Big Learning Platform; clicking on the Big Learning icon on the desktop and searching for 'mental health awareness' using the Catalogue Search facility located on the left-hand button bar. This learning package has six interactive modules that are designed to help staff better understand mental health matters. The modules are broken down into small sections that focus on the signs and symptoms to look out for as well as explaining the range of help and treatment available.



This course is/will become a pre learning requirement for all staff that will be attending the Recognising and Managing Stress Anxiety and Depression learning intervention.

(b) **Recognising and Managing Stress Anxiety and Depression** – a mandatory 1-day face to face training course for all staff that have a people management responsibility. This learning has been designed specifically for Brigade managers/leaders and places stress, anxiety and depression in context of the Brigade's working environment, whilst also providing managers/leaders with the skill sets to be able to engage with, and support colleagues experiencing episodes of poor mental health.

Signposting

5.3 Ensure the dedicated officers and teams/groups referenced in paragraphs 4.3 (b) to (g) inclusive are afforded the time and opportunity to engage directly with staff on all matters relating to mental health, and be trained and able to signpost/support staff to seek professional help from CTS or other external sources when their mental health necessitates such interventions.

5.4 These officers and teams/groups will also be able to offer guidance/advice/support to line managers when dealing with staff who may be experiencing episodes of poor mental health.

Policies and guidance documentation

5.5 Ensure that guidance and policy documentation is available to managers and staff, so they have a clear reference point and are aware of the proactive processes and procedures in place that are there to support them and reduce the impact and longevity of an episode of poor mental health.

(a) **Policy number 915 - Recognising and coping with potentially traumatic events** - guidance for managers regarding station debriefs and CTS interventions after potentially traumatic events and/or critical incidents, and information about reactions an individual might experience and the types of coping mechanisms that should be considered to help ease the effects of such events.

Integral to this policy is the **Post Critical Incident Contact** procedure PCIC Policy 2019.pdf– guidance for staff outlining the procedure followed by Counselling and Trauma Service after a critical incident occurs. The aim of the contact is to reinforce normal processing of a traumatic event and prevent the development of potential longer-term complications such as Post Traumatic Stress Disorder (PTSD). This procedure not only allows for Counselling and Trauma Service to follow up with individuals where there may be specific concerns, but also how individuals can refer themselves to Counselling and Trauma Service for trauma-focussed treatment, should their symptoms persist.

(b) **Policy number 448 - Working with Choice: Flexible working options** – guidance for all staff about flexible working options that might be used as an intervention to avoid and/or cope with mental health challenges as a result of an individual's work/life balance not being properly aligned.

(c) **Policy number 553 - Learning Support** – guidance for all staff about learning support provisions that might be used as an intervention to avoid and/or cope with mental health challenges as a result of an individual presenting with specific learning difficulties.

(d) **Policy number 969 – Menopause** - guidance for all staff about the menopause that might be used as an intervention to avoid and/or cope with mental health challenges as a result of women experiencing menopausal symptoms and a tool for managers to help support them.

(e) **Policy number 653 – Domestic Violence** – guidance to assist staff who are experiencing domestic violence which affects their wellbeing, and for managers who are supporting these staff.

(f) **Policy number 690 – Managing stress within the LFB** – guidance for staff about the responsibility LFB has, to prevent/reduce the causes of stress/effects of stress and what actions are in place to achieve this goal.

Occupational Health Service

5.6 Ensure that as part of all Routine Periodic Medicals (RPMs) for operational staff, and wellbeing clinics for FRS staff, a mental health review is undertaken, and actions required as a result of this intervention are progressed appropriately.

6 Treat

6.1 The Brigade believes that having options in place to treat staff who present with mental health problems is integral to a person's longer-term personal wellbeing, sustaining and building effective working relationships and establishing a positive workplace culture where staff recognise that LFB is supportive of individuals who experience poor mental health episodes. To treat staff the Brigade will:

Internal treatment service provision

(a) **Counselling and Trauma Service** – offer all staff access to our accredited, professional, and confidential counselling service available where people will be able to talk about their mental health and be provided with clinically approved interventions aimed at improving their condition(s).

(b) **Occupational Health Service** – offer all staff access to professional occupational health practitioners where people will be able to talk about their mental health issues in a confidential environment, with support provided to access other service provision if required.

Signposting to external treatment service provision

6.2 Ensure that staff who want to be referred to an external mental health wellbeing service provider are supported to access their chosen service

(a) **The Fire Fighters Charity** – a close working partner with a specific and professional psychological service provision offered to all fire service staff.

Telephone: 0800 389 8820

www.firefighterscharity.org.uk

(b) **Sapper Support** – a 24/7 PTSD support helpline staffed solely by veterans from the military.

Telephone: 0800 040 7783

Text: 07860 018 733

(c) **Shout 85258** – a 24/7 text service for staff that work in the emergency services and require mental health support.

Text: 85258

(d) **Samaritans** - is a registered charity aimed at providing emotional support to anyone in emotional distress, struggling to cope, or at risk of suicide.

Telephone: 116 123

e-mail: jo@samaritans.org

Self-help therapy

6.3 Ensure that staff are given advice and support to access options for self-help therapies available from the NHS and other service providers. CTS, LFBs Occupational Health Service provider (HML), the Wellbeing Team and Inclusion Team are all able to assist in this process upon request.

Workplace adjustments

6.4 Ensure that workplace adjustments are made to support staff experiencing mental health difficulties so that they are not substantially disadvantaged when doing their jobs.

6.5 Workplace adjustments will vary from individual to individual but will be effective and practical in order that a person can continue to discharge their role responsibilities.

6.6 In all instances advice in respect of what workplace adjustments should be considered and/or provided for staff requiring such an intervention can be sought from CTS, Occupational Health Service , the Wellbeing Team and/or the Inclusion Team.

6.7 Workplace adjustments can be record on your Workplace Adjustment passport. Please see details on Hotwire how to record this here.

7 Records

7.1 Records should be sent to RecordsServices@london-fire.gov.uk and will be kept on your electronic personal record file (e-prf) being retained in accordance with Policy number 788 - Electronic personal record files (ePRF) policy. Personal data shall be processed in accordance with Policy number 351 – Data protection and privacy policy.

8 Help and support

Please contact the Wellbeing Team by email to WellbeingTeam@london-fire.gov.uk.

8.1 This policy may also be available on request in other alternative accessible formats as set out in Policy number 290 – Guidance note on translation and interpretation. Please contact Communications on extension 30753 and by email to communications.team@london-fire.gov.uk to discuss your needs and options.

Document history

Assessments

An equality, sustainability or health, safety and welfare impact assessment and/or a risk assessment was last completed on:

EIA	07/05/24	SDIA	H - 26/09/22	HSWIA	21/09/22	RA	

Audit trail

Listed below is a brief audit trail, detailing amendments made to this policy/procedure.

Page/para nos.	Brief description of change	Date
Throughout	Reviewed as current with minor changes made.	24/04/2024
Page 9, para 8.1	Wellbeing team contact details updated.	20/05/2024

Subject list

You can find this policy under the following subjects.

Freedom of Information Act exemptions

This policy/procedure has been securely marked due to:

Considered by: (responsible work team)	FOIA exemption	Security marking classification

LONDON FIRE BRIGADE

Safeguarding adults at risk

New policy number:	**736**
Old instruction number:	
Issue date:	**1 April 2011**
Reviewed as current:	**15 September 2021**
Owner:	**Assistant Commissioner, Prevention and Protection**
Responsible work team:	**Strategy and Policy**

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Key point summary

- All LFB staff have a duty to act on any concern or suspicion that an adult's welfare is, has been, or may be at risk of abuse or neglect. If you have any reason to suspect an adult is at risk, you must report your concerns using this procedure as '**doing nothing**' is not an option. Anyone reporting in good faith that an adult is being or is at risk of being abused or neglected will be fully supported by the Brigade, even if it is subsequently proven that abuse or neglect has not happened.
- Under current legislation categories of abuse include: physical abuse, domestic violence, financial or material abuse, modern slavery, discriminatory abuse, organisational abuse, neglect and acts of omission, self-neglect, radicalisation, disability hate crime. This list is not intended to be an exhaustive one, rather a guide as to the sort of behaviour which could give rise to a safeguarding concern.
- Use the mnemonic ABCDE to identify vulnerability factors:
  - **Appearance** – are they clean, able to look after themselves, properly clothed.
  - **Behaviour** – unusual eye contact, aggressive, confused.
  - **Conversation** – are they able to converse effectively, understand what is being said.
  - **Danger** – obvious risks to health, hoarding concerns/location.
  - **Environment** – any hazards or welfare concerns – enough food, adequate living conditions, hoarding level (clutter image rating scale).

Reporting procedures

- What to do if an individual discloses that they are being abused:
  - Listen carefully, allow the person to talk freely.
  - Ask 'tell me **who** it was?", "**when** did it happen?", "**where** did this happen?" If they won't answer, do not push them, or offer suggestions.
  - Avoid leading questions.
  - Do not investigate or jump to conclusions.
  - Do not promise to keep secrets – explain that you have to let your manager know.
  - Where possible ask the person for consent to share their details with relevant parties. Making a safeguarding referral is **not** dependant on consent being given.
  - Make a written record including the date and time of incident and any injuries observed, using the person's own words where possible.
  - A LFB safeguarding referral **must** be made even if a partner agency, such as the police, have made a referral, or when a referral has been raised previously for the same individual/s.
  - You may worry that you could be mistaken about the cause of injuries or disturbing behaviour. If you are unsure please discuss with your line manager, operational manager, or with the Officer Of the Day through the reporting system in order to obtain another perspective. You will not be at fault for reporting a concern of this nature. **If in doubt refer** and all reported concerns will be treated in confidence.
- Refer to the appendices below for guidance on reporting adult safeguarding concerns within the times stated in the table below:
  - Appendix 2 - Person at Risk (PAR) Form
  - Appendix 3 - Adult safeguarding/child protection concern flowcharts.
  - Appendix 4 - Flowchart for reporting adult safeguarding concerns.

SAFEGUARDING REFERRAL PROCESS TO FOLLOW	
08:00 – 17:00 MON-FRI	1. Safeguarding concerns should be raised with the Base Station Commander using the Person at Risk (PAR) Form. 2. If the Base SC cannot be reached, the next port of call should be one of the other SCs in the Borough, or the local Borough Commander. 3. If none of the Borough SCs or BC can be reached, the Officer Of the Day should be called and the OOD1/2 will contact another BC or SC in that Area initially, or another Area, if none are available and pass the Safeguarding concern across to them to be referred. The OOD1/2 will refer if no Borough based SC/BC is available, to meet the referral time requirement. 4. Whichever officer reviews the referral, they will make the decision to refer/not refer this to the Local Authority. They will justify and confirm their decision in the Person At Risk (PAR form).
ANY OTHER TIME	1. Contact the OOD to check availability of Borough based SC or BC for borough concerned. If none are available, another SC or BC in that Area or another area will be contacted and the Safeguarding concern passed cross to them to be referred 2. The OOD1/2 will refer if no Borough based SC/BC is available, to meet the referral time requirement. 3. Whichever officer reviews the referral, they will make the decision to refer/not refer this to the Local Authority. They will justify and confirm their decision in the PAR form.

1 Introduction

1.1 This policy outlines the roles and responsibilities of **all** London Fire Brigade (LFB) staff in relation to the safeguarding of adults who are suffering from, or are at risk of abuse, neglect, or self-neglect. A key principle of this policy is that all adults at risk, irrespective of age, gender, disability, racial or ethnic origin, religious belief or sexual identity have a right to protection from harm.

1.2 The Care Act 2014 is the first piece of primary legislation for adult safeguarding and places a great emphasis on prevention. The Act recognises that local authorities can only safeguard individuals by working together with relevant partners/organisations on preventative strategies and by raising general public awareness. Fears of sharing information should not stand in the way of protecting adults at risk of abuse or neglect.

1.3 It is recognised that the LFB is not the primary authority in relation to safeguarding adults at risk – that responsibility rests mainly with local authorities. However, the LFB does have a responsibility to ensure that all its staff, many of whom come into contact with members of the public as part of their normal duties, are aware of the issues associated with safeguarding adults at risk and what they should do if they become aware of situations involving these issues.

1.4 Any member of LFB staff who has concerns must report them using the reporting procedure within this policy; 'doing nothing' is not an option. Anyone reporting in good faith that an adult is being or is at risk of being abused or neglected will be fully supported by the Brigade, even if it is subsequently proven that abuse or neglect has not happened.

2 Definitions

2.1 Adult safeguarding means 'protecting an adult's right to live in safety free from abuse and neglect' and aims to prevent abuse or neglect of adults and respond to concerns.

2.2 In line with legislation on adult safeguarding specific safeguarding duties apply to someone who:

- Is aged 18 years and over who has needs for care and support (whether or not the local authority is meeting any of those needs);
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

2.3 Adult safeguarding is built on six principles that are used to evaluate safety from and prevention of abuse or neglect with an adult's capacity to make their own decisions:

- **Empowerment**: support and encourage adults to make decisions and informed consent.
- **Prevention**: develop strategies to prevent abuse and promote resilience and self-determination.
- **Proportionality**: take the least intrusive and most appropriate response to the risk presented.
- **Protection**: support and representation for those in greatest need.
- **Partnership**: local solutions through services working with their communities.
- **Accountability**: accountability and transparency in delivering a safeguarding response.

2.4 People with care and support needs are not inherently vulnerable, but they may come to be at risk of abuse or neglect at any point due to physical or mental health, acquired disability, advancing age, lack of support networks, inappropriate accommodation, financial circumstances or social isolation.

3 Recognising abuse and neglect to adults

3.1 The Care Act (2014) sets out varying types and patterns of abuse (and neglect) and the different circumstances in which they may take place, rather than providing an overarching definition. The list of categories of abuse provided within the Act is not intended to be an exhaustive one, rather a guide as to the sort of behaviour which could give rise to a safeguarding concern.

3.2 The categories may overlap and an abused adult may suffer more than one type of abuse. Also, there may not always be clear evidence of abuse or neglect and therefore some referrals will legitimately be based on a degree of (personal) inference.

Physical abuse – including assault, hitting, slapping, pushing, misuse of medication, restraint, or inappropriate physical sanctions.
Domestic violence – including psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence.
Sexual abuse – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.
Sexual exploitation – Involves exploitative situations, contexts and relationships where adults at risk (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. It affects men as well as women. People who are sexually exploited do not always perceive that they are being exploited. Signs to look out for are not being able to speak to the adult alone, observation of the adult seeking approval from the exploiter to respond and the person exploiting the adult answering for them and making decisions without consulting them.
Psychological abuse – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.
Financial or material abuse – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions, or benefits.
Modern slavery[1] – encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.
Discriminatory abuse – including forms of harassment, slurs, or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion[2].

[1] https://www.gov.uk/government/publications/modern-slavery-uk-action-to-tackle-the-crime

[2] Equality Act 2010. https://www.gov.uk/discrimination-your-rights

Organisational abuse – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.
Neglect and acts of omission – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.
Self-neglect – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It can occur as a result of mental health issues, personality disorders, substance abuse, dementia, advancing of age, social isolation, and cognitive impairment or through personal choice.

The London Multi-Agency Adult Safeguarding Policy and Procedures adds further types of abuse or neglect to the above list. These are:
Radicalisation – is comparable to other forms of exploitation as it aims to attract people to and extreme views and reasoning and to persuade vulnerable individuals of the legitimacy of their case. Following the introduction of the Counter-Terrorism and Security Act 2015 (CT&S Act), The Prevent element within the counter terrorism strategy CONTEST, has become a statutory duty. Please refer to Appendix 1: Prevent: Counter Terrorism Strategy
Disability hate crime – the Criminal Justice System defines disability hate crime as any criminal offence, which is perceived, by the victim or any other person, to be motivated by hostility or prejudice based on the person's disability or perceived disability. The Police monitor five strands of hate crime: disability; race; religion; sexual orientation; transgender.
Female genital mutilation (FGM) – involves procedures that intentionally alter or injure female genital organs for non-medical reasons. The procedure has no health benefits for girls and women. The Female Genital Mutilation Act (2004) makes it illegal to practise FGM in the UK or to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in another country. Further information on safeguarding women and girls at risk of FGM is available via this link.
Forced marriage – is a term used to describe a marriage in which one or both of the parties are married without their consent or against their will. A forced marriage differs from an arranged marriage, in which both parties consent to the assistance of a third party in identifying a spouse. In a situation where there is concern that an adult is being forced into a marriage they do not or cannot consent to, there will be an overlap between action taken under the forced marriage provisions and the adult safeguarding process. In this case action will be co-ordinated with the police and other relevant organisations. The police must always be contacted in such cases as urgent action may need to be taken.
Hate Crime – the police define Hate Crime as 'any incident that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability'. It should be noted that this definition is based on the perception of the victim or anyone else and is not reliant on evidence. In addition, it includes incidents that do not constitute a criminal offence.

Honour-based violence – it has or may have been committed when families feel that dishonour has been brought to them. Women are predominantly (but not exclusively) the victims and the violence is often committed with a degree of collusion from family members and/or the community. Many victims are so isolated and controlled that they are unable to seek help. Adult safeguarding concerns that may indicate honour-based violence include domestic violence, concerns about forced marriage, enforced house arrest and missing person's reports. If an adult safeguarding concern is raised, and there is a suspicion that the adult is the victim of honour-based violence, referring to the police must always be considered as they have the necessary expertise to manage the risk.

Human trafficking – is actively being used by Serious and Organised Crime Groups to make considerable amounts of money. It is run like a business with the supply of people and services to a customer, all for the purpose of making a profit. Traffickers exploit the social, cultural or financial vulnerability of the victim and place huge financial and ethical obligations on them. They control almost every aspect of the victim's life, with little regard for the victim's welfare and health.

Mate crime – a 'mate crime' as defined by the Safety Net Project is 'when vulnerable people are befriended by members of the community who go on to exploit and take advantage of them. It may not be an illegal act but still has a negative effect on the individual.' Mate crime is often difficult for police to investigate, due to its sometimes ambiguous nature, but should be reported to the police who will make a decision about whether or not a criminal offence has been committed. Mate Crime is carried out by someone the adult knows and often happens in private. In recent years there have been a number of Serious Case Reviews relating to people with a learning disability who were murdered or seriously harmed by people who purported to be their friend.

Restrain – unlawful or inappropriate use of restraint or physical interventions. In extreme circumstances unlawful or inappropriate use of restraint may constitute a criminal offence. Someone is using restraint if they use force, or threaten to use force, to make someone do something they are resisting, or where an adult's freedom of movement is restricted, whether they are resisting or not. Restraint covers a wide range of actions. It includes the use of active or passive means to ensure that the person concerned does something, or does not do something they want to do, for example, the use of key pads to prevent people from going where they want from a closed environment.

4 Signs of self-neglect – additional information

4.1 The Care Act has introduced significant change by including self-neglect under the legal definition of abuse or neglect relevant to individuals with care and support needs. For this reason, when self-neglect poses a risk to the safety, health and wellbeing of the individual and/or others, a safeguarding concern should be raised to the local authority.

4.2 Self-neglect can result from the unwillingness and/or inability to care for oneself. It covers a wide range of behaviour which can be categorised under three main areas:

- Lack of self-care - this includes neglect of one's personal hygiene, nutrition and hydration, or health, to an extent that may endanger safety or well-being.
- Lack of care of one's environment - this includes situations that may lead to domestic squalor or elevated levels of risk in the domestic environment (e.g. health or fire risks caused by hoarding).

- Refusal of assistance that might alleviate these issues. This might include refusal of care services in either their home or a care environment or of health assessments or interventions, even if previously agreed.

4.3 Self-neglect includes behaviour such as hoarding. When such behaviour is encountered, the Clutter Image Rating (CIR) should be used to assess the level of clutter in the premises. In cases where hoarding is classified as CIR level 5 or above a safeguarding concern needs to be raised. When a home is identified as being up to level 4 of the CIR, staff will act in accordance to Policy number 829 - Hoarding.

4.4 These behaviours can be the result of (an interplay between) mental health issues, substance abuse, advancing age, social isolation or personal choice. When dealing with concerns about self-neglect, it is necessary to find the right balance between a person's autonomy and the duty to protect the person's health and wellbeing. A robust risk assessment, which is preferably multi-agency and includes the views of the adult, is pivotal to decision making.

4.5 If the individual does not give or is unable to give their consent to information sharing and/or safeguarding actions, refer to section 5 below of this policy. All the decisions need to be fully explained and recorded and other agencies are to be informed and involved as necessary.

5 Mental capacity within adults safeguarding

5.1 Any safeguarding or welfare concern that LFB staff raise needs to clarify whether an individual has agreed to provide consent for their information to be shared with third parties. All decision for concerns must take into account the individual(s)' ability to make an informed choice about the way they want to live their life and the risk they want to take. To this end, understanding a person's mental capacity is important in determining whether they can make decisions in their best interest. This includes the ability to:

- Understand the implications of their situation;
- Take action themselves to prevent abuse/the escalation of risk;
- Participate to the fullest extent in the decision for referral.

5.2 The Mental Capacity Act 2005 (MCA 2005) provides a statutory framework to protect people who cannot make decisions for themselves due to a temporary or permanent impairment or disturbance. The Act also states that we should always start from the assumption that a person has the capacity to make decisions; therefore, the referrer is <u>not</u> expected to make a professional medical assessment but to ascertain if the person has mental capacity at one point in time to:

- Understand the information relevant to the decision;
- Retain that information long enough for them to make the decision;
- Use or weigh that information as part of the process of making the decision;
- Communicate their decision (whether by talking, using sign language or by any other means such as muscle movements, blinking an eye or squeezing a hand).

5.3 If the individual fails any of the above, then it can be reasonable to believe that they lack the mental capacity at that very moment to make an informed decision in their best interest.

5.4 It should also be noted that if an individual has the mental capacity to make informed decisions about their safety and does not want any action to be taken, this does not preclude the sharing of information with relevant agencies. This can be where:

- There is a public interest i.e. not acting will put others at risk.
- Their vital interest is compromised – i.e. there is a (immediate) risk of death or major harm.

- There is a duty of care i.e. a crime has been or may be committed.

5.5 Reasons for overriding consent must be made clear on the Person at Risk (PAR) Form. Please refer to Appendix 2: Person At Risk (PAR) Form.

6 Welfare concerns

6.1 Welfare concern is the term used to refer concerns which do not strictly sit under adult safeguarding processes, because 'abuse' as defined in the Care Act has not happened and/or the person does not meet the criteria listed in the Act. Please refer to Appendix 3 - Adult safeguarding/child protection concern flowcharts.

6.2 The Act, however, requires local authorities to ensure the provision of preventative services to help prevent, delay or reduce the development of care and support needs. This means that in line with the Prevention Principle in the new legislation, where the vulnerability of/risk to the person needs further consideration and action to prevent it escalating to a safeguarding issue in the future, concerns must be raised and addressed appropriately.

6.3 Welfare concerns may be fire risk related (previously known within LFB by the operational term Serious Outstanding Risk) and/or welfare related and could be triggered by a number of issues including, but not exclusive to, the following:

- Evidence of no or inadequate heating, malnutrition, poor housing and living conditions which are not the consequence of either third party abuse and neglect or self-neglect. Rather, a person may be in need of assistance from the health, housing, the local Social Services Department or from other agencies, but is not accessing these services.
- Signs of cognitive and/or physical impairments which would increase the risk of fire, hinder the ability to recognise the risk of fire and/or escape the fire.
- Signs of fire risk such as evidence of unreported previous fires, burns on carpet or clothes, unsafe candle use, hoarding up to level 4. Please refer to Policy number 829 – hoarding.

6.4 It is recognised that because an individual may present a combination of characteristics, the above categories are likely to overlap. A person also has the right to make life choices and refuse services. However, as the objective of raising concerns of this nature is to lower the risk of harm to the person and/or third person/ parties(s) and promote their wellbeing and they will not be excluded from the referral processes.

6.5 When a welfare concern has been identified during a Home Fire Safety Visit (HFSV), a welfare concern must be raised via the HFSV database. This can be done by checking the tick box for 'Person At Risk' (PAR) on the HFSV database, which in turn will open up the PAR form for staff to use. For further guidance refer to Appendix 1: Adult welfare concern (flowchart B).

6.6 When a welfare concern has been identified outside of a HFSV the referrer needs to complete the PAR form with as much relevant detail as possible. The PAR form can be accessed via the safeguarding hotwire page or the start menu..

6.7 The base station commander (SC) will signpost the individual to relevant departments/agencies that will be able to provide appropriate assistance and support. This requires a holistic partnership approach to prevention. In these instances, the SC will discuss fire risk measures to put in place such as arson letter boxes, fire retardant bedding, telecare and sprinklers. In regard to fire related risk, in the context of safeguarding the focus is always on the risk to the person rather than the property.

6.8 A welfare concern, however identified, must be acted on and referred without delay.

7 Reporting procedures

7.1 All LFB staff have a duty and must act on any concern or suspicion that an adult at risk is being, has been or is at risk of being abused, neglected or exploited.

7.2 It is acknowledged that reporting concerns can be challenging, particularly if those concerns involve another member of LFB staff. The LFB will support anyone who, in good faith, reports concerns about a member of staff that relate to an adult at risk being - or at risk of being - abused or neglected, even if those concerns are proven to be unfounded. For further information, refer to the Policy number 569 – Confidential Reporting ("whistleblowing") policy. **Please note that this method of raising concerns about abuse/neglect of an adult at risk is only applicable where members of staff are suspected to be involved.** All other concerns should be raised using the process outlined below.

7.3 Although staff are encouraged to be alert to signs and indicators of abuse, incidents may only come to light because the person discloses the information themselves. It is important to remember that, if an adult at risk tells someone that they are being abused, they are usually doing it because they want it to stop, even if they ask that person to do nothing with the information.

7.4 Staff receiving disclosures about abuse should respond sensitively.

- Listen carefully, allow the person to talk freely.
- Gather relevant information by asking 'tell me **who** it was?', '**when** did it happen?', '**where** did this happen?' If they won't answer, do not push them or offer suggestions.
- Avoid asking leading questions.
- Do not investigate, make judgements or jump to conclusions.
- Do not promise to keep secrets - explain that you have to let your manager know so that they can speak to the people who could help protect them.
- Where possible, ask the person for consent to pass their details on to people who may be able to help them. The first decision is whether or not to override the wishes of the adult at risk, if they do not consent to any action being taken. There will be some circumstances where consent should **not** be sought i.e. where it may place the person at increased risk of harm, where it may hamper the prevention or investigation of a serious crime and/or where it may lead to an unjustified delay in raising a concern/or where there is a public or vital interest to do so.
- Make a written record of your concerns as soon after they have been identified as possible. This should include the date and time of incident and any injuries observed, using the person's own words where possible, as this will assist as to what action be taken. This informal record must be kept secure and securely disposed of in accordance with the requirements of the GDPR and/or Data Protection Law once no longer needed.

7.5 Where there is, or there is the possibility of, an immediate risk or a crime has been committed, LFB staff must act in the best interests of the adult at risk and contact the police straight away via Control or on 999 as well as following LFB internal procedures for reporting concerns by following Appendix 4 - Flowchart for reporting adult safeguarding referrals/welfare concerns. In such circumstances, if it is possible to do so and without compromising their own safety, two members of staff should stay with the person at risk until the police arrive.

7.6 Where other agencies are present, such as the police, and they have made the decision to raise a safeguarding concern, **the LFB are also required to raise a separate concern**, following the internal procedures. Likewise, where LFB have previously raised a concern for the individual at risk, staff are still required to raise a new one.

7.7 The designated safeguarding team (DST) comprises of the base station commander (SC), another SC in the borough and the borough commander (BC). During working hours (between 08:00 and 17:00), where there is an immediate risk to the individual, all concerns should be raised with the base station commander OR another station commander in the borough OR the local borough commander in writing using the PAR form within 4 hours, and within 24 hours for all other concerns. In the event that there is no DST member available, the concern will be passed to the OOD who will assume this role.

7.8 Outside working hours (between 17:00 and 08:00) concerns should be reported to the officer of the day (OOD) who will check the availability of the DST senior officers in order of above. If no DST senior officer is available, the OOD will assume this role. In all cases, **the referral process should be started, and actions taken, immediately**.

7.9 As the base SC/BC will not be the first port of call for making referrals, it is the responsibility of the other DST members/the OOD to update the base SC/BC with details of any concerns raised.

7.10 The referrer needs to complete the PAR form with as much relevant detail as possible. The PAR form can be accessed via the safeguarding hotwire page or the start menu . Guidance on completing the PAR is available on the Safeguarding Hotwire page.

7.11 In the event that the referral process cannot be completed before those involved go off duty at change of watch, the DST senior officer/OOD (as detailed above) must be contacted, who will decide whether the watch need to stay on duty to complete the referral, or whether the referral can be handed over for completion to the on-coming watch (to prevent any unnecessary delay).

7.12 The responsibility for deciding whether to refer the matter to the safeguarding adults team within the local Social Services Department (SSD) lies with the DST senior officer/ OOD. A separate guidance document has been prepared to assist the DST senior officer/OOD to decide when a referral is warranted. Please refer to Appendix 5 - Guidance for senior officers - raising concerns in relation to adults at risk.

7.13 On receipt of a concern, liaison with the relevant local Social Services Department (SSD) for guidance should take place, to establish whether the concern should be referred as a safeguarding or welfare concern. If contact is made through a switchboard, personal and sensitive information should only be shared with the duty Social Worker and NOT reception or security staff or operators. Refer to Sections 8 and 9 of this policy for information on handling safeguarding data and information sharing.

7.14 Once the decision has been made to refer, this should be confirmed in writing by completing the reviewer's decision section in the PAR form. The Social Issues Mailbox is automatically copied into every PAR form raised.

7.15 When raising a concern to SSD, it must be made clear that this is a safeguarding adult at risk or a welfare concern issue. The referral should be made to the borough where the incident happened.

7.16 All correspondence that sits outside the PAR form, meaning sent before and/or after raising an official referral using the PAR form, should be marked " OFFICIAL –SENSITIVE PERSONAL DATA" in the subject title of the email and copied to the Social Issues Mailbox. Policy number 619 - LFB security classifications system applies.

7.17 By using the 'attach file' function in the PAR form, the referrer and DST/OOD have the ability to attach additional documents/emails to the PAR form when making a referral, or to add retrospectively to the referral e.g. further information/correspondence received from external

agencies etc. Note that attachments cannot be accessed by external agencies. However, this information may be of significant importance for both internal and external auditing, and potential Safeguarding Reviews.

7.18 The DST/OOD should be the only points of contact with SSD in respect of safeguarding concerns.

7.19 All telephone referrals must be followed-up in writing within 24 hours using the PAR form.

7.20 Where it is decided that raising a concern to SSD is not warranted, the relevant base SC will be informed. The Welfare Concern process will then be followed without delay. The decision not to refer to SSD must be recorded on the PAR form by the DST/OOD along with the reason why and any action taken to address the concern.

7.21 The deputy assistant commissioner (Prevention and Protection) with responsibility for Prevention will be responsible for managing, maintaining and interrogating the electronic record of all safeguarding concerns raised and for providing statistical information gathered through it as requested. Access to the electronic record of concerns will be strictly limited in line with Data Protection Law principles around the handling of personal and sensitive information.

8 Guidance on handling safeguarding data

8.1 The gathering, processing, storing and destruction of personal data is governed by the Data Protection Law. All LFB staff must follow the advice and guidance set out in Policy number 351 - Data Protection and Privacy Policy, when handling personal data, including safeguarding information.

8.2 All staff must comply with Policy number 619 - LFB security classifications system. All safeguarding correspondence should be marked 'OFFICIAL – SENSITIVE PERSONAL DATA' in the subject title of the email.

8.3 In some circumstances staff may have access to or be given highly sensitive or private information. It is important that these details are appropriately secured at all times and only shared when it is in the interests of the adult at risk to do so. If there is any doubt or uncertainty seek guidance from the Information Access Team and copy in the Social Issues mailbox.

8.4 All staff must comply with the Policy number 485 - ICT Acceptable Use Policy (AUP), the safeguarding policy and the Data Protection Law at all times when using LFB's computers and data. When gathering, processing, storing and destruction of safeguarding data you must always be mindful that an adult at risk might suffer harm if safeguarding data is compromised.

8.5 You are responsible for:

- Ensuring you are aware of your information security responsibilities, relevant to your job or function.
- Operating within the scope of your job function.
- Only accessing the systems you are authorised to use.
- Safeguarding the hardware, software and information in your care.
- Preventing the introduction of malicious software to LFB's information systems by following the best practice advice issued in the AUP.
- Complying with the AUP at all times when using LFB's computers and data.

8.6 Access to LFB's safeguarding databases are strictly limited to the deputy assistant commissioner (Prevention and Protection) with responsibility for Prevention and authorised staff. Please refer to Appendix 6 - Protocol for the use of adults at risk databases.

8.7 Officers responsible for sharing safeguarding data with partner agencies must ensure that approved facilities are used for transmitting the data using a secure, encrypted solution (the London Fire Brigade uses Egress Switch for email security).

8.8 Officers transmitting safeguarding information to external partner agencies must:

- double check the correctness of recipient email addresses before sending
- copy in the Social Issues (SI) mailbox.
- attach a record of the communication to the PAR form record.

This provides an audit trail and quality assurance tool to oversee all safeguarding/welfare concerns from the initial concern through to the decision making that may or may not prompt (further) actions. **Local databases should not be kept within boroughs.**

8.9 Access to safeguarding data is restricted to designated staff as it is used to hold all personal data as per Policy number 442 - Information security policy.

8.10 All parties will comply with their obligations under the General Data Protection Regulation and the Data Protection Law, ensuring that it processes Personal Data fairly and lawfully in accordance with data protection law.

8.11 Any events that are believed to have led to a breach of an individual's personal data, under data protection law must be reported to the LFB's Data Protection Officer (DPO) without undue delay via dataprotectionofficer@london-fire.gov.uk (as described in Policy number 351 - Data protection and privacy).

9 Information sharing

9.1 Information sharing is vital to safeguarding. The data protection laws (GDP) and human rights law are **not** barriers to justified information sharing but provide a framework to ensure that personal information about living individuals is shared appropriately.

9.2 Wherever possible the best approach is to be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

9.3 While transparency is the best approach, it is not always the case that formal consent can be gained in safeguarding situations and information may need to be shared without formal consent. The GDPR sets a high standard for consent and where this is not possible, the LFB can look for a different lawful basis for the information sharing. Public authorities, employers and other organisations in a position of power over individuals should avoid relying on consent unless they are confident they can demonstrate it is freely given.

9.4 Where possible, share information with the family/persons knowledge, and where possible, respect the wishes of those who do not agree to having their information shared. Where that is not possible, you will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be clear of the basis upon which you are doing so. Where you do not have their agreement, be mindful that an individual might not expect information to be shared.

9.5 Before any information is shared, all reasonable steps must be taken to ensure that the information being shared is necessary for the purpose for which it is being shared, is shared only with those people who need to have it, is accurate and up to date, is shared in a timely fashion and is shared securely.

9.6 The decision about what information is shared and with whom will be taken on a case by case basis will be made/approved by a senior officer (either an assistant commissioner (AC), deputy assistant commissioner (DAC), BC, SC, or the nominated safeguarding officer in the Prevention and Protection Department. A record will be made of what is shared, with whom and for what purpose.

9.7 In most cases, the legal basis for sharing information about safeguarding issues will be the LFB's public task to take action in the event, or situation that one or more individuals may die, be injured or become ill (Fire and Rescue Services Act 2004; Section 11). The LFB have further obligations to work with and support safeguarding laws.

9.8 The above process describes what should happen on a case by case basis, given the circumstance of one or more individuals. If information about vulnerable people is to be shared on a regular basis with the same trusted organisation, then a data sharing agreement is recommended. A data sharing agreement sets out the purpose of the data sharing, covers what is to happen to the data at each stage, sets standards and helps all parties to be clear about their respective roles. It helps you to demonstrate your accountability under the GDPR/Data Protection Law. Any data sharing agreement is to be run past the Brigade's Information Access Team (IAT) to ensure it meets all requirements under data protection law.

10 Avoiding false allegations

10.1 There is much staff can do to avoid situations which may give rise to misinterpretation. This includes:

- In the event of an injury to an adult at risk, ensure that a written record is made as soon as practicable and the statement witnessed by another adult.
- Keep a record of any allegation made against you and make the OOD aware of the allegation. Never let an allegation go unreported.
- Never do anything of a personal nature for an adult at risk such as accompanying an individual to the bathroom, helping them change clothes, or bathing them.
- Respect everyone by treating them courteously and with dignity at all times, irrespective of age, gender, ethnicity, disability or sexual identity.
- Never trivialise abuse of adults at risk.

11 Disclosure and barring service

11.1 The new disclosure and barring service (DBS) was established in 2012 and its aim is to protect both children and adults at risk by preventing those who were known to pose a risk of harm accessing these groups through their work.

11.2 The DBS guidance states that employers must refer someone to the DBS if they:

- Dismissed them because they harmed a child or adult.
- Dismissed them or removed them from working in regulated activity because they might have harmed a child or adult otherwise.
  OR
- Were planning to dismiss them for either of these reasons, but the person resigned first.

11.3 To comply with the requirements of the DBS, LFB staff in roles which involve working or volunteering with children or adults at risk in 'regulated activities' will be subject to a DBS check (previously criminal records bureau check) at enhanced level.

11.4 Normal operational duties (including delivery of routine community safety provision such as HFSVs) are not considered 'regulated activities' under the Department of Health and Department for Education guidance. However, some FRS roles and volunteer operational roles (working on central youth engagement/intervention schemes for example) will involve participation in 'regulated activities', and as such will require enhanced DBS check clearance.

11.5 Policy number 726 – disclosure and barring policy provides details of the roles to which this policy applies. It also sets out the LFB's policy on DBS checks, the disclosure and barring scheme and the recruitment of ex-offenders, and provides information on the circumstances that will trigger a referral to the DBS.

12 Safeguarding adults boards (SABs)

12.1 SABs (representing all London boroughs) are multi-agency boards which have been established to promote, inform and support safeguarding adult work. In line with their role of developing links with inter-agency partnerships aimed at promoting the safety and wellbeing of residents at a borough level, most BCs sit on SABs on behalf of LFB. More information on SABs and BCs' work is outlined in Appendix 7 - The role of borough commanders (BCs) at safeguarding adults boards (SABs).

13 Review

13.1 This policy will be subject to any necessary updates in line with changes to legislation, guidelines or best practice as issued by the appropriate agencies/bodies.

Appendix 1 - Prevent: Counter Terrorism Strategy

Overview

Prevent forms part of "Contest", the UK Strategy for Countering Terrorism which consists of four strands: **Pursue, Prevent, Protect, Prepare.**

Prevent primarily aims to reduce the threat of terrorism by placing preventative measures across agencies to support and divert people vulnerable to radicalisation. This Strategy became a statutory duty in 2015 and, although we are not subject to the statutory duty, our wider prevention role and interaction with communities make us valuable partners in preventing terrorism.

Why is it relevant to the LFB?

Staff may come across indications of terrorist activities whilst conducting Home Fire Safety Visits (HFSVs) or carrying out inspections in a range of commercial and domestic buildings. This may include leaflets, books or posters supporting or encouraging radical views e.g. Right Wing, Islamist extremism.

There could also be a role in the engagement of individuals – particularly in **offering diversionary activities to vulnerable young people through LFB Youth Engagement Programmes**. Indeed, such programmes can represent a powerful tool to understand, prevent and overcome youth marginalisation and consequently, safeguard vulnerable individuals from the threat of radicalisation.

What should staff do to comply with Prevent?

All staff need to be aware of where, how and to whom report concerns related to threat of radicalisation and/or terrorist activities.

Prevent is closely linked to Safeguarding legislation, as radicalisation is considered a form of exploitation and therefore concerns should be raised as detailed in LFB Safeguarding policies. However, should suspicions about any immediate terrorist risk/threat to the public be raised at any time, staff should contact the duty national inter-agency liaison officer (NILO) via Brigade Control. Staff can also contact the Anti-Terrorism Hotline on 0800 789 321 but must inform the duty NILO if they have done so.

Borough Commanders are advised to check with their local authority community safety partnerships or safeguarding boards to confirm the referral path available in their area and the appropriate protocols used for sharing of information.

All station-based staff should complete the Home Made Explosives Awareness Ad Hoc training entry in the Station Diary.

LFB Youth Engagement Programmes offer a range of activities which are powerful tools to understand, prevent and overcome youth marginalisation, hence safeguarding vulnerable individuals from radicalisation.

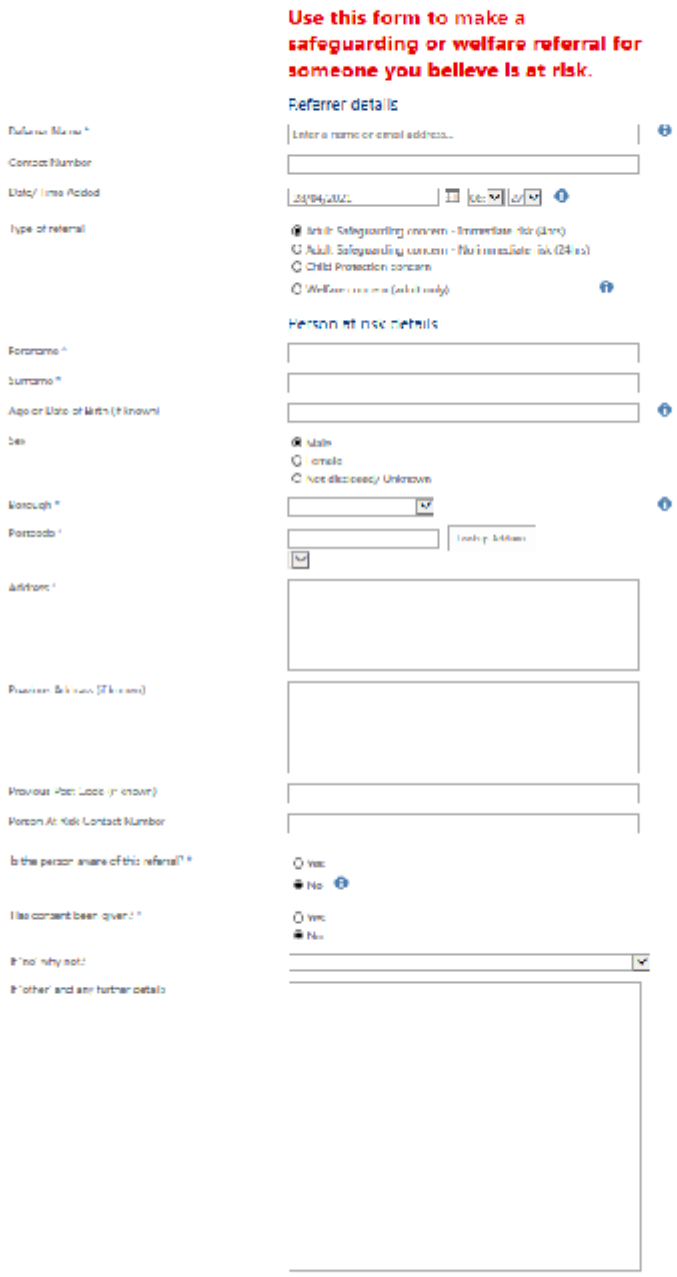
Managers should make their staff aware of the need to recognise and report concerns around radicalisation of people and places used to support terrorist activities. They should be aware of staff's changes in attitude and/or behaviour which may be represented as part of a spectrum which ranges from mild interest through "obsession" to "fanaticism" and "extremism" and also unusual access or attempts to gain access to sensitive information outside of the need of their role.

For further information please refer to the following Government documents:

Prevent Duty Guidance (2015)

2010 to 2015 Government Policy: Counter-Terrorism

Appendix 2 - Person at Risk (PAR) Form



Use this form to make a safeguarding or welfare referral for someone you believe is at risk.

Referrer details

Referrer Name *

Enter a name or email address...

Contact Number

Date/ Time Added

28/04/2021 00 00

Type of referral

Adult Safeguarding concern - Immediate risk (24hrs)

Adult Safeguarding concern - Non immediate risk (24hrs)

Child Protection concern

Welfare concern (adult only)

Person at risk details

Forename *

Surname *

Age or Date of Birth (if known)

Sex

Male

Female

Not disclosed/ Unknown

Borough *

Postcode *

Address *

Previous Address (if known)

Previous Post Code (if known)

Person At Risk Contact Number

Is the person aware of this referral? *

Yes

No

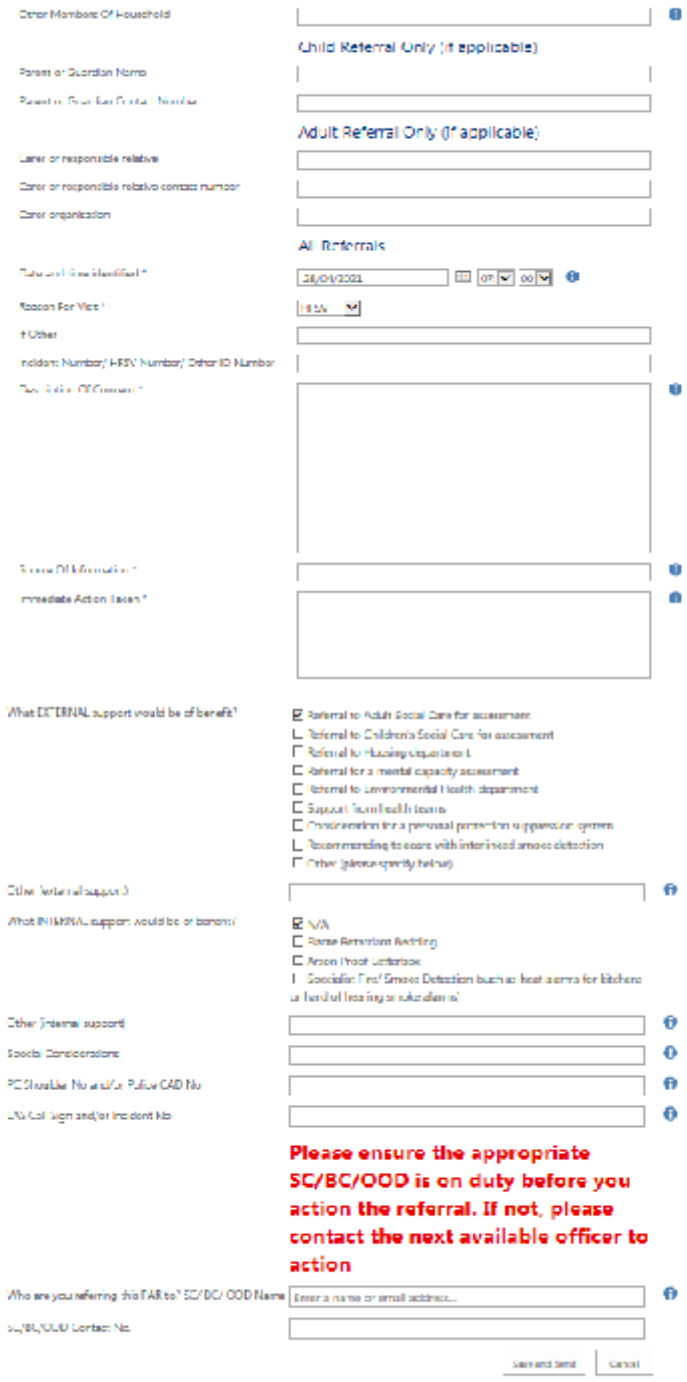
Has consent been given? *

Yes

No

If 'no' why not?

If 'other' add any further details


Other Members Of Household
Child Referral Only (if applicable)
Parent or Guardian Name
Adult Referral Only (if applicable)
Carer or responsible relative
Carer or responsible relative contact number
Carer organisation
All Referrals
28/04/2021
Reason For Visit *
If Other
Incident Number/ HRN Number/ Other ID Number
What EXTERNAL support would be of benefit?
Referral to Adult Social Care for assessment
Referral to Children's Social Care for assessment
Referral to Housing department
Referral for a mental capacity assessment
Referral to Environmental Health department
Support from health teams
Consideration for a personal protection equipment system
Recommending to cope with interlinked smoke detection
Other (please specify below)
What INTERNAL support would be of benefit?
N/A
Home Retention Visiting
Arson Proof Letterbox
Specialist Fire/ Smoke Detection such as heat alarms for kitchens
Other (internal support)
Social Considerations
PC Shoulder Number/Police CAD No
LAS Call Sign and/or Incident No
Please ensure the appropriate SC/BC/OOD is on duty before you action the referral. If not, please contact the next available officer to action
Who are you referring this FAR to? SC/ BC/ OOD Name
Enter a name or email address...
SC/BC/OOD Contact No
Save and Send
Cancel

X

To be completed by the SC/ BC

Reviewer's decision

Reviewer's Name: Enter a name or email address...

Reviewer's Contact No:

Date/ Time Reviewed: 1/10/2021 12 44

Reviewer's decision:
- ○ Adult Safeguarding concern
- ○ Child Protection concern
- ○ Welfare concern (adult only)
- ○ No further action required

Reason for decision (refer/not refer):

Recommendations for adult/ Child Social Care:
- ☐ Referral for Adult Social Care assessment
- ☐ Referral for Children's Social Care assessment
- ☐ Referral to Housing department
- ☐ Referral for a mental capacity assessment
- ☐ Referral to Environmental Health department
- ☐ Support from health teams
- ☐ Recommendation for a personal protection suppression system
- ☐ Recommending telecare with interlinked smoke detection to BS5839 Part 6 category LD1 standard
- ☐ Other (please specify below)

If other, please specify:

SC Name: Enter a name or email address...

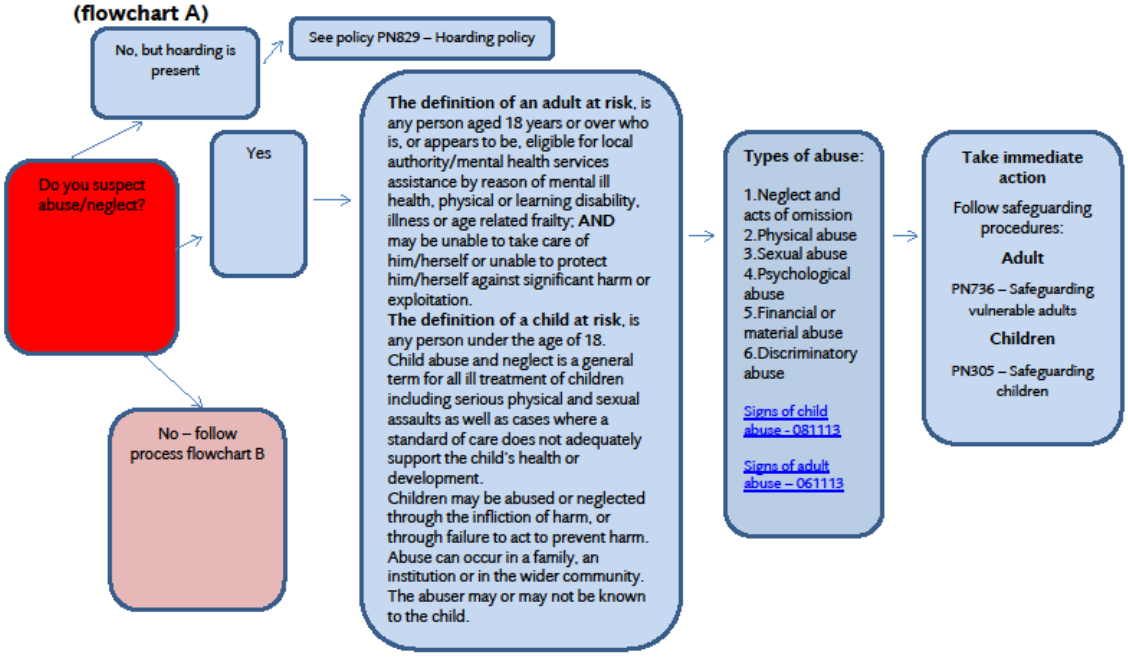
SC Contact No:

Local Authority area / address:

Save and Send | Cancel

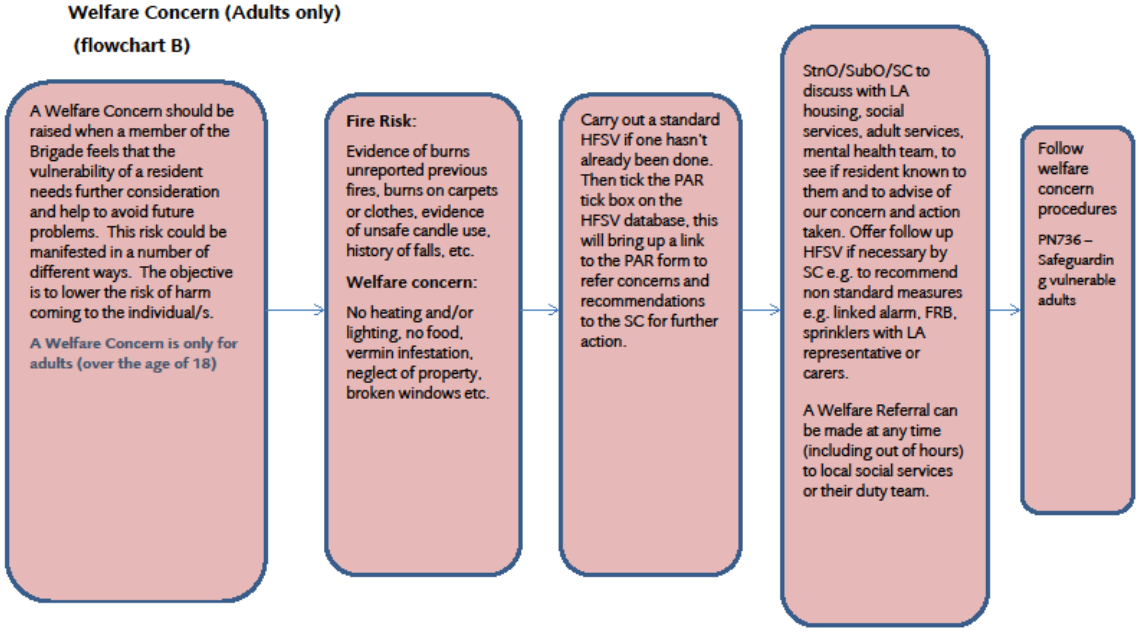
Appendix 3 - Adult safeguarding/child protection concern flowcharts

(flowchart A)

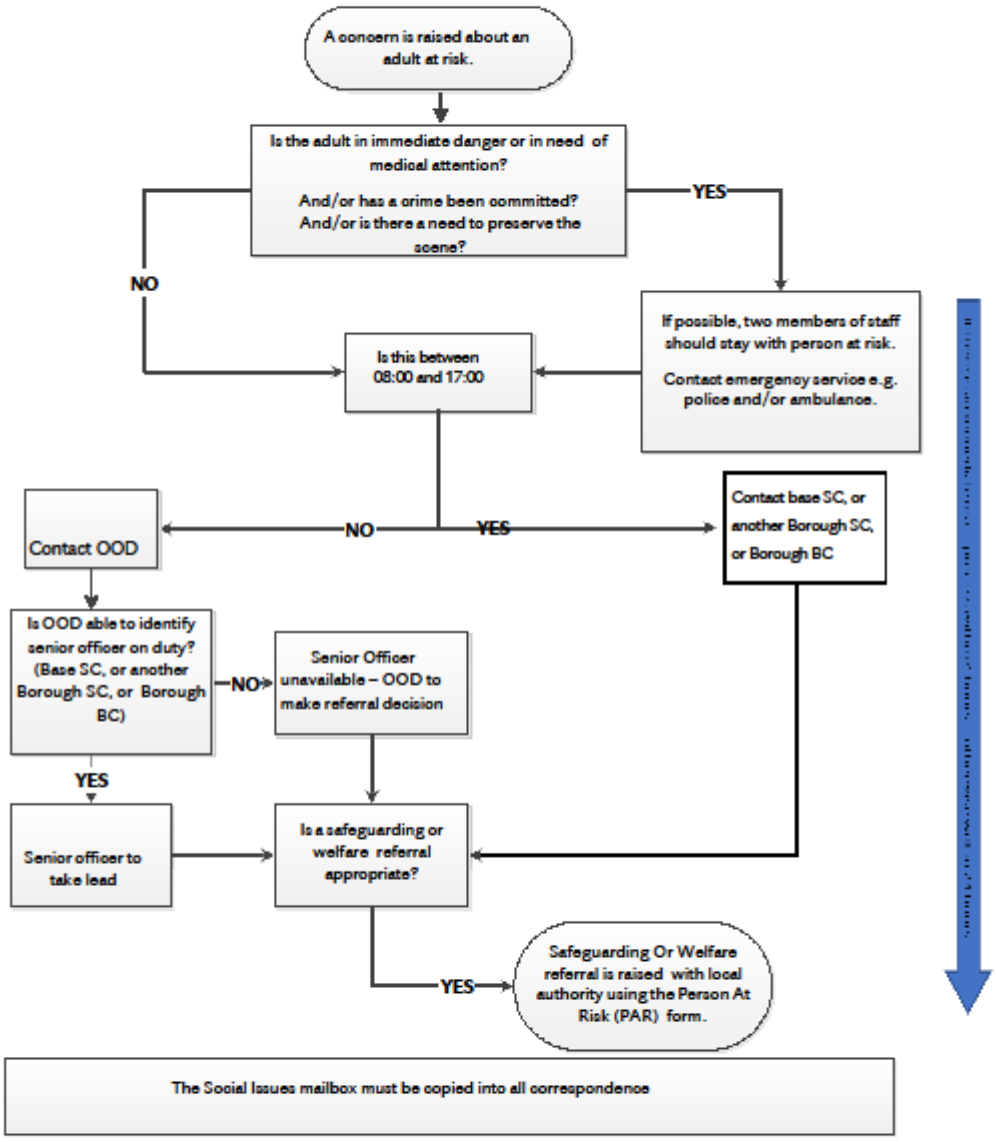


Welfare Concern (Adults only)

(flowchart B)



Appendix 4 - Flowchart for reporting adult safeguarding referrals/welfare concerns



Appendix 5 - Guidance for senior officers - raising concerns in relation to adults at risk

Introduction

This guidance is intended to assist Brigade senior officers in making an informed decision concerning adults at risk. However, it cannot provide a definite answer as to when an adult safeguarding concern is warranted. If in doubt, staff should seek advice from the designated safeguarding team (DST)/officer of the day (OOD), who will in turn seek advice from the relevant Social Services Department (SSD) if needed.

The DST consists of the base station commander (SC), another SC in the borough and the borough commander (BC).

In cases where persons under the age of 18 are involved, the matter would automatically become a child protection issue and Policy number 305 – Safeguarding children applies.

This document should be read in conjunction with Policy number 736 - Safeguarding adults at risk.

The safeguarding adult process

The safeguarding adult process only applies when the adult concerned has care and support needs regardless of whether they are receiving them, and because of these needs are unable to protect themselves from abuse or neglect.

This process follows four key stages:

Stage 1 - Concerns

Under stage one, the person raising the concern is expected to report it through the Brigade's internal reporting procedures. The DST/OOD has the responsibility for deciding the most appropriate course of action, including whether or not to raise a safeguarding concern with the local authority and is therefore accountable for their decision. This decision must be primarily based on an assessment of whether the adult concerned:

- Meets the criteria for an 'adult at risk' (as defined in the Care Act –see section 2 of Policy number 736 – safeguarding adults as risk);
- has the mental capacity to make an informed choice about their own safety;
- is able to protect themselves; and
- whether the situation involves abuse or neglect/self-neglect (refer to section 3 of Policy number 736 – safeguarding adults at risk).

The seriousness or extent of abuse or neglect is often not clear when concern is first expressed. It is important, therefore, when considering raising a concern, to take account for the feelings of the person at risk and to approach reports of incidents or allegations with an open mind. What this means in practice is working through a process of assessment to evaluate if:

- The person is suffering or is likely to suffer abuse or neglect.
- The intervention is in the best interest of the adult(s) and/or in the public interest.
- A crime has been committed.
- Incidents are repetitive and targeted.

- The incident involves a member of LFB staff.
- There are signs of self-neglect/hoarding.
- There are signs of radicalisation.*[3]

You MUST raise a concern if any of the above criteria applies. This list is by no means exhaustive - in any situation where you feel abuse or neglect has occurred, a zero tolerance approach should be adopted and a referral must be made to the relevant organisation. The need to take action is no less important in those circumstances where abuse or neglect may be unintentional. The primary focus remains how to safeguard the adult.

A safeguarding concern must be raised even if another agency has already raised their own or LFB have raised a concern previously for the same individual.

Mental capacity and consent of adults at risk

All decisions for concerns must take into account the ability of the adults at risk to make informed choices about the way they want to live and the risk they want to take. Capacity must entail both the ability to make a decision in full awareness of its consequences for themselves and others. With regard to consent, the Care Act statutory guidance advises that the first priority in safeguarding should always be to ensure the safety and wellbeing of the adult. Refer to Section 5 of this policy for more information.

When a safeguarding concern is not warranted

You may decide that 'abuse' as defined in the Care Act has not occurred. Yet, in line with the Prevention Principle in the Act, it is highly likely that the individual would benefit from additional support to stop the deterioration of their situation and prevent it leading to a safeguarding issue in the future.

This means that there is still concern about the welfare and safety of the adult at risk and the DST must pass the concern in writing using the Person at Risk (PAR) Form to the relevant base SC. The SC, via the process in the Welfare Concern detailed in section 6 and Appendix 1 of this policy, will signpost the individual to relevant departments/agencies that will be able to provide appropriate assistance and support.

The decision not to refer to SSD must be recorded on the Person at Risk (PAR) form by the DST/OOD along with the reason why and any action taken to address the concern. This information may be used for quality assurance purposes at a later stage.

Other considerations

It should be noted that there is a real danger of staff tolerance growing with continued exposure to seemingly minor issues. This can lead to complacency, an acceptance of behaviour that would not be tolerated in other settings and may result in incidents not being referred when this would be the expected course of action.

Therefore, it is important to record all incidents and monitor trends so that repeated or targeted incidents are identified and that referrals are made when abuse occurs or is alleged.

If, after considering the above you are still in doubt, you should raise a concern or contact the relevant SSD to discuss the incident further.

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[3] *Please note that the anti-terrorism strategy 'Prevent' is encompassed by Safeguarding legislation. For this reason. BCs are responsible for making their staff aware of this threat and of the need to report concerns around radicalisation of people and/or places used to support terrorist activities. For more information refer to Appendix 6

Stage Two - Enquiry
The purpose of an enquiry is to decide whether or not the local authority or any other organisation/person should take any action to protect the wellbeing and safety of the individual. The scope of the enquiry as well as who leads it is determined by, and proportionate to, the circumstance of each individual case.

Once a decision to refer has been made by the DST, the SC from the ground where the incident happened will then take on the role of liaising with SSD to provide them with any additional information and answer any questions. Although the local authority has the lead role in making enquiries or requesting other agencies to do so, where a crime has been committed or is suspected, early involvement of the Police is essential. However, it is possible that, where the crime is fire related there may be a joint enquiry between the Police and LFB.

Stage 3 – Safeguarding plan and review
The safeguarding plan aims to set out the steps to be taken to assure the wellbeing and safety of the adult at risk, the provision of support, along with any necessary ongoing risk management strategy. The plan should outline the roles and responsibilities of all individuals and agencies involved and identify the lead officer who will monitor and review the plan. The SC/BC is likely to be involved where a fire risk has been identified regardless of whether it was the LFB that raised the original referral. The SC/BC would then be responsible for taking part in a strategy discussion or meeting and implementing the sections of the plan that relate to fire safety/risk.

With this in mind, it would be necessary to agree responsibility for actions. For instance, where it has been identified that a fire door needed to be replaced with one of the correct fire rating, the responsibility would rest with the landlord or resident's representative, not the SC. Reviews of safeguarding plans and decisions about plans should be communicated and agreed with the adult at risk. The review process may determine that either the safeguarding plan is no longer required or that it needs to continue and may also instigate a new safeguarding enquiry.

Stage 4 – Closing the enquiry
The safeguarding adults process may be closed at any stage if is it is agreed that an ongoing enquiry is not needed or if the enquiry has been completed.

Closure records should state the reason for this decision and the views of the adult at risk to the proposed closure. It is the responsibility of the LFB officer supporting the safeguarding enquiry to copy in the Social Issues Mailbox in all correspondence including actions taken, information received from external agencies and closure records and attach it to the PAR form record. To attach a file to the PAR form, click on **'Attach File'** icon on the top left hand side of the form, and then click '**Browse'** to choose and upload files from your computer. This enables the Care, Health and Safeguarding (CHaS) team to monitor information and close the safeguarding file.

Refer to Section 4 of the 'London Multi-Agency Adult Safeguarding Policy and Procedures', for details on each stage. https://londonadass.org.uk/safeguarding/review-of-the-pan-london-policy-and-procedures/

Concerns rejected by Social Services Departments

In cases where concerns are rejected by the SSD, the DST/OOD must request a full written explanation as to why a referral is not warranted. The SSD response should be attached to the PAR form. Consideration must be given to raising it as a welfare concern before the case is closed.

Appendix 6 - Protocol for the use of adults at risk databases

Introduction

This protocol applies to any database which is used to store data relating to adults at risk. The director of operational delivery will maintain a central register of such databases. No new database and no significant amendments to existing databases may be undertaken without the prior written approval of the director of operational delivery. The LFB is committed to ensuring that information, including that relating to its clients, along with the IT systems that process, store, display or transmit this information, are properly protected and operated in accordance with data protection legislation.

The aim of the protocol is to manage information about adults at risk so that:

- Access to information is reliable, authorised and properly controlled.
- Assurance is provided such that information can be used with confidence for its accuracy, authenticity and completeness.
- Risks to information assets can be quickly and successfully identified and appropriate, timely and cost-effective mitigating actions can be taken.
- The organisation is compliant with all relevant legislation, its regulatory environment and is following industry best practices.
- Employees are aware of their information security requirements, act on these needs and adopt an attitude of collective responsibility for maintaining information security.

Adults at risk databases

Databases containing personal information relating to adults at risk may only be established for the purpose of administering the LFB's community safety initiatives and schemes, which are run as part of the Brigade's statutory duty to promote fire safety. Databases must be developed and maintained in accordance with the Brigade's standard methodology for software development and must conform to the following Brigade policies and procedures which are outlined in summary form in this protocol but which should be fully reviewed by all users of vulnerable adults' databases:

Policy number 485 - **ICT acceptable use policy (AUP)** which sets out the rules for all LFB staff, including temporary staff, contractors and third parties who are granted access to ECT equipment and networks. It provides guidelines on how to ensure the security of the Brigade's systems e.g.: use of passwords, email accounts, internet.

Policy number 351 – **Data Protection and Privacy Policy** which set out the rules on how to manage and deal with personal data including the right of access to personal data, how long users should keep it, the obligation to correct mistakes, dealing with subject access requests, etc.

Policy number 621 – **Information sharing arrangements** which sets out the Brigade's policy and approach to information sharing.

Policy number 442 - **Information security policy** which set out the Brigade's approach to information security including responsibilities, access to systems, policy compliance, risk management, etc.

Information stored

Personal information held on vulnerable adults databases is subject to safeguards and restrictions imposed by or under the Data Protection Law and related legislation, concerning the way such information is collected, stored and processed. Only adults at risk personal data necessary for the following should be stored on a database:

- The administration of authorised community safety initiatives and schemes.
  AND
- The proper recording of referrals made to other agencies.

In accordance with the principals of the Data Protection Law, all data stored on vulnerable adults databases, must:

- Only be used for the purpose for which it was obtained and shall not be further processed in any manner incompatible with that purpose;
- be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed;
- be accurate and kept up-to-date;
- not be kept longer than is necessary for the purpose(s) for which it is obtained. In the case of data about vulnerable adults, it must be reviewed after six years after the scheme/activity/referral has been completed.

The LFB's deputy assistant commssioner (Prevention and Protection) with responsibility for Prevention or a nominated safeguarding officer in the Prevention and Protection Department is authorised to delete entries after this period.

Individuals have the right to access personal information about themselves held by the LFB by making a subject access request.

Security

Staff who use adults at risk databases are responsible for:

- The security of LFB IT resources and information.
- Operating only within the scope of their job function.
- Only accessing the systems they are authorised to use.
- Safeguarding the hardware, software and information in their care.
- Preventing the introduction of malicious software on the organisation's Information systems.
- Reporting any suspected breach of the Information Security Policy.
- Ensuring that they are aware of their information security responsibilities, relevant to their job or function.
- Access to the Brigade's person at risk database will be strictly limited to duty DACs, BCs, SCs, the safeguarding manager and staff within Prevention with responsibility for recording, managing, maintaining and monitoring safeguarding concerns.

Appendix 7 - The role of borough commanders (BCs) at safeguarding adults boards (SABs)

Background

In November 2010, approval was given by the Authority for London Fire Brigade (LFB) to pursue membership of SABs as it is recognised that there is potential for LFB to contribute to the multi-agency approach to safeguarding adults at risk.[4] In line with their role of developing links with inter-agency partnerships aimed at promoting the safety of residents at a borough level, BCs were identified as being best placed to attend SABs on behalf of LFB.

The SAB role and structure

SABs are statutory multi-agency boards established by the local authority in each borough. The core members include the Local Authority (LA), Clinical Commissioning Group (CCG), Police, and NHS England. A SAB may also include members that the LA considers appropriate to attend, such as ambulance and fire services.

SABs oversee and lead on adult safeguarding across the community. Their focus is on the prevention of abuse or neglect and on the promotion of adults' wellbeing. As such, their main objective is to ensure local safeguarding arrangements exist and that partners act to help and protect adults who have care and support needs, are at risk of abuse or neglect and unable to protect themselves.

The Board is an important source of advice and communication with other key local partnerships to share information and workplans; SABs therefore represent the appropriate forum for complex and challenging cases such as self-neglect to be discussed and addressed strategically. This means that **BCs are expected to follow up individual safeguarding and welfare concerns that have been previously raised in order to receive an update on progress and actions taken.**

SABs must conduct a Safeguarding Adult Review (SAR) when an adult dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SAB must also commission a SAR if an adult with care and support needs has not died, but the SAB knows or suspects that the adult has experienced abuse or neglect.

As a result of LFB membership, fire safety, in terms of risks to vulnerable adults and how joined up interventions can result in better outcomes, is now on the Boards' agenda. Consequently, even in those cases which do not warrant a SAR, BCs should be able to convene ad hoc multi agency meetings to look at fire fatalities which could lead to valuable lessons being learned to prevent future fire death.

The BC are expected to assess and disseminate the outcomes of reviews and safeguarding concerns in order to inform wider LFB adult safeguarding policy and prevention strategies.

[4] LFEPA report FEP 1606, September 2010

Document history

Assessments

An equality, sustainability or health, safety and welfare impact assessment and/or a risk assessment was last completed on:

EIA	02/02/22	SDIA	L - 11/08/20	HSWIA		RA	

Audit trail

Listed below is a brief audit trail, detailing amendments made to this policy/procedure.

Page/para nos.	Brief description of change	Date
Page 9 para 8.7	Hyperlink added to provide information for DACs.	25/05/2011
Appendix 3, 3(a) and 5	The ICT acceptable use policy (AUP) has replaced the code of practice on the use of computers (CoPUC) policy and these paragraphs have been updated accordingly.	30/04/2012
Pages 2-4.	Key Point Summary added.	18/08/2014
Page 22	'Subjects list' table - template updated.	05/01/2015
Throughout	Major changes throughout. Please read policy to familiarise yourself with content.	05/02/2015
Throughout	Top Management Review changes.	17/06/2015
Throughout	Major changes made throughout this policy, please re-read to familiarise yourself with the updated content.	21/06/2017
Page 19 and 21	Minor formatting changes made to page 19 and an arrow added to the flowchart on page 21.	22/08/2017
Throughout	Major changes throughout. Please read policy to familiarise yourself with content.	15/06/2020
Page 4	Safeguarding referral process to follow table updated.	03/08/2020
Throughout	Changes throughout. Please read policy to familiarise yourself with content.	15/09/2021
Throughout	Terminology updated in line with the Youth and CS Reviews.	26/04/2022
Throughout	Minor changes.	16/06/2022
Throughout	References to Data Protection Act (DPA) updated to Data Protection Law.	23/06/2022
Throughout	Changes: a) terminology in line with departmental restructure; b) referral timings, c) location of the Person At Risk (PAR) form.	06/09/2022

Subject list

You can find this policy under the following subjects.

Adults	Domestic violence
Harassment	Vulnerable adults
Mobile Data Terminals (MDTs)	

Freedom of Information Act exemptions

This policy/procedure has been securely marked due to:

Considered by: (responsible work team)	**FOIA exemption**	**Security marking classification**

Policy | Procedure

LONDON FIRE BRIGADE

Supporting health and wellbeing policy

New policy number:	**1005**
Old instruction number:	
Issue date:	**23 January 2023**
Reviewed as current:	
Owner:	**Assistant Director, People Services**
Responsible work team:	**Policy, Pay and Reward**

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1 Introduction

1.1 This policy sets out the arrangements for supporting staff health and wellbeing and applies to all employees.

1.2 The Brigade's Wellbeing Strategy focusses on the **prevention** and **treatment** of poor **psychological**, **physical** and **workplace** wellbeing, as well as the promotion of good psychological, physical and workplace wellbeing. The Supporting health and wellbeing policy is a tool for bringing the Wellbeing strategy to life when you need it most, during a period of ill-health.

1.3 This policy will equip employees and managers with the knowledge and tools to support themselves and each other in maintaining good levels of health and when recovering from a period of ill-health. Providing support at the right time can be instrumental in supporting employees to continue to succeed in the workplace and enables the Brigade to deliver excellence through having the best people and being the best place to work.

1.4 This in turn will support employees to bring their whole selves to work in providing the reassurance that in cases of ill-health or disability employees will receive appropriate support to succeed in their roles as long as they are able. The policy also provides detail on how support will continue throughout a period of absence both through locally agreed arrangements and employee support services.

1.5 This policy should be applied in line with the Brigade's values:

- Service – We put the public first.
- Courage – We step up to the challenge.
- Learning – We listen so that we can improve.
- Teamwork – We work together and include everyone.
- Equity – We treat everyone fairly according to their needs.
- Integrity – We act with honesty.

Section 1 – Employee section

2 Employee support services

Occupational Health

2.1 Occupational health exists to keep people well, productive, and safely 'in work', by providing independent specialist medical advice to employers and employees. This advice includes:

- Promotion of health and wellbeing.
- Advice and strategies for managing risks to health from work.
- The effects of work on health, and health on work.
- Interventions, adjustments, and support, to enable and sustain a return to work.
- Clinical advice to manage health issues.

2.2 Our Occupational Health Service (OHS) provides a range of support including access to occupational health physicians (doctors), occupational health advisers (physiotherapists), nurses, Wellperson screenings, functional restoration programmes and post incident support. Further

details can be found here or by contacting the Wellbeing Team on extension 30490 or wellbeingteam@london-fire.gov.uk.

Counselling and Trauma Services

2.3 This service provides an opportunity to talk in confidence to a professionally trained counsellor. The subjects that can be covered may be personal (e.g., relationship problems, sexual orientation, gender identity), work related (e.g., bullying, trauma) or health-related issues (e.g., Post-Traumatic Stress Disorder, anxiety, depression).

2.4 Further detail can be found here or by contacting Counselling and Trauma Services by email using PSC&TS@london-fire.gov.uk.

2.5 If you need to speak to a counsellor urgently or need to request a Post Critical Incident Contact (PCIC) please call Control on 0208 555 1200 extension 50208 and ask for the duty counsellor to be paged.

Mental Health First Aiders

2.6 The Brigade has a number of Mental Health First Aiders across staff groups and Brigade locations. Mental Health First Aiders are not professional counsellors, therapists, or psychiatrists, they are colleagues who have been formally trained by Mental Health First Aid England to administer mental health first aid in the workplace and have attained a Mental Health First Aid Certificate. They are trained to:

- Spot the early signs and symptoms of emotional distress and potential mental health issues.
- Start a supportive conversation with a colleague who may be experiencing a mental health issue or emotional distress.
- Explain and maintain confidentiality.
- Listen to a person non-judgementally with compassion and understanding.
- Assess the risk and severity of the situation and signpost a person to professional support.

2.7 For more information about how to contact your local Brigade Mental Health First Aider please contact the Mental Health and Trauma Team Co-ordinator at wellbeingteam@london-fire.gov.uk.

Fitness Advice Team

2.8 The Fitness Advice Team can provide all staff with information, advice and guidance related to physical wellbeing matters. This includes:

- Helping to prepare for the periodic fitness testing programme (operational staff only).
- Understanding more about the types of activities you should be undertaking.
- Learning about the food you should be eating to improve your overall fitness levels.
- Getting advice about returning to work following sickness or maternity leave.
- Specialist advice to women who may be experiencing episodes of poor physical health as a result of the menopause.

2.9 Please contact wellbeingteam@london-fire.gov.uk if you need support in any of these areas.

Equality Support Groups

2.10 Equality Support Groups (ESG's) provide independent and confidential support, signposting and guidance to their members. Our ESG's are listed below. Further information can be found here and in Policy number 965 - Equality support groups.

- Asian Fire Service Association (AFSA)

- Black & Ethnic Minority Members (BEMM) – FBU Group
- Disability Working Group (DWG)
- Dyslexia and Neuro Diverse Support Group
- Emerald Society – Irish Group
- Fairness – Black and Ethnic Minority Group
- LGBT+ – Sexual Orientation and Gender Identity / Expression
- Menopause Action Group (MAG)
- Mental Health Support
- Military Veterans Support Group
- Parents and Carers
- Phoenix – Domestic Abuse Group
- Women in the Fire Service (WFS)
- Women's Advisory Committee (WAC) – FBU Group

Firefighters Charity

2.11 The Firefighters Charity offers specialist lifelong support for all staff groups, empowering individuals to achieve psychological, physical, and social wellbeing throughout their lives. For further information on how they can provide support please contact them on 0800 3898820 or go to their website www.firefighterscharity.org.uk.

Welfare Fund

2.12 The Welfare fund is a stand-alone membership organisation and can provide access to:

- Gyms/health centres etc (via the Blue Light Card).
- Hardship fund.
- Welfare care packages for members who are suffering from an illness or bereavement.

For further detail on this you can visit www.lfbwelfarefund.com, call 020 7407 3964 or email info@lfbwelfarefund.com

Chaplaincy

2.13 Guy's and St Thomas' Hospital Trust provide the London Fire Brigade with a multi-faith chaplaincy service. It comprises a chaplaincy team leader and a team of chaplains drawn from the major world faiths. The service is available during the normal working day with an on-call facility at other times and weekends.

The Chaplaincy Service provides:

- Pastoral support to members of staff on an individual and confidential basis.
- Advice and support for funerals.
- The conduct of funeral services.
- Advice about faith issues to individual members of staff and managers to assist service delivery and employment requirements.

2.14 The chaplaincy can be contacted via email to mia.holborn@gstt.nhs.net.

Trade Unions

2.15 The Brigade has recognised trade unions who can offer advice and support on all issues affecting you at work including your health and wellbeing. Union representatives are trained to provide support and representation in any formal processes. Union membership also entitles you to free legal advice if appropriate.

People Services

2.16 People Services is a large department full of knowledge and expertise across a wide range of areas including Wellbeing, Inclusion and Diversity, Neurodiversity, Learning Support and Resilience, and HR Services. People Services are here to support you and can answer any questions or concerns that you may have. If you have any questions or concerns, please contact the HR Helpdesk on 0208 555 1200 extension 89100 and they can advise you of the best person to speak to provide the necessary support.

Long Covid Support

2.17 Staff who have had symptoms of Covid-19 for more than four weeks and need support either to get back to work or to remain at work can access the following support:

- Occupational Health
- Royal Brompton Hospital
- Functional Restoration Programme
- Fitness Assessments (Operational staff only)

2.18 Further information regarding these services can be found here or by talking to your line manager.

3 Supporting your health at work

Employee Support Meeting

3.1 An Employee Support Meeting (ESM) can take place at your request or at the request of your line manager where there is a concern regarding your health and any support that you may require. The meetings will be held either with your line manager or an alternative agreed point of contact, and can take place whilst you are at work, or absent from work. They are used to discuss your health and wellbeing to understand what support you may need. You will be given at least 7 days' notice of this meeting unless otherwise mutually agreed and they will normally take place at either a Brigade location, via video call or via a telephone call.

3.2 You may be accompanied by either a work colleague or a Trade Union Representative. You may instruct a work colleague or Trade Union Representative to attend the meeting on your behalf and/or provide a written submission rather than attend the meeting in person.

3.3 The specific discussion at any ESM will be dependent on your needs at the time. During an ESM the following may be discussed, if appropriate:

- An update on your health and any support you may be receiving.
- Signposting to additional services available.
- Return to work plan such as a phased return to work, workplace adjustments, training or refamiliarisation.
- Review of adjustments in place and their continued effectiveness.

3.4 Where your health condition is likely to result in you being unable to return to your contractual role, an ESM may also be arranged to discuss:

- Redeployment.
- Ill-Health Retirement.

3.5 There is the potential for a lot of information to be discussed during an ESM and, particularly during a period of ill-health, it may be difficult to take it all in. A representative from People

Services will also attend ESMs where redeployment and ill health retirement are discussed to ensure that you have all the information relating to these processes that you may need.

3.6 After the meeting your manager or alternative agreed point of contact will also send you an accurate summary of the meeting, including contact details of any support services discussed. A copy of this will be placed on your e-prf.

Stress Risk Assessments

3.7 If you believe your role or other work-related factors may be having a detrimental impact on your psychological health, you can complete a workplace stress questionnaire. It is important that this is completed as soon as you realise that work may be the trigger for your stress. This is a useful tool to allow managers to understand the areas of concern and starts a conversation as to how a manager can support you. When used proactively, before illness, the Stress Risk Assessment can be used to reduce likelihood of future sickness through the implementation of proactive support. Further detail can be found in Policy number 690 – Managing stress within the LFB.

Reasonable adjustments

3.8 If you have a health condition or a disability, in accordance with the Disability Provisions of the Equality Act 2010, reasonable adjustments should be made to support your health and wellbeing whilst at work. You are considered to be disabled under the Equality Act 2010 if you have a physical or mental impairment that has a substantial and long-term adverse effect on your ability to carry out normal daily activities. Such adjustments will be referred to within the Brigade as workplace adjustments.

Workplace adjustments

3.9 Examples of workplace adjustments to support your health and wellbeing include provision of specialist equipment, a change in working pattern or a change in working location. These adjustments can be temporary, or permanent, dependent on your needs, but their effectiveness will be reviewed in an ESM at least every 6 months. You should discuss, with your line manager, the adjustments available to you. Discussion regarding adjustments, including what has been agreed and what cannot be facilitated at present will be recorded in your Workplace Adjustment passport. Please visit the Workplace Adjustment passport details on Hotwire here to record this.

Reduced hours

3.10 There may be times that your long term and substantial health condition impacts on your ability to undertake the full remit of your role and, although you have not had sickness absence, Occupational Health have advised that a period of reduced hours would support your wellbeing. Reduced hours will not normally exceed a period of 6 weeks.

3.11 If you feel that you need more than 6 weeks of reduced hours within a 12-month rolling period, you should discuss this with your line manager. It may be possible to facilitate this with the use of annual leave, unpaid special leave, or a temporary change in your contractual hours.

Disability Treatment Leave

3.12 It is recognised that if you have a disability, you may require time off from work for attending clinic appointments or other assessment, medical treatment and/or in-patient or out-patient recuperation/rehabilitation, for a reason relating to your disability. Where it lasts for one or more whole days (part day absences for disability treatment will be recorded as CTV (Gone to Visit)

Disability Treatment Leave (DTL) will be given. This will normally be limited to sixteen working days per year.

Surgical treatment for visual deficiencies

3.13 There are several surgical techniques available for the purpose of correcting vision to avoid or reduce the requirement for glasses or contact lenses. If you are considering refractive surgery, then you should seek an assessment with a reputable eye surgeon to discuss the risks and benefits of the various options. All staff are advised to consult with the OHS.

3.14 If you are operational, then it is likely that a minimum period of two months light duties will be recommended post operatively. After two months you will need to attend for a medical assessment with the OHS to present the post-surgery check-up report from the surgeon to confirm that the operation has been successful and not resulted in any complications. The OH will advise on your fitness to return to full duties. The OHS will undertake further investigations as necessary to determine your fitness for role and this may include a referral for further assessment/investigation to confirm that a satisfactory recovery from surgery has been made and there are no visual impairments that might compromise ability to safely discharge your role.

Tetanus vaccinations

3.15 Due to risk of exposure to the bacterium *clostridium tetani* involved in firefighting and other operational duties, you are encouraged to ensure you are adequately protected against tetanus by means of vaccination. Treatment of a tetanus prone wound (puncture wounds, burns or scratches) by qualified staff is possible, however many injuries that could cause tetanus could go unrecognised. Immunisation will reduce the risk of this occurring.

3.16 You are advised to check with your general practitioner (GP) records to determine your immune status and arrange vaccination through the National Health Service (NHS). Early recognition and treatment can be lifesaving.

3.17 Operational staff who are deployed outside of the UK are advised to contact the Wellbeing Medical Team in advance of travelling, so that advice can be sought as to whether any additional booster injections are recommended.

3.18 You are advised to keep a record with you at all times when on duty to confirm when and what combination type of anti-tetanus injections have been received. Appropriate cards can be provided on request from GPs at the time of immunisation or from previous medical history also available from the GP.

Union street gym

3.19 The Brigade provides a gym at union street for you to use to maintain your fitness and wellbeing. Details of its opening times and conditions of use, including the reporting of any defects to equipment, accidents or near misses are on Hotwire. You must undertake a gym induction before using the gym and details of how to do arrange this are also on the Hotwire page.

4 Employee responsibilities during sickness absence

Sickness reporting procedure

4.1 Should you feel too unwell to attend work, you should contact your manager by telephone at least one hour, or as soon as reasonably practicable, prior to the commencement of your work time. During this initial contact you should advise of the nature of your sickness absence and agree when future contact will take place i.e., will you call again before the following shift, or do

you know that you will be unable to work for a minimum period of time. It is acknowledged that in some circumstances you may not feel comfortable reporting your condition to your line manager. In this case you must let your manager know that you will not be able to attend work and agree who you would be most comfortable reporting your condition to.

4.2 If you feel that reporting your sickness to your line manager might be detrimental to your wellbeing, you should report your sickness to a more senior manager. For operational watch-based staff, where a more senior manager cannot be located prior to the commencement of the employee's shift, your sickness is to be reported to the Officer of the Day (OOD).

Certification

Up to 7 consecutive calendar days

4.3 Upon your return to work you will be required to complete a self-certification form. The form will be sent to your Brigade email address for you to complete.

8 consecutive calendar days or more

4.4 If your period of sickness lasts 8 consecutive calendar days or more, you will be required to submit a 'Statement of Fitness for Work Note' also known as a 'Medical Certificate' from your GP or a hospital to cover your sickness absence from day 8. These should be submitted to your line manager or agreed point of contact as soon as practicable after they are obtained. They can be submitted electronically via email and should be clear and easy to read. If your certificate is not clear enough your line manager may ask you to provide the original.

4.5 You must provide consecutive medical certificates for the full period of sickness absence. This is for the purposes of paying Statutory Sick Pay (SSP) and occupational sick pay. Your GP is unable to backdate certificates, so it is advised that you schedule your appointments with the GP in good time to ensure you are able to obtain a medical certificate covering your dates of absence.

4.6 It is important to understand that failure to provide medical certificates may result in your entitlement to occupational sick pay and/or SSP ceasing.

4.7 Where the GP advises that you 'may be fit for work with recommendations' your manager will review the recommendations, seeking support from the OHS if necessary. The recommendations will be discussed with you, and you will be advised whether they can be accommodated. All agreed adjustments will be updated in your workplace adjustment passport.

4.8 If you become unwell whilst abroad and are unfit to travel back to the UK, you will need to follow normal sickness reporting procedures as detailed above. If your medical condition prevents you from returning to the UK by the 8th day of sickness, you will need to obtain an appropriate medical statement confirming that you are unfit to travel to the UK.

Contact

4.9 It is important that you and your line manager maintain regular contact during your sickness absence to:

- Monitor your progress in terms of your return to health.
- Provide you with information relating to support services available.
- Provide you with information so that you can make informed decisions (for example, in relation to sick pay entitlement).
- Ensure that you remain informed about events in the workplace.

4.10 It is the joint responsibility of you and your line manager, or your agreed point of contact, to agree how often the contact should take place. This will be dependent on your individual

circumstances, but contact should be made at least every 28 days. Contact can take place over the phone, via video call, in person or in certain circumstances via email.

4.11 It is important that you make yourself available for any agreed contact. If you become unavailable for any agreed contact, you must contact your line manager as soon as possible so that alternative arrangements can be made.

4.12 Staying connected with your team or watch can help you to continue to feel a part of the workplace and reduce anxiety when retuning to work. Your manager will speak to you about the type of contact you would like to receive from your colleagues and, if appropriate, ensure you remain engaged in non-work focussed team activities.

Referral to Occupational Health Service

4.13 There may be instances when your manager feels it is necessary to refer you to OHS. This may be because:

- You or your manager are concerned about your wellbeing or fitness for work.
- You have reached a sickness absence trigger point (as set out in section 12).

4.14 Before you are referred to the OHS, your line manager will speak to you about the reason for the referral, the referral process, and obtain your verbal agreement. If you do not agree to a referral to the OHS or withdraw your consent to release the outcome report to your line manager, your line manager will only be able to provide support based on the information that they hold about your medical condition. This may limit the support that your line manager is able to provide. More detail about what to expect from an OHS referral can be found here.

Attendance at OHS appointments

4.15 It is important that you attend OHS appointments as this will help your manager to understand your health condition and what support they may be able to give you. Failure to attend OHS appointments or provide consent to release reports will mean that your manager will make a decision on your fitness to perform your role, and any support you may require, based on the information already available to them.

Physiotherapy

4.16 Training for and participating in sporting events may increase your risk of injury. Occupational Health Physios can support you with strengthening exercises and stretching routines to minimise this risk. All Occupational Health outcome reports will be sent to your line manager or alternative agreed contact with consent. It is therefore important that you advise your line manager of your request to ensure that they are able to provide any necessary additional support. If you are fit for work and feel you would benefit from physiotherapy then appointments for watch-based, flexi-duty and control staff will be made in off-duty time.

5 Work related absence

Due to Service

5.1 Within the Brigade, a Due to Service Injury is an injury which occurred whilst on duty having arisen out of or in connection with work as a result of an authorised duty.

5.2 Support on the 'Due to Service' process can also be obtained by contacting the Wellbeing Team on extension 30490. Further detail on the 'Due to Service' process and how to put in a request can be found here.

5.3 Your sickness absence will automatically be recorded as 'Not Due to Service'. If you feel that your sickness should be considered as 'Due to Service' it is important that you have a conversation with your line manager as soon as possible. Applications for a due to service classification should be submitted to the line manager within three months of the event which caused the sickness absence, or three months of the commencement of the relevant period of sickness if later, unless the employee can demonstrate there are reasonable grounds for a longer period to apply. If you feel unable to approach your immediate line manager then you can contact either an alternative manager or, if you are a member, a Trade Union representative and ask for their support to initiate the process for you.

5.4 In order for Due to Service to be agreed three criteria must be met:

- The event occurred whilst on duty.
- The event has arisen out of or in connection with work.
- The event occurred as a result of an authorised duty.

Industrial injuries disablement benefit

5.5 You are entitled to Disablement Benefit if an injury arising out of and in the course of your employment results in incapacity lasting more than 15 weeks. For Disablement Benefit purposes, an accident means any unexpected happening or incident at work. Benefit is paid only if the accident results in personal injury, whether or not the effect of the injury is immediate (for example, breaking a leg in a fall) or delayed (for example if a minor cut later turns septic). Generally, an accident which happens at work is treated as having occurred as a result of the work and Disablement Benefit will be paid unless there is evidence to the contrary.

5.6 If you have an accident on duty which may cause continuing disability, you are advised to inform the Department for Work and Pensions (DWP) of the accident as soon as possible even if you do not proceed on sick leave at the time of the accident to ensure there is no undue delay in the payment of any subsequent Disablement Benefit. Form BI 100A, which is available from local social security offices or via the DWP web site, should be used for this purpose.

5,7 In cases where a Form BI 100A (Industrial accident) or BI 100PD (Industrial diseases) is received from the DWP in respect of your sickness absence and your sick pay is being adjusted as though State benefit for sickness were receivable, deductions will be continued at sickness benefit rates, but you will be required, in writing (a) to agree, that, in the event of benefit for injury being ultimately received, any excess sick pay granted shall be recoverable by the Brigade, by deductions from future pay, or if you are not still in the Brigade's service, you shall repay the excess sick pay and (b) to undertake to inform People Services Department immediately notification is received from the DWP that State benefit for injury is payable.

5.8 For the purpose of the Social Security Acts and Regulations any accident at work must be entered promptly in the Accident Book. In compliance with these requirements, the provisions of Policy number 463 – Accident books must be followed.

5.9 The reporting and investigation of accidents resulting in personal injury are required under both Social Security and Health and Safety legislation. Instructions for dealing with investigations are contained in the Brigade's Policy number 368 - Health, safety and environmental event investigation policy (personal injuries near misses and traffic accidents). All injury events details are to be recorded within the Safety Event Reporting Database (SERD) in accordance with the policy.

6 Supporting your finances

Sick pay

6.1 Details of the sick pay you will receive during a period of sickness absence can be found in

- Policy number 558 – Operational staff pay rates and sick pay policy.
- The Staff Code for FRS and Control Staff.

6.2 You will be notified in advance should your contractual sick pay be affected whilst you are off sick. A letter will be sent to you advising you of the change in pay and the date at which it will take effect. You will be provided with approximately 28 days' notice. In exceptional circumstances your sick pay may be extended, the letter you receive will detail how you can apply for an extension.

Welfare Fund

6.3 The London Fire Brigade Welfare Fund is a standalone membership organisation.

6.4 Some of the benefits of being a member, serving or retired include:

- The death benefit scheme.
- Access to gyms/health centres etc (via the Blue Light Card).
- Hardship Fund.
- The Welfare Fund provides a welfare care package for members, who they know are suffering from an illness or bereavement, in the form of a card, flowers or voucher.

6.5 For further information on the fund, visit www.lfbwelfarefund.com, call 020 7407 3964 or email info@lfbwelfarefund.com.

Annual leave

6.6 Sickness absence and an associated reduction in pay may have an impact on your wellbeing because of financial instability. If you are on half or nil pay it is possible for you take some of your accrued annual leave whilst on sickness absence resulting in you being paid full pay for the period of your annual leave.

6.7 If you wish to do this, please contact your line manager or agreed contact who will support you to progress your request.

7 Outside Employment

7.1 You will not be able to undertake outside employment while you are off sick. However, if your outside employment is considered to be beneficial to your recovery and will not aggravate or restrict your ability to recover and return to your substantive role, then you can contact your line manager to discuss this further.

7.2 Further detail regarding outside employment and sickness can be found in Policy number 551 - Outside employment.

8 Returning to work

8.1 Recovering from illness is not always a quick or straightforward process and there may be occasions where you are fit to return to work, however you are not well enough to undertake all the aspects of your role straight away. If you are well enough to undertake only some of the duties of your contractual role your manager will consider, in consultation with the OHS, whether

it is possible for you to return to work and what support they can provide to gradually rebuild your resilience to return to your full role. In such circumstances, during an ESM prior to your return to work, your manager may discuss with you:

- **Restricted Duties** - This may be either a temporary change to your duties or only fulfilling certain aspects of your role until your condition improves further to allow you to undertake your full substantive role.
- **Phased Return to work** - This can help build your confidence and a gradual return to your full role. This would be a temporary arrangement to support a full return to your role. The first 6 weeks of a phased return to work will be paid at full pay, following this you will be paid for the hours worked. Leave may be used to further extend this period. If however you find that a change in working hours supports your condition on a longer term basis you can consider putting in a request to change your hours on a permanent basis via Policy number 448 - Working with choice – flexible working options.

Return to work meeting

8.2 Upon your return to work your line manager will arrange a return to work meeting. This will give them the opportunity to welcome you back, provide you with any updates or changes that may have occurred, confirm any temporary changes to your working arrangements and confirm any necessary support that you may require to support your return to work.

9 Redeployment

9.1 Whilst it is hoped that you can return to your role, there are occasions where this might not be possible, because of your health condition and the specific demands of your role. OHS may advise that you are unlikely to be able to return to your current role but may be able to carry out alternative roles within the organisation.

9.2 If you have been advised by the OHS that you are not likely to be fit for the foreseeable future to carry out your role, or they are unable to give a timescale for a full return to your role, your manager will arrange an ESM to meet with you to discuss how they can support you. In the first instance every effort will be made to find you a role within the same staffing group. If this is not possible then your line manager will work with you, within your agreed redeployment period, to identify a suitable role within a different staffing group, subject to vacancies.

9.3 Upon identifying a role of interest, you may be required to participate in the recruitment process to ensure that you have the appropriate knowledge, skills, and experience for the role. To secure redeployment you will be required to meet the minimum criteria for the role. Additionally, where available, short term development opportunities may be provided to support you to gain a better understanding of the role.

9.4 Should you be successful in securing the new role and your current salary is higher than that of your new role, you will be given three years pay protection if you are operational, and one year pay protection if you are FRS or Control.

10 Ill health retirement

10.1 Occasionally when an employee is too unwell to undertake any work, ill health retirement (IHR) can be explored. This will only be considered when all reasonable avenues of support have been exhausted and the OHS have advised that they are not likely to become well enough to fulfil their role, they are unable to determine whether a recovery will be made, or they are unable to provide a prognosis.

10.2 This can only be explored for members of the Firefighters Pension Scheme or the Local Government Pension Scheme once reasonable adjustments and/or redeployment have been fully considered (see sections 3.8, 3.9 and all of 9).

10.3 Learning that you may be unable to work in the future can be very upsetting and difficult to take in. Support can be provided by:

- Your line manager or point of contact.
- Your colleagues.
- Counselling and Trauma Services.
- Firefighters Charity.
- Trade Union Representative.
- Pre-retirement workshops.

10.4 Your manager will arrange an ESM with you to discuss the advice received from Occupational Health and the process for ill health retirement will only start with your consent.

10.5 The Brigade will obtain a medical opinion from an Independent Qualified Medical Practitioner (IQMP) for those individuals in the Firefighters Pension Scheme, or from an Independent Registered Medical Practitioner (IRMP) for those in the Local Government Pension Scheme on the individual's medical capability to undertake their role.

10.6 The medical opinion will be considered by the Brigade and a decision will be made as to whether you are to be ill health retired. Your line manager will contact you to discuss the outcome and you will also receive written confirmation of the decision, including the medical rationale for the IQMP/IRMP's opinion. If you are dissatisfied with the medical opinion provided, the letter will outline your rights of appeal.

10.7 Should the decision be that you are to be ill health retired you will be provided with notice on full pay in accordance with your contract of employment. You will not be required to provide a medical certificate for the period of your contractual notice.

11 Dying to work charter

11.1 In the unfortunate event that you become terminally ill, the Brigade has committed to providing support following a diagnosis by:

(a) Allowing you to continue undertaking safe and reasonable work should you wish to do so.

(b) Providing you with security of work, peace of mind and allowing you to choose the best course of action for yourself and your family, to help you through the challenging period with dignity and without undue financial loss.

11.2 Should you receive such a diagnosis, at a time that you feel able, you should share this with your line manager or point of contact so that they can support you.

12 Sickness absence triggers

12.1 Even though your manager may have taken steps to support your medical condition it is understood that this support may not avoid sickness absence.

12.2 The following sickness absence triggers have been set to provide you and your manager with a guideline as to the level of sickness absence(s) which may require additional support.

6 month rolling period

- 3 separate instances, or

- a total absence of 6 working days or over in any six-month period.

12 month rolling period

- 5 separate instances, or
- a total absence of 8 working days or over in any twelve-month period.

These sickness absence triggers do not include any maternity related illness, short term due to service sickness absences or the first 10 days of a period of Covid-19 sickness prior to 1 June 2024.

12.3 An ESM may be arranged by your manager when these sickness absence triggers are reached, and a conversation will take place to determine whether any further or additional support may be required and set targets for a sustained return to work.

12.4 If your sickness absence(s) is/are considered to be as a direct result of a disability (see section 3.8) then your manager will consider this and, as a workplace adjustment, your sickness absence trigger thresholds will be doubled.

12.5 Sickness absence triggers are monitored over a 12 month rolling period, should you reach an absence trigger within an active monitoring period, your manager may invite you to a further meeting as provided for in Policy number 873 – sickness capability policy.

Section 2 – Managers section

13 Training and support

13.1 As a manager you are responsible for supporting the health and wellbeing of your team and at times you are likely to have a team member with a medical condition who requires support to enable them to come to work.

13.2 To assist you in providing support the following resources are available:

- Education sessions with the OHS on how to support employees.
- Education sessions with People Services on supporting health in the workplace.
- Support from People Services.
- Computer based training every 2 years on supporting individuals within the workplace.
- Case conferences with the OHS.
- Medical Panels.

13.3 It is appreciated that as a manager dealing with complex cases can sometimes have an impact on your wellbeing also. Support is also available to you from:

- Counselling and Trauma Services.
- People Services.
- Your line manager.

13.4 A full list of support services can be found in section 3.

14 Employee Support Meetings

Creating a safe space to talk

14.1 An important part to having an ESM is to make sure that it takes place in an environment where the individual feels safe to be able share their thoughts and feelings.

14.2 You should allocate plenty of time for the meeting in a private, quiet, and neutral location, which in some cases may not be Brigade premises, where you will not be interrupted. This can be at a Brigade location, via a video call or through a telephone call.

14.3 Remind the individual of the confidentiality that will be maintained and encourage the person to talk, using simple open questions whilst actively listening to what is being said, alongside not being judgemental and/or making any assumptions about what is discussed.

14.4 Respond calmly and clearly to any questions asked and be understanding and reassuring in relation to the matters raised. If you are unsure about the answers to any questions advise that you will have to seek further information/support and will get back to them within a given timeframe.

14.5 The ESM is in place to encourage the employee to be open about how they are feeling from both a psychological and physical perspective, so a safe space to be able to share this information is an important part of making the ESM successful.

Thinking of the bigger picture

14.6 A health condition can often be exacerbated by psychological ill health. This can be related to isolation from colleagues and friends.

14.7 The individual may suffer from:

- The absence of structure to their day.
- Worry about the financial implications of being off sick.
- Concerns that they may not be well enough to fulfil their role again and uncertainty in their future.

14.8 When holding an ESM being mindful of these potential concerns will allow you to offer the appropriate support suited to their needs.

Notification of ESM

14.9 As a manager you are responsible for providing the individual with 7 days' notice of an ESM in writing and advising that they have a right to be accompanied by either a work colleague or a trade union representative. This can be either via letter or via email.

Recording discussions

14.10 Once you have held the ESM it is important to provide a written summary of the meeting. This allows for the individual to have a copy of the information that has been shared with them in the meeting. A copy of the outcome letter or email must also be placed on the e-prf.

15 Agreeing a contact strategy

15.1 It is important to agree how you will keep in touch with the employee whilst they are off sick. This allows you as a manager to continue to understand how you can support the employee in a return to work. There is no set timetable as to when contact should be made as this will be dependent on the individual and their particular circumstances.

15.2 It is important to have a conversation with the individual to mutually agree how often contact should take place. This will give you an opportunity to get updates on the individual's condition and will assist your understanding as to whether the level of support you are providing needs to change. This also allows you to provide the individual with any updates or changes in the

workplace such as any changes in the team or watch, changes to policies or changes to OHS appointments etc.

15.3 You should be mindful of the individual's ability to process information. If you are updating them on policy changes, consider the format of this information if necessary. It may be appropriate in some cases to delay sharing information.

15.4 When considering how frequent contact should be, consideration can be given to:

- When the individual's medical certificate is due to expire.
- When the individual's next GP/specialist appointment is.
- When the next OHS appointment is.
- Will it be by telephone or video call.
- Would the individual prefer to attend a Brigade location (this also offers the opportunity for them to remain engaged with their colleagues).

15.5 Contact should be at least once every 28 days if the sickness absence is long term and should be recorded on the Individual Contact Record on StARS. This should also include the details of any agreed Brigade alternative point of contact for the employee.

16 Working with Occupational Health Service

16.1 Managers should give consideration to referring an individual to the OHS when:

- They have been on sickness absence for 28 days or more.
- There are concerns about their health or fitness to undertake their role.
- They have exceeded a sickness absence trigger as set out in section 12.

16.2 Prior to referring an employee to the OHS, you must speak with them to discuss the referral, the purpose, and the process. During this conversation you should ask the employee to confirm that they agree to the referral being made; this agreement can be verbal. Employees can withhold consent and can change the consent given at any time in the process. If consent is withheld, your decisions regarding the support that can be offered to them can only be made based on the information available. If consent is withdrawn, you should speak with the employee to understand their concerns and see what can be done to address these.

16.3 The purpose of a management referral to the OHS service is to try to establish:

- How you can continue to support an individual's health at work where there are concerns.
- The likely duration of absence or unavailability to undertake all aspects of their substantive role.
- What support can be provided to assist an individual's recovery and full return to their substantive role.
- Whether there are likely to be any limitations upon the individual's ability to return to their existing role and if these are temporary/permanent.
- Whether the absence is caused by a condition that is likely to last beyond 12 months that has a 'substantial' and **'long-term'** negative effect on the employee's ability to do normal daily activities.

16.4 In cases of sickness absence, People Services will contact the manager to determine when a referral is required to the OHS. Managers should consider the following:

- How long the individual has been absent from work.
- Information from the individual regarding their condition and any planned treatment.

16.5 Further guidance on how to complete a management brief and get the best use out of it can be found here.

17 Reduced hours

17.1 When an employee has a health condition it is sometimes possible for it to affect their ability to undertake the full remit of their role.

17.2 If advice from the OHS is received that the employee would benefit from a reduction in hours to support their condition, consideration should be given as to whether this recommendation can be supported.

17.3 Reduced hours would not normally exceed 6 weeks. Whilst working reduced hours, employees can be supported on full pay. If an employee feels that they require more than 6 weeks, then the request can be considered by using annual leave or a change to contractual hours.

17.4 If the condition is long term and the employee requests a further period of reduced hours in accordance with 18.3, there is no requirement to seek OHS advice unless a new/additional medical condition is disclosed.

17.5 Any changes to hours to support a medical condition should be recorded in the workplace adjustment passports.

18 Outside employment

18.1 If an individual contacts you to request that they continue to undertake outside employment whilst off sick, you must review the request. Consideration should be given to whether the outside employment is likely to aggravate their condition or restrict their ability to recover and return to their substantive role with the Brigade. Advice on the impact the outside employment may have on the individual's health can be sought from the OHS to assist you in your decision making.

18.2 Further detail regarding outside employment and sickness can be found in Policy number 551 – Outside employment.

19 Return to work

19.1 When an individual is well enough to return to work, they may initially not be able to undertake their full substantive role. In such circumstances you should arrange an ESM with them to consider the following:

- **Restricted Duties**
  Consider the medical advice from the OHS as to what they are well enough to undertake and determine whether there is alternative work, fitting these criteria, available for them to undertake.
- **Phased Return to work**
  Consideration of a phased return to work can be given where you feel that this would support a return to full hours. OHS advice may be sought if needed, however decisions regarding specific working hours are made by you, as you are better placed to understand what can be facilitated. Such arrangements will usually only last for one or two weeks, but this can be extended up to six weeks depending on the circumstances.

19.2 In exceptional circumstances where a phased return to work exceeds a six week period, these cases will need to be agreed by a Head of Service or DAC and the Assistant Director of People Services. This decision must be confirmed in writing and placed on the e-prf. A longer phased

return to work may also be facilitated using outstanding annual leave with the employee's agreement.

19.3 Where, following the agreed phased return to work period, the employee is unable to return to their full contractual hours (either on a restricted duties or substantive role basis), but you are able to continue to accommodate their working pattern, the employee will be paid in accordance with the hours worked for the duration of the arrangement (which should last no longer than 6 months). Any requests for a permanent change to working hours/pattern must be progressed in accordance with Policy number 448 - Working with choice - flexible working options.

Return to work meetings

19.4 When an employee returns to work following an episode of sickness absence you should conduct a return to work meeting and record the outcome on StARS. Ideally the return to work meeting should take place as soon as possible on the day they return to work.

19.5 The purpose of a return to work meeting is to:

- Welcome the employee back.
- Provide updates on any changes in the employee's absence.
- If necessary, discuss a return to work plan including training and introduction to new team members or workstreams.
- Discuss support required and any adjustments that may be made to support the employee's ability to remain at work.

19.6 If the employee indicates at this point that their absence was a result of them undertaking their role, consideration should be given as to whether the sickness absence should be classed as Due to Service. Further detail as to how and when to record a due to service sickness absence can be found here.

20 Redeployment

20.1 Redeployment is to be explored when one of the following applies:

- An individual has not been able to fulfil their substantive role due to either long term sickness or long term light/amended duties or a mixture of both and there is no clear indication as to when they are likely to be able to fulfil their substantive role; or,
- occupational Health has provided an opinion that an individual is not likely to be fit for their substantive role or they are unable to give a timescale for a full return to their role.

20.2 Discussions regarding redeployment can be very difficult for the employee as it can signify an end to their chosen career. You should arrange an employee support meeting with the individual to:

- Understand their feelings around redeployment.
- Understand whether they feel they can apply for and succeed in any available roles.
- Understand what development they may need to support them into an alternative role.
- Discuss what contractual changes redeployment entails.

20.3 Advice must be sought from People Services before an ESM is arranged to discuss redeployment and a representative from People Services will attend the ESM with you to provide support.

20.4 For further detail regarding what support can be provided please refer to section 10.

21 Ill health retirement

21.1 In most cases the support mechanisms outlined within this policy will assist in supporting an employee's health and assist their ability to attend work on a regular basis. There may however be a small number of cases where these support mechanisms are not effective in assisting employees to attend work on a regular basis or be able to undertake their substantive role owing to the severity of their condition. In these cases, Ill health retirement can be explored for members of the Firefighters Pension Scheme and the Local Government Pension Scheme only.

21.2 Should you have an individual who you believe meets the criteria to be progressed to an Independent Qualified Medical Practitioner (IQMP) or an Independent Registered Medical Practitioner (IRMP) you must contact People Services to discuss this further.

21.3 People Services will support you by arranging a meeting with you and the employee to discuss the process for ill-health retirement. They will obtain information regarding the individuals pension scheme, complete the necessary forms for OHS and ensure an appointment is arranged with an IQMP or IRMP to review the case.

21.4 If a decision is reached that an employee is to be ill health retired, you will be contacted by a colleague in People Services to inform you of this decision. As the point of contact for the individual you will be asked to inform them of the decision and let them know that they will receive confirmation in writing. The outcome letter will confirm the decision made and any rights of appeal. It is important to keep regular contact with the individual once they have been notified of the decision as they will require support in coming to terms with it. You may wish to discuss at an appropriate time how they wish for the decision to be communicated to their colleagues and whether they are well enough to attend an event to celebrate their service.

21.5 It would be useful to remind them of the support that we will continue to provide until their last day of service and support that is available after they have left the organisation.

22 Risk assessments

22.1 A health condition may result in a change of support that an individual requires.

22.2 When an employee notifies you of a health condition you will need to consider whether a risk assessment is required to understand whether there are any elements in the workplace that are likely to result in an increased risk to their wellbeing or safety. This can be done when the employee has declared a health condition and is continuing to work or, prior to them returning from sickness absence This will allow you to understand what measures you can put in place to avoid or minimise that risk.

22.3 Policy number 690 - Managing stress within LFB and Policy number 673 - Risk assessment procedure, provide further information as to how to undertake a risk assessment.

23 Medical panels

23.1 In some complex medical cases it may be necessary for you to seek advice from the Medical Panel.

23.2 If a case is to be put forward you should speak to the individual and, where possible, the Trade Union representative and update them on this process.

23.3 If the individual wishes they may provide a written submission to be considered by the panel.

23.4 The Medical Panel meet approximately every 6 weeks and is formed of representatives from OHS, General Counsel, People Services, Health and Safety and Central Operations. These panel

meetings can be used to discuss specific, complex medical cases where a view is required from all parties to determine whether an individual can remain safely at work.

23.5 The Medical Panel may also be used to provide support and advice when making adjustments and deciding whether recommended adjustments are reasonable. If you require further guidance on and how to escalate a case to the Medical Panel, please contact People Services.

24 Sickness absence triggers

24.1 When a sickness absence trigger is reached, as set out in section 12, you should consider whether it is appropriate to arrange an ESM.

24.2 If the sickness absence(s) is/are considered to be as a direct result of a disability (see section 4.3) then, as a workplace adjustment, the sickness absence trigger threshold will be doubled.

24.3 If you are unsure whether the sickness absence is as a result of a disability, then advice can be sought from Occupational Health or People Services.

24.4 The sickness absence triggers set out in 12.2 excludes any maternity related illness, short term Due to Service sickness absences or the first 10 days of a period of Covid-19 sickness absence prior to 1 June 2024.

24.5 An ESM can assist in determining whether the individual requires additional support as set out in section 14.

25 Records

25.1 Please send records by email to RecordsServices@london-fire.gov.uk. Records will be kept on your electronic personal record file (e-PRF) and retained in accordance with Policy number 788 - Electronic personal record file (ePRF) policy. Personal data shall be processed in accordance with Policy number 351 – Data protection and privacy policy.

26 Help and support

26.1 Please contact the HR Helpdesk on ext. 89100 option 3 or by email to IT.HR@london-fire.gov.uk for help, support or further information.

26.2 This policy may also be available on request in other alternative accessible formats as set out in Policy number 290 – Guidance note on translation and interpretation. Please contact Communications on extension 30753 and by email to communications.team@london-fire.gov.uk to discuss your needs and options.

26.3 The Brigade invites your engagement so that it can learn so if you have a suggestion that can improve this policy then please submit your idea via the Staff Suggestion Scheme on Hotwire as set out in Policy number 887 – Staff suggestion scheme. Any changes do need to go through the agreed engagement, consultation, negotiation or governance requirements.

Document history

Assessments

An equality, sustainability or health, safety and welfare impact assessment and/or a risk assessment was last completed on:

EIA	09/05/24	SDIA	L - 17/09/24	HSWIA	11/01/23	RA	N/A

Audit trail

Listed below is a brief audit trail, detailing amendments made to this policy/procedure.

Page/para nos.	Brief description of change	Date
Page 2 para 1 & 2 Page 3 para 3.1–3.3 Page 8 para 4.13 Page 22	Introduction consolidated into one. References to Wellworks removed. Surgical treatment for visual deficiencies added. Appendix information added within policy and appendix removed.	07/09/2023
Page 5 para 2.10 Page 8 para 3.15–3.18	Equality Support Groups updated. Tetanus vaccinations added.	10/10/2023
Page 4 para 2.10 Page 8 para 3.19 Page 10 para 5.5	Equality Support Groups list updated. Union Street gym details added. Industrial injuries disablement benefit details added.	14/11/2023
Page 5, para 2.23	Bullet point relating to fortnightly huddles that were in place during the 'lockdown' period has been removed.	15/01/2024
Page 5 para 2.10 Page 7 para 3.9 Page 7 para 3.12 Page 12 para 6.1	Military Veterans Support Group added. Workplace Adjustment passport Hotwire link added. Disability treatment leave increased to 16 days. Policy number. 396 replaced by Policy number 558.	18/03/2024
Page 3, para 1.5	Values included.	25/03/2024
Page 20, para 21.2	HR Adviser replaced with People Services.	24/04/2024
Throughout Page 21, para 25.1 Page 21, para 26.2 and 26.3	Covid 10 days sickness adjustments removed wef 01/06/24. Records Services and Data protection details added. Access to alternative policy format details and Staff Suggestion scheme details added.	31/05/2024
Throughout Page 4, para 2.8	References to other sections of the document were modified due to incorrect references being retained after previous re-drafting. Removal of references to now defunct role of 'Local Wellbeing Partners'.	10/06/2024
Throughout	Updated exclusions for sickness absence triggers to include the first 10 days of a period of Covid-19 sickness prior to 1 June 2024.	08/07/2024
Page 15, para 12.4	Updated reference to Section 3.8.	01/10/2024

Subject list

You can find this policy under the following subjects.

Freedom of Information Act exemptions

This policy/procedure has been securely marked due to:

Considered by: (responsible work team)	**FOIA exemption**	**Security marking classification**

LONDON FIRE BRIGADE

Learning support policy

New policy number:	**553**
Old instruction number:	
Issue date:	**17 January 2008**
Reviewed as current:	**29 January 2024**
Owner:	**Assistant Director, People Services**
Responsible work team:	**Learning Support and Resilience**

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1 Introduction

1.1 This policy sets out the Brigade's arrangements for the management and support of neurodiverse employees and those with learning challenges. This includes employees who have a 'hidden disability' and takes into account the overlapping nature of many of these conditions. This policy applies to all employees.

The conditions that are considered in this policy are:

- Dyslexia
- Dyspraxia or development co-ordination disorder (DCD)
- Dyscalculia
- Autism spectrum condition
- Attention deficit (hyperactivity) disorder (ADD/ADHD)

Note: This list of conditions is not exhaustive and medical conditions are supported by the Wellbeing team.

1.2 Please click on the links above for more detailed information on these conditions and please also refer to the Learning Support Hotwire page for additional support and guidance.

1.3 This policy should be applied in line with the Brigade's values:

- Service – We put the public first.
- Courage – We step up to the challenge.
- Learning – We listen so that we can improve.
- Teamwork – We work together and include everyone.
- Equity – We treat everyone fairly according to their needs.
- Integrity – We act with honesty.

2 Commitment

2.1 The Brigade makes the following commitment to neurodiverse employees and those with learning challenges:

- We will seek to support you if you have specific learning difficulties, basing the support provided on your clearly defined individual needs and evidence of learning challenges.
- We will accept the following documents as evidence of learning challenges: full dyslexia diagnostic report, full psychological assessment report; cognitive assessment report, full screening report and/or medical report.
- We will make workplace adjustments to a recruitment process for you, where you can provide evidence of your learning challenges.
- We will, where appropriate, make workplace adjustments to the training/work environment/job role to support you with a specific learning difficulty in undertaking your development, duties and responsibilities, where you can provide evidence of your challenges.

2.2 You are expected to fully engage with the following:

- Any recommended diagnostic assessment process.
- The workplace adjustments that are provided to your work environment/job role.
- One-to-one support provided by the Learning Support Advisor (LSA) and any review of the workplace adjustments provided.
- Any other interventions recommended to assist you.

3 Disclosure

3.1 You are expected to disclose your challenges to your line manager and the Learning Support Team if you require learning support. This will enable the Brigade to identify and recommend appropriate workplace adjustments in the workplace.

3.2 If you do not wish to disclose your need for workplace adjustments, it will not be possible for managers to support you. This is because the managers will have no knowledge of the need for workplace adjustments. You will be asked to sign a non-disclosure form.

3.3 Where you sign a non-disclosure form; disclosure of the disability should only occur when the Learning Support Advisor has serious concerns about your wellbeing.

3.4 Where you have reported your medical condition to a member of the Learning Support and Resilience team, Occupational Psychologist or to Occupational Health, and it is determined that a workplace adjustment is necessary, your line manager will be informed of the workplace adjustment that is required.

3.5 You will be issued with a Workplace passport identifying your workplace adjustments. You are responsible for sharing your adjustments with your line managers, the Assessment Centre and Training Department when required.

4 Legal considerations

4.1 The Equality Act (2010) and the Public Sector Equality Duty places the Brigade under a duty to make reasonable adjustments for neurodiverse employees.

4.2 Neurodiversity is a disability under the Equality Act (2010), and the Public Sector Equality Duty explains how equality principles can be integrated into the day-to-day business of public authorities including the Brigade. A person has a disability if they have a physical or mental impairment, and the impairment has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities (note: long term has been interpreted as lasting or is likely to last for at least 12 months).

4.3 Under the Equality Act (2010) it is unlawful for an employer to treat a disabled person less favourably, because of their disability. It is also unlawful for an employer to treat a disabled person less favourably for a reason related to their disability without justification.

4.4 Failure to make reasonable workplace adjustments to a provision, criteria or practice of the Brigade, or to a physical feature of a workplace which places a disabled person at a substantial disadvantage may be unlawful and cannot be justified.

5 Resources for individuals and managers

5.1 If you have made a manager aware of your learning challenges, and there are no workplace concerns, and the manager assesses that support or adjustments are not necessary, it is still advisable for the manager to contact Learning Support and consider the support measures outlined on the Learning Support Hotwire page.

6 Screening and diagnostic assessments

6.1 The Learning Support and Resilience Team will arrange for employees experiencing learning challenges to undergo an assessment.

6.2 Detailed information regarding the Brigade's screening and diagnostic process is provided on the Learning Support Hotwire page.

7 Assessment and development centre support

7.1 Learning Support and Resilience Team will recommend workplace adjustments for you. These will be outlined in your Workplace Passport. You will be responsible for advising the Assessment Centre and Training Programming that you will require workplace adjustments.

8 Workplace risk assessment

8.1 The Learning Support and Resilience team will arrange a workplace risk assessment for neurodiverse employees and their line managers. The aim is to review workplace adjustments and identify potential risks to performance and agree interventions to mitigate them.

9 Records

9.1 Please send records by email to RecordsServices@london-fire.gov.uk. Records will be kept on your electronic personal record file (e-PRF) and retained in accordance with Policy number 788 - Electronic personal record files (e-PRF). Personal data shall be processed in accordance with Policy number 351 – Data protection and privacy policy.

10 Help and support

10.1 Please contact the Learning Support and Resilience team by email to learningsupportadvisors@london-fire.gov.uk. Additional support, guidance and contact details can be found on the Learning Support Hotwire page.

10.2 This policy may also be available on request in other alternative accessible formats as set out in Policy number 290 – Guidance note on translation and interpretation. Please contact Communications on extension 30753 and by email to communications.team@london-fire.gov.uk to discuss your needs and options.

10.3 The Brigade invites your engagement so that it can learn so if you have a suggestion that can improve this policy then please submit your idea via the Staff Suggestion Scheme on Hotwire as set out in Policy number 887 – Staff suggestion scheme. Any changes do need to go through the agreed engagement, consultation, negotiation or governance requirements.

Document history

Assessments

An equality, sustainability or health, safety and welfare impact assessment and/or a risk assessment was last completed on:

EIA	28/05/24	SDIA	**H** – 10/08/23	HSWIA	11/08/23	RA	

Audit trail

Listed below is a brief audit trail, detailing amendments made to this policy/procedure.

Page/para nos.	Brief description of change	Date
Throughout	This policy has been rewritten, please read to familiarise yourself with the updated content.	23/08/2012
Page 19	Subjects list and Freedom of Information Act exemptions tables updated.	03/02/2015
Throughout	This policy has been reviewed as current, please re-read to familiarise yourself with the content.	28/10/2016
Throughout	Further amendments made following review, in particular to the appendices. Please re-read to familiarise yourself with the content.	17/11/2016
Throughout	References to Development and Training department now changed to People Services.	10/04/2018
Throughout	This policy has been reviewed as current with minor changes made throughout. Please re-read to familiarise yourself with the content.	07/06/2019
Throughout	This policy has been reviewed throughout, please re-read the content to familiarise yourself with the changes.	30/07/2019
Appendix 1 paragraphs 12 and 20	Specification of diagnostic tests and cases that may be referred	16/08/2019
Page 24	SDIA and HSWIA updated.	17/08/2023
Throughout	Reviewed as current with minor amendments made. Appendices added to Hotwire.	29/01/2024
Page 2, para 1.3 Page 4, para 7.1	Values included. Workplace adjustment passport Hotwire link added.	25/03/2024
Page 4, para 9.1 Page 4, para 10.2	Data protection details added. Access to alternative policy format details added.	24/04/2024
Page 4, para 9.1 and 10.3	Records Services and Staff Suggestion scheme details added.	10/06/2024

Subject list

You can find this policy under the following subjects.

Learning support	Dyslexia
Equalities	

Freedom of Information Act exemptions

This policy/procedure has been securely marked due to:

Considered by: (responsible work team)	**FOIA exemption**	**Security marking classification**