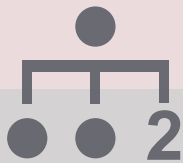


Sexual Safety Collaborative

Standards and guidance to improve sexual safety on mental health and learning disabilities inpatient pathways



NATIONAL
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MENTAL HEALTH

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Preface: Ensuring sexual safety under extraordinary circumstances

We are living in extraordinary and uncertain times. Everyone has had to make drastic changes to how they live and interact because of the COVID-19 pandemic, including in the delivery of health and social care in England. Throughout these challenging circumstances, keeping people sexually safe must remain a high priority.

The sexual safety standards should be upheld regardless of the current global, national or local circumstances.

The sexual safety standards outlined in this document exist to enable safer environments for people. Operational procedures or guidance that have been developed or are in place to support the delivery of care during COVID-19, should complement the sexual safety standards, not undermine them.

Services will need to be supported by strong leadership to face the challenges of maintaining sexual safety while the global pandemic continues.

Services will need to consider a range of challenges, including:

- Managing the demands and uncertainties brought about by COVID-19, and meeting the needs of each **person** in a **trauma-informed** and person-centred way.
- The different ways of training and educating staff, and of remote working with the wider multidisciplinary team.
 - Ensuring that **people** have digital access, to remain connected with their families, friends and social networks.
 - Considering how an increase in people's digital use can lead to additional vulnerabilities or potential problems with sexual safety.
 - The impact personal protective equipment (PPE) may have on the ability to develop therapeutic relationships with people, to identify distress, engage in non-verbal communication, and the potential for **re-traumatisation** from staff wearing PPE.
 - How different ward structures (for example infection wards, shielding wards) will impact the location in which people receive care.
 - Use of physical space, with consideration of the whole environment in which care takes place, how people occupy their space and using external spaces more effectively.
- The additional pressures on NHS staff and staff from external organisations because of the COVID-19 pandemic, and on their ability to provide appropriate support.

Many of the terms used in this guidance have been defined in a glossary at the end of the document. In the guidance, each glossary term is in **pink bold text** when it is first used, and can be clicked on to take you to the definition of that term.

Addressing these challenges will not be easy. Services should be supported to find local solutions to these challenges that are **co-produced** with people who use services and adhere to the sexual safety standards and guidance.

Ensuring **sexual safety** while managing the impact of COVID-19 will be challenging. It is important that services can share their learning around what works and what does not, which is one of the aims of the Sexual Safety Collaborative (see [Section 2](#)).

The following case example outlines some of the ways the Ruby and Ivory Wards, who are part of the Sexual Safety Collaborative, are facing the challenge of ensuring sexual safety during COVID-19.

Case example: Ruby and Ivory Wards (East London Foundation NHS Trust)

Ruby and Ivory Wards are a unit from East London Foundation NHS Trust. At the start of the COVID-19 outbreak, they were required to turn the Ivory Ward into a COVID-19 ward. Inpatients on Ivory Ward were moved to Ruby Ward, which became a mixed-sex ward for initial assessment and monitoring for the national lockdown period (March to July 2020). This situation presented challenges for staff and service users, and increased anxiety about ensuring sexual safety, as well as how they could maintain the work they had been doing with the Sexual Safety Collaborative.


The ward team were determined not to compromise the sexual safety standards. They screened every new service user coming onto the ward to establish history and risk, and responded quickly to any concerns raised or incidents of sexual safety, moving people from the ward rapidly if necessary. Importantly, they continued to adhere to the Ward Charter on Sexual Safety and to maintain the expected standards of behaviour. They also collected data on feelings of safety on the ward and people's ability to talk to someone if they did not feel safe. They kept sexual safety as a standing item on their community meeting agenda, despite having to make significant changes to how they ran community meetings to adapt to social distancing.

The desire to keep sight of and continue their work on improving sexual safety, despite the significant changes to how they were required to operate, demonstrated an impressive level of commitment to the sexual safety standards and importance of the work.

For further information, contact:

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Alice Phillips, Clinical Nurse Manager, Ruby Triage Ward; Email: alice.phillips3@nhs.net

A decorative border at the top of the page consisting of a grid of overlapping diamond shapes in various colors including teal, orange, pink, and purple.

Supporting statement



Amy Herring,
Expert Reference
Group co-
chair, Expert by
Experience; Lead
Governor, Sussex
Partnership NHS
Foundation Trust;
National Adviser
in Children and
Young People's
Mental Health

I am pleased to see the publication of the incredibly needed guidance and standards to address sexual safety in mental health, autism and learning disability inpatient settings. It gives me confidence knowing that they were co-produced among a diverse range of backgrounds and experiences to ensure multiple perspectives and ideas were captured in the formation of the standards and guidance.

It does not matter whether you are an individual using the services, working as a member of staff, or visiting a loved one, no one should be subjected to sexual incidents or feel unsafe in their environment. We all need to continually learn from when incidents and mistakes take place; we all need to build a safe environment where we can continue communicating and exploring our understanding of healthy relationships, sex and what safety means for individuals; and we all have a responsibility to create and maintain a culture of safety which allows people to speak up if they feel unsafe, and be able to disclose sexual incidents without fear of humiliation and embarrassment.

Finally, it should be reminded to all that we have heard numerous times that 'sexual safety incidents are common on mental health wards' – sexual incidents have no place within mental health wards, and particularly within our wider health and care system. Every person, whether inpatient, staff or visitor, has the right to be treated with dignity and respect. The physical, psychological and emotional safety of any individual should always remain a concern and be upheld as a priority – even during a pandemic.

Executive summary

A **sexual safety incident** can happen to anyone, of any sex, sexual orientation or gender identity. Such an incident can cause significant lasting distress to the person, and have a negative effect on their recovery and long-term outcomes.

In 2018, the Care Quality Commission (CQC) found that 1,120 sexual safety incidents (out of nearly 60,000 reports) occurred over a three-month period across NHS trust mental health wards, affecting not only service users but also staff and visitors.¹ To address these findings and respond to the recommendations for improvement, NHS England and NHS Improvement (NHSE/I) commissioned the National Collaborating Centre for Mental Health (NCCMH) to develop standards and guidance on improving sexual safety in inpatient environments. NHSE and NHSI also established a national quality improvement (QI) Sexual Safety Collaborative. The Sexual Safety Collaborative will run until 2021, supporting inpatient mental health teams in NHS mental health trusts to embed these standards and improve ward sexual safety.

The sexual safety standards are applicable to **all people within the inpatient environment** and can be used to keep everybody safe: those receiving care, staff and visiting staff, families, friends and visitors.

The standards and guidance should be read with these four key principles in mind:

1

People's rights. Everyone has the right to be safe from sexual harm, and to feel safe and supported on a ward. People of legal age to consent also have a right to have a safe and **age-appropriate** relationship with another person, to express their sexuality and to have their personal sexual needs met, such as through masturbation in private. Organisations should have the right structures in place for staff to understand these rights, and support people to meet their needs safely (though not to engage in **sexual activity** with another person on hospital premises). This is especially important for people who are on an inpatient ward for a long time.

2

Organisational responsibility. Organisational responsibility, commitment and leadership is crucial to ensuring that all people in inpatient settings are safe from sexual harm. Sexual safety needs to be supported at every level of the organisation, to make sure that the right support and structures and resources are in place to enable the standards to be implemented.

3

Trauma-informed approach. Organisations that use a trauma-informed approach aim to acknowledge and understand any previous trauma a person may have experienced, and how it has affected them in the past and present. Being on an inpatient ward can itself be a traumatic experience, so action should be taken to provide a physical environment that is conducive to sexual safety. Care should be delivered in a way that makes people feel physically and psychologically safe without inadvertently traumatising or re-traumatising people.

4

Safeguarding. Safeguarding and sexual safety are system-wide responsibilities. The safeguarding and sexual safety of people within inpatient settings is the responsibility of **all staff**. These sexual safety standards must be integrated into each organisation's safeguarding policies and practices, as well as the organisations following their statutory duties over the sexual safety of the people in their care.

Additional general principles are that:

- people are encouraged to voice their needs or concerns at any time
- staff are made aware of how they can immediately access support from other members of staff if they need it, particularly if they have safety concerns
- while some groups of people might appear more vulnerable than others, individuals may still have the capacity to make decisions about their care. Judgements over capacity will be made in line with the [Mental Capacity Act 2005](#).



How to navigate this document

This document contains guidance and recommendations for care that encourage practical changes to inpatient service delivery in mental health and learning disability care settings.

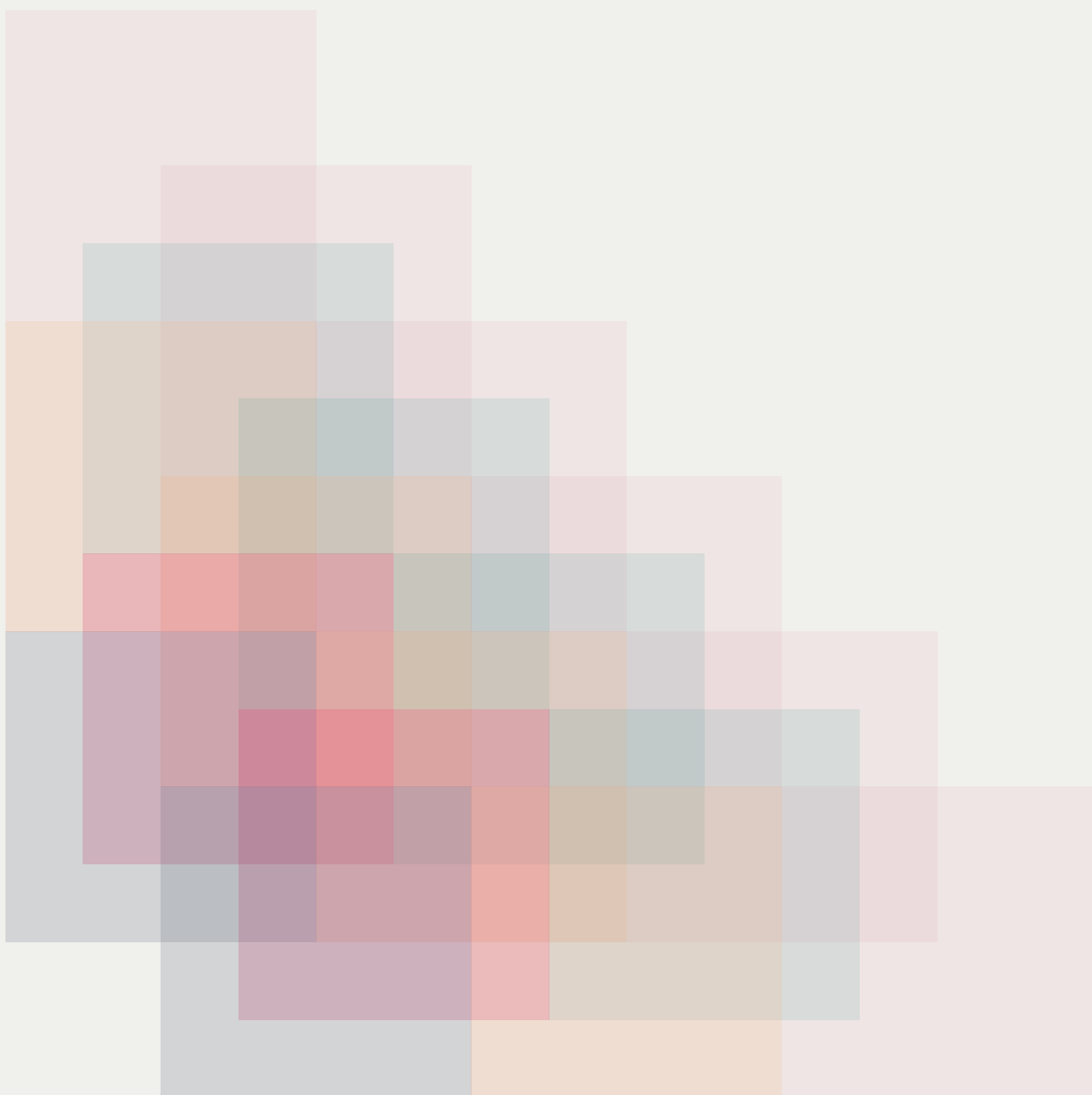
Part 1 contains the 26 standards in full, with an overview of the standards, who they apply to and who they can be used by.

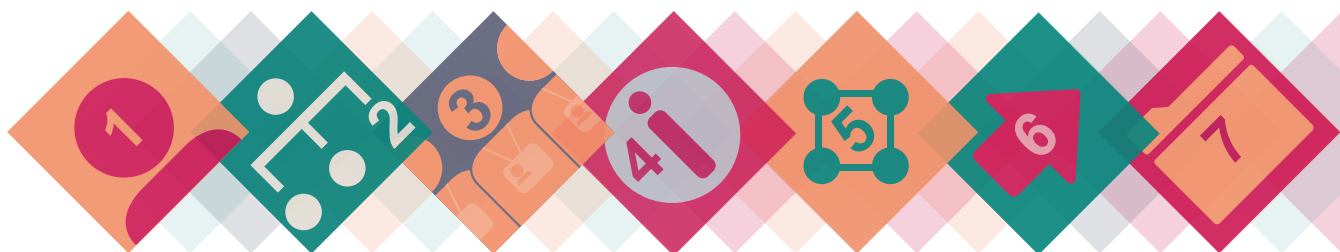
Part 2 contains:

- the context, background and development of the standards
- guidance on implementing the standards (including expectations of staff and the role of the police in a sexual safety incident)
- service scenarios (examples of how the standards might be applied in practice)
- examples of positive practice from services
- a list of resources, with links
- the members of the expert reference group (ERG).

Part 1: Sexual Safety Standards

- An overview of the sexual safety standards
 - Who the standards are for
 - About the standards
- Domains 1 to 7
 - The full list of 21 standards grouped into 7 domains





Overview of the sexual safety standards

Who are the standards for?

These sexual safety standards can be used by staff in inpatient services that provide care for people of all ages and genders with mental health problems, learning disability and/or autism diagnosis as their primary presenting problem, and by commissioners and providers .

They refer only to inpatient assessment and treatment services^a – not residential settings. This includes inpatient pathways for:

- acute mental health
- children and young people's mental health
- eating disorders
- forensic mental health
- learning disability
- mental health rehabilitation
- older adult mental health
- perinatal mental health
- psychiatric intensive care units (PICUs).

The QI programme is currently only open for NHS wards, but these standards are also relevant for inpatient services in the private sector in England.

The standards are applicable to all relevant inpatient environments, including single- or mixed-sex wards, communal areas and outdoor spaces, and to all staff working in these settings.

The standards can also be used by services in Wales, Scotland and Northern Ireland, but differences in legislation (see [Section 4.3.8](#)) and legal definitions may affect the applicability of some of the standards.

Finally, promoting sexual safety is equally important in outpatient and custodial care settings and, while it is hoped that these standards and guidance will be relevant, further work may be required to address the needs of service users and staff in these settings.

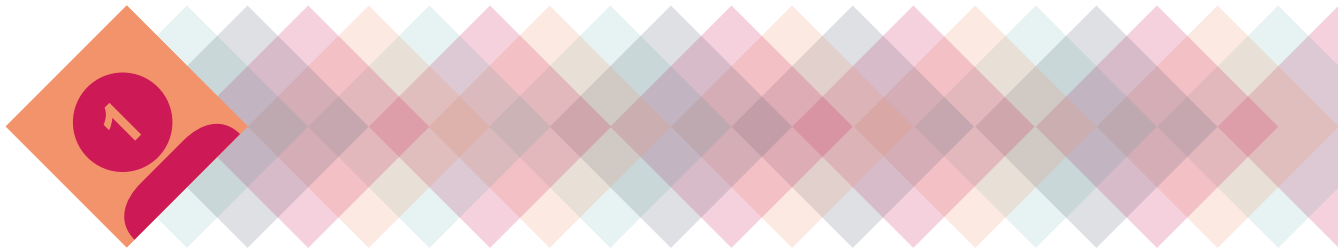
About the standards

The standards were co-produced with people with experience of inpatient care, staff who work in inpatient settings and other experts in the field of sexual safety.

There are 26 standards, grouped into seven domains. Each standard has corresponding guidance and expected outcomes.

[Section 6](#) contains fictional service scenarios to demonstrate how the standards can be applied in practice. There are links to the scenarios from relevant sections in Part 2.

^a In the standards and guidance, an inpatient setting refers to a mental health or learning disability service that is designated as a hospital (including settings that may be located in the community rather than on hospital grounds), where people receive 24-hour nursing care and have access to a multidisciplinary team, with oversight from a consultant psychiatrist.



Domain 1: Understanding and responding to the needs of the individual

1.1

The needs of each person are understood and responded to.

- Meeting the needs of the service should not compromise the safety of the person.
- Care and support are provided in a culturally competent way that is attentive to each person's needs, and to their level of risk of experiencing inequalities in terms of their sexual safety.

Note:

Staff will need to recognise and understand the complexity of this issue to balance meeting the requirements of the service and the sexual safety needs of the person.

1.2

Care and support are provided following a trauma-informed approach. The care environment and daily interactions ensure a person's physical as well as **psychological safety**.

- Each person is cared for or supported in a service that takes a trauma-informed approach and focuses on each person's needs and strengths. People are cared for in a way that takes into consideration their previous and current experiences and relationships, the trauma they may experience because of their mental health problems and the impact these have on their wellbeing.
- Staff explain to, and discuss with, the person how information about them will be shared – when information might be shared, what kind of information will be shared, who with and for what purpose.

Potential outcomes:

Benefits of working in this way include creating safer environments for people, their families, **carers** and staff; reducing the possibility of re-traumatisation; improving the overall quality and experience of care and support; ensuring that care is rights-based; reducing restrictive practices^b; improving people's engagement with the service and helping the person to feel that they have a choice around their care.

Further detail:

See [Section 4.3.1](#) and [Section 4.3.2](#)

^b Reducing restrictive practice (RRP) is the focus of another national QI collaborative run by the NCCMH from 2018 to 2021, also in the MHSIP programme. See the [RRP Collaborative web page](#) for more information.

1.3

Sexual safety is considered on an individual basis in the context of past trauma, past relationships and experiences. The outcomes of these conversations are documented and inform the person's care plan; the plan is regularly reviewed.

- Each person has a conversation to explore what makes them feel psychologically safe. Staff are competent to routinely ask relevant questions of people's past or current experiences of violence or abuse in a kind and sensitive manner.
- If people initially choose not to engage in discussions related to sexual safety, staff give them time and support to find the appropriate opportunity and/or person to have these conversations with rather than assuming that they do not want to engage.
- Staff are aware of how a person's age, social, cultural and religious factors can affect their perception of sexual safety and sexual behaviour, and modify their approach and style of discussion to meet their needs and level of understanding.
- Staff are aware of how having a learning disability or autism diagnosis can affect a person's perception of sexual safety and sexual behaviour, and modify their approach and style of discussion to meet their needs and level of understanding.
- Staff consider how to support a person to feel comfortable and safe during this conversation. This might include considering the location (to minimise distractions and external noise) and timing (on admission or at another time when the person feels more comfortable).
- Staff are familiar with the person's care records and care plan, so that any previously recorded disclosures are approached with sensitivity and understanding, rather than the person having to disclose their experiences or trauma again.
- Staff ensure that diagnostic factors, symptoms or admission status do not overshadow any distress or concern a person may have regarding sexual safety.
- If staff members or visitors on the ward wish to have conversations around sexual safety in the inpatient environment, the same considerations are given to them. Any agreed actions and plans are documented and brought to the attention of ward or service managers.

Note: Staff have a duty of care to ask all adult service users about their experience of violence and abuse in a safe, kind and sensitive manner, in line with [National Institute for Health and Care Excellence \(NICE\) guidance](#) and [Department of Health policy](#). Given the high prevalence of trauma in people accessing mental health care, **routine enquiry** by clinical staff has a crucial role to play in the recognition of any abuse and the provision of appropriate support.

Potential outcomes: Knowing what makes each person feel safe and unsafe, and their triggers, can contribute to a better understanding of how to provide person-centred, individualised care and support. It may help to avoid situations that could traumatise or re-traumatise the person.

1.4

The service establishes what makes people feel safe, including from sexual harm, and determines priority actions to address these needs.

- People are given the choice of staying on a single-sex or mixed-sex ward,[°] and this can be used to facilitate discussion around privacy, dignity, personal space and safety. They should have a say about who is involved in their care and support (including the sex of their care coordinator or named member of staff, where possible). These choices need to strike the necessary balance between giving privacy and maintaining safety.
- People are involved in every conversation where decisions are made about their care and/or support, so that these are made collaboratively. They are given as much information as possible to help them make an informed decision around what can help them feel safe. People can involve their family members, friends, carers or advocates in these discussions.
- An existing [advance statement](#) outlining the person's preferred treatment options should be honoured, especially if the person's ability to make informed decisions is being influenced by their current mental health state. This is particularly pertinent when considering the person's preference for a single-sex or mixed-sex ward. When no longer in crisis, staff will discuss with the person whether to update (or create) their advance statement.

1.5

People have clear access to a named member of staff or dedicated specialist services that can offer support or advocacy for concerns of a sexual nature.

- All people are made aware that this option exists and that they will be supported to access advocacy if they need it.
- Staff are aware of services with sexual support expertise and advocacy so that they can assist people to access these.
- Time and space are given for external advocates to come to the inpatient environment.
- People receiving care, staff and visitors are supported to access external advice (which would be anonymous, if they wish) or make disclosures around sexual safety, particularly if they are concerned that speaking to someone on the ward may negatively influence their care or the relationships with other staff.

[°] For some wards, finding available beds and thus offering choice can be difficult. Commissioners and providers should work together to review the local need for inpatient services and ensure that there are sufficient beds available on local single-sex wards for service users who request them. It should also be noted that most inpatient services for children and young people are mixed-sex, so providing choice around admission to a single-sex ward may not be feasible in many areas.

Potential outcomes:

Having named individuals may lead to improved reporting and faster responses to concerns, incidents or requests for advocacy. There will be someone available who is competent to respond to a disclosure, is familiar with the legal procedures that follow and can provide trauma-informed support.

There may be online databases of local services (though the quality of the databases will vary), including sexual wellbeing support and advocacy services for diverse populations (children and young people; older adults; people with a learning disability; autistic people; people from Black, Asian and Minority Ethnic [BAME] communities; people from lesbian, gay, bisexual, transgender, queer and other [LGBTQ+] communities; people with sensory impairments). This may also include services for staff who have been directly affected.



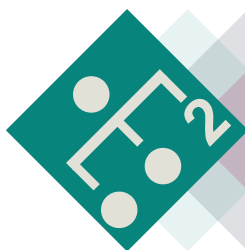
1.6

The physical aspects of the ward environment are regularly reviewed and plans are established to address any identified risk areas.

- Environmental and contextual factors that may increase the risk of a sexual safety incident, or that might inadvertently cause unnecessary distress, are identified and addressed, and preventive measures are put in place. This could include high-risk locations or certain times of day, taking into consideration everyone who uses the space (service users, staff and visitors).^d
- Points of elevated risk are identified and acted on. If needed, modifications are made to service delivery that are co-produced where possible, more supervision is provided in communal areas and clearer routes of access to support from staff are created. This plan is regularly reviewed and updated.

Notes: Approaches to identify and manage risks in the physical environment can also be used for the assessment and management of sexual safety. For example, assessing visibility in the physical environment for the prevention of self-harm² (for example, blind spots on the ward) alongside the patient profile and compensating factors (such as staffing levels and skills), would be applicable for reducing risks to sexual safety.

^d High-risk locations may include outdoor areas, communal spaces or smoking areas, and high-risk times might include escorted leave, when staff are less visible (for example, when they are in the office) and when there is an increased movement of people (for example, at meal times). Instances that could cause distress include spaces on single-sex wards where service users might encounter someone of the opposite sex (for example, when accessing medication or to speak with a specific member of staff).



Domain 2: Improving organisational culture

2.1

An atmosphere is encouraged where people feel comfortable talking in an age- and culturally appropriate way about sexual safety, relationships and sexual behaviours.

- Age- and culturally appropriate discussions on sexual safety are embedded into existing processes (such as admission, care planning and other health checks or assessments) and are made part of regular supervision for staff. These discussions take into account the different levels of understanding of sexual safety people may have, and the conversations are tailored to meet the needs of those participating.
- Sexual safety is a regular item on the agenda at team meetings and at inpatient community meetings, to encourage open discussion among staff and service users and facilitate shared learning and reflection. Service managers and ward leaders support these discussions.
- Staff have relevant training and supervision if they find it difficult to engage in conversations about sexual safety. This takes into account any religious or cultural beliefs or preferences that could affect their ability to engage with people.

Potential outcomes:

Support and encouragement from team leaders to engage in conversations about sexual safety will help empower staff to raise concerns or report sexualised comments or behaviour from colleagues towards service users, visitors or other members of staff that may otherwise have gone unnoticed or unreported (see [Section 4.3.14](#)).

2.2

A change in organisational culture around improving sexual safety is supported at every level of the organisation, to proactively uphold the sexual safety of all people within the inpatient environment.

- Sexual safety is included as a potential risk on the organisation's health and safety plan and risk assessments, to ensure it is given due consideration.
- Sexual safety is on everyone's agenda, to encourage collective ownership. An executive board member has overall responsibility for improving sexual safety, while clinical leaders lead by example and consider the attitudes and values needed to implement and sustain change. Service leads listen, welcome, foster and sustain a culture that embraces change and supports flexibility to implement change.

Potential outcomes: Embedding change at every level means that leaders make staff feel supported and empowered to implement change in their service and in their daily interactions with the people who use it. Involving human resources or occupational health departments in this change will help ensure that appropriate staff support and response structures are in place when staff are involved in a sexual safety incident. The CQC recommends that trusts nominate an executive board member to hold overall responsibility for ensuring that approaches to improving sexual safety are embedded within all services for which the trust is responsible.¹ Sexual safety or trauma-informed training may be required, depending on the person's experience in this area.

2.3

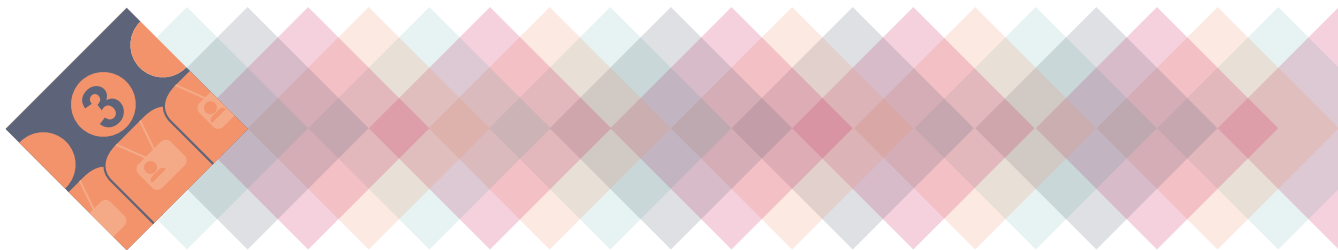
Learning from previous sexual safety incidents and examples of successful approaches to ensuring sexual safety are embedded in organisational practice.

- Following a sexual safety incident, aside from meeting with the people directly involved, support is offered to others using the service including visitors. This will ensure that everyone has the opportunity to voice concerns or offer suggestions for service improvement.
- Staff and service managers work with the people directly involved to reflect on possible areas for improvement, and highlight concerns and discuss preventive strategies to avoid similar incidents occurring in the future. Positive aspects of practice are discussed, to share learning and support staff in their professional and personal development.

Note: It may be useful to establish a local (for example, ward-, unit- or trust-wide) sexual safety forum for staff and service users to voice suggestions for continuous improvement, or introduce a knowledge management system to track lessons learned over time.

Potential outcomes: By promoting a service culture that encourages learning from any previous sexual safety incidents and **near-misses**, future incidents can be prevented and any examples of good practice can be embedded into the delivery of care.

Being transparent about having a learning culture is likely to demonstrate the service's dedication to improving overall safety and foster improved, trusting relationships between people who use services and those who deliver care.



Domain 3: Staff: training, support and skills

3.1

Staff are accessible for people at all times; they have the competence and can take time to build therapeutic relationships that meet the needs and safety concerns of people who use or work in the service.

- People can contact staff when they need to, at all times (see [Standard 1.6](#) for conducting environmental risk assessments and staff requirements). There are clearly defined ways to immediately access staff or get their attention, such as alarms, which are made known to all people on the ward, including visitors.

Note: Services may need to evaluate and adjust their staffing levels and resource requirements to meet this standard.

Potential outcomes: Improved visibility of staff may help people feel safer. More staff presence may reduce the number of incidents of a sexual nature, can facilitate quicker responses to incidents, and can improve staff members' awareness of signals or triggers for people on the wards. This allows staff to adjust care accordingly, and can improve relationships between staff and service users.

3.2

Co-produced training on sexual safety, trauma-informed care and responding to incidents is provided to all staff

- Training instils values, knowledge and skills concerning sexual safety. It is tailored to the needs of staff and the ward environment, and includes:
 - definitions and terminology around sexual safety
 - consideration of individual, social and cultural variations in interpretations and beliefs related to sexual behaviours, age and developmental age, acknowledging **unconscious bias**
 - how to ask relevant questions and use appropriate approaches to help people disclose their past or current experiences of violence or abuse
 - how to action and escalate sexual safety concerns or respond to incidents involving service users or staff
 - how to provide support or access to support for people who raise concerns about sexual safety
 - understanding how sexual safety concerns or incidents may affect families and carers.
- Key training delivery is co-produced with people who have experienced inpatient care, to ensure that it is relevant and that it is practical for staff.
- Training is provided to all staff working in the inpatient environment.

Note: Training needs to be tailored to the setting and the needs of the people being supported, for staff to effectively support their sexual safety. For instance, a children and young people's inpatient service should provide training relevant to adolescence and sexual development, including gender identity and exploration of sexuality.

Further detail: See [Section 4.3.7](#).

3.3

Supervision to improve practice around sexual safety is mandatory for all staff.

- Discussions about sexual safety are embedded into routine supervision sessions as part of trust policies.
- Teams hold multidisciplinary reflective practice and offer group supervision, to facilitate shared learning.

Potential outcomes: Regular one-to-one supervision (or, in some situations, group sessions) offers an opportunity for staff to improve their practice around sexual safety and voice personal concerns in a supportive environment. Supporting staff to access high-quality supervision is likely to improve reporting, encourage reflective practice and foster their confidence in responding to incidents effectively and efficiently.

Further detail: See [Section 4.3.6](#).

3.4

Clear support procedures are in place for staff who are directly affected by a sexual safety incident.

- High-quality mental health support (either independent or in-house) is available and accessible to staff who are directly affected by a sexual safety incident on the ward, or who are experiencing difficulties following a previous sexual safety incident.
- Support includes a time-appropriate conversation led by someone with specialist skills in sexual safety, with explicit discussions about staff wellbeing and the impact of the work, and follow-up support as required.

Potential outcomes: By offering staff access to immediate support following an incident, long-term staff wellbeing is also likely to improve, contributing to a more positive and supportive care environment.



Domain 4: Access to resources, information and education on sexual safety

4.1

A clear, co-produced, age-appropriate ward agreement is produced based on the sexual safety standards.

- The agreement is clearly defined, rights-based and outlines acceptable and unacceptable behaviour for all people in the inpatient environment.
- The agreement is available to everyone on the ward and regularly updated to reflect any service or policy changes.
- The agreement is shared with individuals at a time that is appropriate to them. Accessible information is available (for example, easy read, large print, Braille or audio versions) for people with a learning disability or sensory impairment, and in the appropriate language for people who have limited English language proficiency.

Potential outcomes:

Clear information gives every person in the ward environment a defined, shared understanding of acceptable and unacceptable behaviour. Access to this information is likely to empower individuals to report anything that violates the agreement. ([Appendix A](#) for an example ward agreement.)

4.2

Everyone is supported to access age- and culturally appropriate information and education around sexual wellbeing and healthy sexual relationships.

- Information is presented in the most appropriate way for communities and individuals (digital notice boards in communal areas, notice board reminders, posters, leaflets) and is clear and understandable.
- People of legal age to consent who are receiving care, as well as staff and visitors, can access education or resources on key aspects of sexual health and relationships relevant to their individual needs and level of understanding. The resources have definitions and information on consent and capacity for age-appropriate sexual activity, and are delivered in a way that is sensitive to social, cultural and intersectional factors.
- Some people may have been desensitised to certain sexual behaviours as a result of abuse or trauma, and they may need support to redefine their perceptions of sexual wellbeing.

Potential outcomes:

Promoting sexual health and wellbeing will give legally consenting people a greater understanding of healthy sexual relationships and consensual sexual activity. It can also further normalise conversation around sexual wellbeing and empower people to make informed future decisions about their sexual experiences.

Further detail:

See [Section 4.3.9](#).



Domain 5: Multi-agency working and collaboration

5.1

Relationships are built and maintained with all organisations that can provide independent support following a sexual safety incident, and ongoing support once the person returns to the community.

- Expert knowledge of specialist organisations, which may have a better understanding of additional needs following a sexual safety incident, is embraced.
- Working relationships are built with statutory and non-statutory organisations (including peer support and advocacy services, police, sexual assault referral centres [SARCs], safeguarding, community teams, domestic and **sexual violence** support, genitourinary medicine and sexual and reproductive health clinics^e) to better understand the capacity of these services and make sure that people can receive immediate and ongoing support.
- If an affected person, including a staff member, is receiving care out of area, they are given an option to engage with services in their home area, to support continuity of care.

Potential outcomes:

Setting up and maintaining high-quality working partnerships with local voluntary, community and social enterprise (VCSE) organisations can help improve overall individual experience, including experience following discharge. Establishing a clear, accessible and up-to-date list of community services gives people options about where they receive support. It is important that such a database is maintained and kept up to date. A multi-agency approach may also facilitate follow-up to historical sexual safety incidents, which may be particularly relevant to individuals who experience delayed harm and experience further distress once they return to the community.

Further detail: See [Section 4.3.10](#).

^e These services will offer confidential, independent support that might not otherwise be available and can enhance access to sexual health screening and post-exposure prophylaxis (PEP).

5.2

Dedicated local sexual safety champions^f are in place on each ward to establish and maintain relationships with local organisations.

- At least two named staff members per ward (with appropriate training and experience) are sexual safety champions who can build rapport with local organisations.
- Shared learning events or collaborative training programmes are encouraged between the organisations.

Potential outcomes:

A dedicated sexual safety champion can be a point of contact for advice, information or quick action, and can help promote seamless care between multiple agencies. Working with the police may help the whole force increase their understanding of sexual safety in mental health care settings, leading to more person-centred and compassionate post-incident approaches.

5.3

All stakeholders who are involved in responding to an incident work to the same definitions, terms and response approaches.

- Key approaches and procedures concerning sexual safety are determined collaboratively between people who use services, staff, clinical leaders and third-party stakeholders. Staff and people who use services have the opportunity to test the planned approaches and procedures in the clinical environments.
- A memorandum of understanding between all organisations is developed to ensure a joint-working agreement for the use of these definitions and terms.^g
- Terminology and language around sexual safety are respectful and carefully considered. They remain consistent when responding to sexual safety incidents, whether the person directly affected is a service user, staff member or a visitor, with a flexible approach based on the person's needs and communication abilities.

Potential outcomes:

Through collaboration, policies and procedures will be shaped by relevant experience and reflect expert opinion, leading to a more pragmatic, person-centred and user-friendly approach. A shared understanding of the key definitions and terminology around sexual safety among the key stakeholders will lead to more consistent care.

^f Champions in mental health raise awareness, challenge stigma and provide peer support. It can be general or, as in this guidance, specific to one area of mental health.

^g NHS Improvement have produced guidance on drafting a [memorandum of understanding](#).



Domain 6: Responding to a sexual safety incident

6.1

Clear policies and procedures are in place around responding to sexual safety incidents.

- All staff have access to clear policies and procedures detailing:
 - How to respond to sexual safety incidents of varying severity (and those that have occurred outside office hours), and disclosure of a historical sexual safety incident.
 - The immediate response actions, who to involve (including liaison with the police), how to advise people about their options and next steps (for example, what actions may affect the integrity of forensic evidence in advance of an investigation), and how to provide follow-up support for those directly affected (including staff members, and those against whom a false accusation has been made).
 - The appropriate timeframes for reporting an incident, how to complete an incident report form with the person and how to keep them informed about future actions taken to ensure their safety.
 - Staff and organisational responsibilities for safeguarding and their legal duties to raising concerns for adults with care and support needs, and children and young people, under the [Care Act 2014](#) or the [Children Act 1989](#) and the [Children Act 2004](#).
 - Professional boundaries between staff and service users and what staff can expect to happen if they breach these boundaries or are knowingly involved as an **initiator** in a sexual safety incident, including policies around investigation, suspension and dismissal.
- These procedures are regularly reviewed and updated; they are brought to staff's attention during induction and regular training.
- Policies are shared with necessary external organisations, such as support and advocacy services for sexual wellbeing.

Potential outcomes:

Providing clear, instructional and culturally sensitive information will lead to an efficient response to incidents, increase uniformity in responses and minimise the possibility of personal bias, unconscious bias or mistakes because of variation in staff working practices. Co-produced flow charts or step-by-step diagrams to outline these processes can also be helpful.

6.2

People are listened to, validated and supported when any disclosures of sexual safety incidents arise.

- All disclosures are taken seriously and investigated consistently. When someone discloses a sexual safety incident, they are not told the allegation is untrue or that they are not believed.
- Inconsistent and non-chronological trauma narratives³ do not cast doubt on a disclosure or a person's experience.
- Staff reassure the person who has been directly affected that they are not to blame and that talking to someone is the right thing to do.
- After the disclosure, due process is followed to investigate it and ensure that the person or people accused is/are given the same opportunity to discuss their perspective of events as the disclosing person.

Potential outcomes:

It takes courage for a person to talk about a sexual safety incident they have been affected by. Believe their distress, allow them to express their level of distress and harm in their own words, and trust in the formal investigative process. Simple actions following an incident – such as actively listening without judgement or disbelief, providing a safe environment and offering support – will facilitate a more open, trusting atmosphere and may improve reporting of any future incidents.

6.3

Personal characteristics, mental health diagnosis and symptoms do not overshadow the sexual safety incident or the harm, either psychological or physical, that it may cause to the person.

- In line with the [Equality Act 2010](#), a person's personal characteristics or circumstances are not used to cast judgement on them, overlook a disclosure, minimise the effects or devalue the distress of an incident. However, these characteristics can give a useful context to better understand their experience of the incident and any subsequent needs.
- Staff remain aware of any potential biases or judgement which may influence how they respond to different people and communities.
- Any identified biases are considered and managed through multidisciplinary teamwork and supervision.

Note: Seeing the person for who they are rather than through their diagnosis is integral to person-centred care. It ensures that people can access the most appropriate support to meet their needs at the time they need it. This applies to people who have been admitted to hospital under the Mental Health Act or voluntarily.

6.4

Access to support is provided as soon as is appropriate to anyone who has been affected by the sexual safety incident, in line with their agreed care plan or staff support policy.

- Support is offered to all people involved in the sexual safety incident, including the person directly affected, the accused person, and any witnesses, bystanders and staff.
- Support is provided following the principles of **trauma-informed care** and in line with the person's agreed care plan, with due consideration to psychological as well as physical harm.
- There is no delay to accessing support and it is provided as soon as the person feels it is appropriate or as stated in their care plan.
- If appropriate, support continues following discharge.
- If a person is dissatisfied with the way an incident has been handled, they are supported to access alternative independent help.

Potential outcomes:

Providing support at a time appropriate for the person affected ensures that it can be more individualised and can allow time for any delayed effects of harm to become apparent.

6.5

Sexual safety incidents that reach the threshold of investigation are dealt with within the timeframes set out in the relevant safety incident framework.

- Sexual safety incident case reports do not remain open indefinitely but are reviewed within the timeframes of the relevant safety incident framework (the NHS [Serious Incident Framework](#), until the [Patient Safety Incident Response Framework](#) currently in development is introduced) and within the trust's serious incident procedures until a conclusion has been reached.
- Open cases are reviewed collaboratively with the person directly affected at regular timepoints. Other people involved in incidents under investigation are regularly updated about the progress.
- Appropriate steps are taken to ensure the decision to close the case is made when the person involved is satisfied that this should be done (though we acknowledge that this may not be possible, and this should be made clear to the person).
- Retractions are systematically followed up, to guard against a disclosure being retracted because of feelings of self-blame, reluctance to endure post-incident procedures or experiences of re-traumatisation.
- Appropriate additional support is provided during the investigation, to address its impact on the mental health of the person directly affected, and on any witnesses bystanders or staff.

Note: The timeframe for each case will differ, affected by factors such as the affected person's capacity at the time of the investigation. It is important to remember that robust investigations require adequate time and expertise.

Potential outcomes:

Regular reviews of any open cases allow the person to process what has happened, make sense of the situation and for potential delayed effects of the incident to surface. They also ensure that the true impact of the incident can be reported, and that the person engages with the investigation when they feel more able to do so.



Domain 7: Incident recording and data analysis

7.1

Data are collected and inputted within 24 hours following a sexual safety incident, in line with local procedures.

- Procedures are in place to ensure that accurate, high-quality and recent data are collected in response to all disclosures, sexual safety incidents and adverse events.
- These data incorporate the key aspects of each incident, including: time, location, severity and any other significant details (such as whether the person directly affected was a service user, staff member or other visiting person on the ward).
- The person who has been directly affected is given the opportunity to rate the level of harm themselves.
- Similar data regarding near-miss incidents are also recorded to enable the identification of common factors and themes to aid continuous learning.
- Policies for data storage and usage are clearly explained to the person involved.
- Sexual safety incident reporting and related governance processes are compliant with the [Serious Incident Framework](#) and data are handled in line with the [Caldicott Principles](#).

7.2

Quarterly analyses of incident data are conducted to review progress on improving sexual safety.

- The service produces a quarterly report (in line with regular safeguarding reports and reviewed by the responsible executive board member) providing an update on the frequency and type of sexual safety incidents that have occurred in that period, including the level of psychological and physical harm caused.
- The report contains a review of the actions that have been taken to improve safety.

Note: Performing a [root cause analysis](#) is a powerful method to aid the identification of underpinning factors and fundamental issues.^h

7.3

Incident data are used to plan local service provision and resourcing.

- Services use recent sexual safety incident data when planning internal service provision and external resourcing from independent and VCSE organisations.

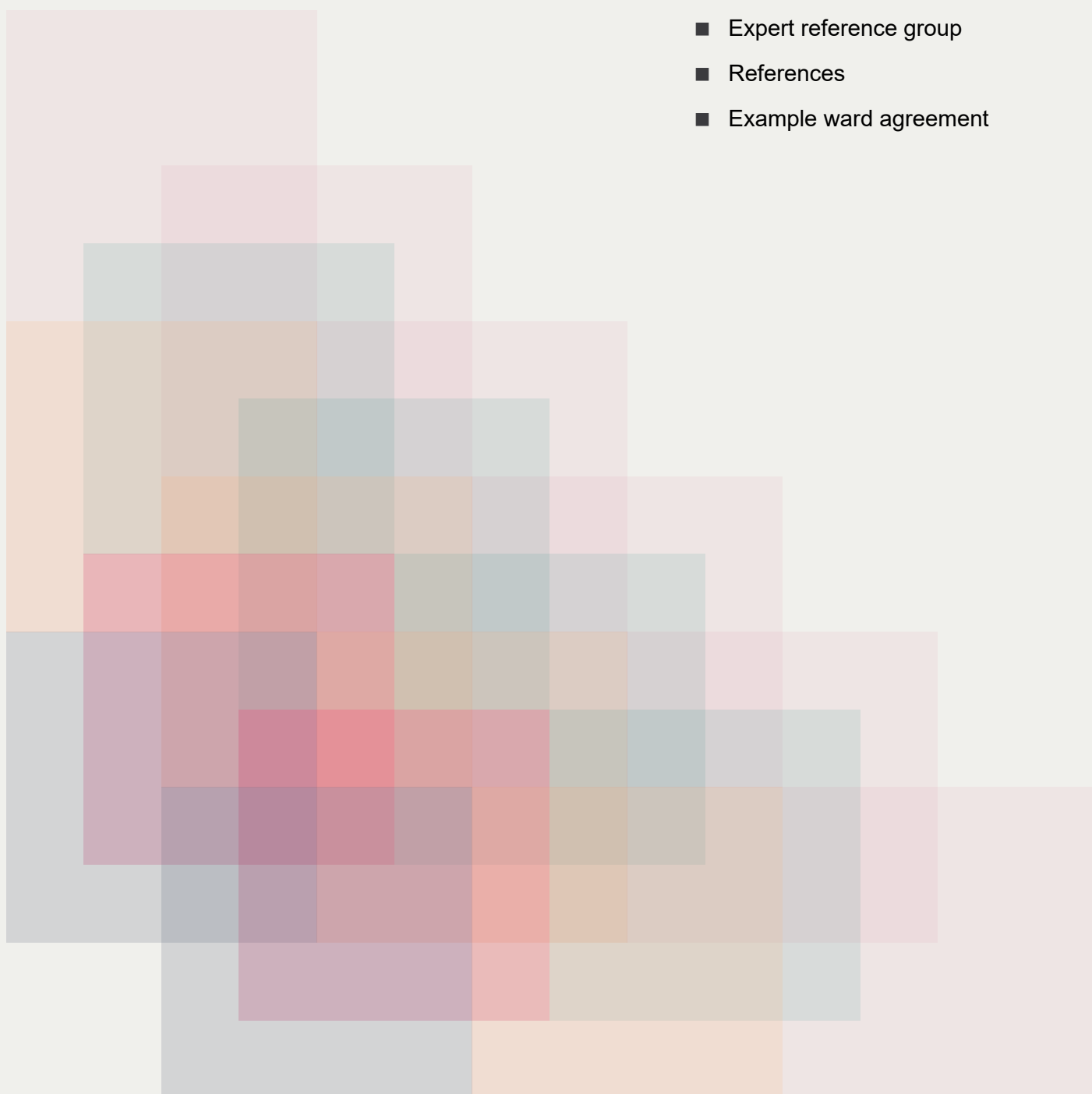
Potential outcomes: This data-driven approach, alongside individuals' experiences, helps to identify trends that can then be used to make modifications to service delivery and inform risk management and resource prioritisation.

Further detail: See [Section 4.3.15](#).

^h A root cause analysis involves asking, 'Why?', usually five times, with each answer providing the basis for the next question, to get to the underlying cause of the problem.

Part 2: Guidance to support the implementation of the standards

- Background
- Sexual Safety Collaborative
- Developing the standards
- Sexual safety in inpatient environments
- Implementing the standards
- Service scenarios
- Positive practice examples
- Helpful resources
- Expert reference group
- References
- Example ward agreement



1. Background

The CQC's 2018 report [Sexual Safety on Mental Health Wards](#)¹ found that sexual safety incidents comprised 1.6% of all incident reports on NHS mental health wards. Almost two-thirds of the people affected were using services, while one-third were staff and visitors. More than a third of these incidents were categorised as **sexual assault** or **sexual harassment**. A significant proportion were related to nakedness or exposure, including non-sexual exposure, and verbal abuse using words of a sexual nature. There were also allegations of **rape**.¹

The findings show that addressing sexual safety and effectively managing **sexual behaviours** on mental health wards is complex. Mixed-sex wards still exist across the country, and significant investment and assurances for the prevention of out of area admissions would be required for these to be eliminated. Furthermore, while providing people with the choice of single-sex accommodation is necessary, it will not eliminate **sexual safety incidents** that involve people of the same sex or a staff member.

See the NHS Confederation's briefing on [Delivering same-sex accommodation in mental health and learning disability services](#).

The government has dedicated up to £250 million (June 2020) to eradicate dormitory style accommodation (where two or more people share the same bedroom) on mental health wards across England, which will further help to address sexual safety. However, while individual en suite bedrooms would improve privacy and dignity, they would not prevent sexual safety incidents in communal spaces or outdoor areas.

To adequately address system-wide concerns around sexual safety, clinical leaders need to support best practice and drive change at every level of the healthcare system. This includes creating an open and honest culture on mental health wards for the discussion of sexual safety, and to promote sexual wellbeing, ensure the appropriate management of risks in the ward environment, and provide staff with learning and development opportunities on subjects such as trauma-informed care. The CQC report also highlights the importance of working collaboratively with local police and safeguarding teams.

People with mental health problems, including people with a learning disability and those with an autism diagnosis, have the right to engage in safe and fulfilling sexual relationships throughout their lives.ⁱ However, they may be vulnerable at times, lack the capacity to make informed decisions or choices about their relationships, or have experienced some form of abuse that affects how they form relationships. Because sexual relationships and activity are not permitted on hospital premises, it is imperative that staff are aware of the meaning and importance of sexual safety, including how it differs for children and young people, so that they can ensure the safety of service users, their own safety and that of visitors to the ward.

ⁱ The legal age of consent to any form of sexual activity in the UK is 16 (see the [Sexual Offences Act 2003](#)).

International progress

Of other countries making progress in improving sexual safety, in Australia the New South Wales government has developed [Sexual Safety of Mental Health Consumers Guidelines](#), with recommendations on preventing, responding to, reporting and recording sexual safety incidents, and addressing the specific sexual safety needs of people from different groups. The Mental Health Complaints Commissioner in Victoria has published [Ensuring sexual safety in acute mental health inpatient units](#), guidance on [The Right to Be Safe](#) report that highlights preventive actions that can be taken to improve sexual safety and sexual wellbeing, and ways of appropriately responding to sexual safety incidents.

1.1. Background of the Sexual Safety Collaborative

The Sexual Safety Collaborative is led by the NCCMH on behalf of NHSE/I and has the following objectives:

1. Produce a set of standards on sexual safety for the mental health and learning disability inpatient pathways (including a strategy to measure and support QI).
2. Run a national QI Sexual Safety Collaborative from October 2019 to August 2021 (it was paused from March 2020 to September 2020 due to COVID-19 restrictions), to support inpatient mental health teams in NHS mental health trusts across England to use QI approaches to improve sexual safety on their wards.
3. Produce a library of resources, building on best practice, to support the work of mental health trusts in improving sexual safety.

The aim of the Sexual Safety Collaborative: To increase the percentage of service users, staff and visitors who feel safe from sexual harm within mental health and learning disability inpatient pathways.

The first phase of the Sexual Safety Collaborative involved bringing people together to develop the sexual safety standards (see [Section 2.1](#) for more information).

The second phase seeks to use the standards to improve people's feelings of safety from sexual harm. This is being led by the national QI collaborative, established as part of the Mental Health Safety Improvement Programme (MHSIP).

The standards are nationally applicable, but the Sexual Safety Collaborative does not currently have the capacity to operate across all wards in the country. Therefore, 57 teams (units) from 74 NHS wards in 42 trusts across England have been selected for the collaborative, with wards including adult acute, children and young people's mental health, dementia/older adult, forensic, learning disability, PICU and rehabilitation. The wards will be supported to implement the standards, using learning that emerges from the Sexual Safety Collaborative or through their own local approaches.

Participating wards have the support of QI coaches when implementing the standards and adopt a systematic QI methodology to drive change. The QI initiative has been co-produced with people who have experience of receiving inpatient care, families and carers, and staff who work or have worked on inpatient wards. To support improvement and share learning, learning sets are held with the participating wards every 2 months. Learning generated during the Sexual Safety Collaborative is then cascaded through NHS trusts for the benefit of other wards.

For more information on the Sexual Safety Collaborative, visit the [MHSIP website](#).

^j The library of resources and learning from the Collaborative will be publicly available online and can also be followed on Twitter using the hashtag #MHSIP.

2. Developing the standards

This work was driven by findings from mental health inpatient wards, but the standards also apply to assessment and treatment inpatient settings that provide care for people with a learning disability or autism diagnosis as the primary presenting condition, including any learning disability inpatient settings for children and young people, adults and older adults. However, they do **not** include residential settings.

When implementing these standards in learning disability inpatient settings, it is important to acknowledge related factors to do with consent, capacity and sexual expression alongside the recommendations in this guidance. When developing the standards, we consulted people with experience of providing care to people with a learning disability and of raising the important topic of sexual wellbeing and sexual safety in learning disability settings.

2.1. How have the standards been developed?

The development of the standards was guided by an **ERG** of advisers with backgrounds and experiences related to sexual safety in inpatient settings. The ERG included people with experience of inpatient care, nurses, psychiatrists, occupational therapists, sexual violence advisers, people who work in NHS estates teams, members of the police force, and academics with a research interest in sexual safety.

An equalities focus group (**EFG**) was established, to ensure that the standards reflect social, cultural and intersectional factors that may affect a person's experience of care, or which may place people at greater risk of feeling unsafe during their care. The EFG aimed to reflect and represent the diverse range of people who may be at greater risk of experiencing inequalities in terms of their sexual safety. This can include (but is not limited to):

- children and young people, particularly looked-after children
- older adults
- people from BAME groups
- people from LGBTQ+ communities
- people who are homeless or have no fixed abode
- people who are working in the sex industry
- people who have substance misuse problems
- people with a learning disability or neurodevelopmental disorder
- people with sensory impairments
- women.

The ERG and the EFG were consulted at each stage of this work.

Finally, the development process has been informed by expert opinion from representatives at the CQC and NHSE/I, including those involved in the production of the CQC report on sexual safety in mental health wards.

2.2. How will the standards be monitored?

These standards will be embedded into CQC inspecting cycles. A brief guide will be published by the CQC to outline how inspectors will assess inpatient environments for sexual safety. Recognising that it may take time for some areas to implement these standards, the CQC will be looking at each trust's overall journey towards improving sexual safety over a given period rather than the immediate implementation of the standards.

3. Sexual safety in inpatient environments

Everyone has the right to have an age-appropriate relationship that is based on mutual consent with whomever they choose. This right also applies to people accessing mental health or learning disability inpatient care. However, the hospital is a public place in which people are unwell, often at their most vulnerable, and may not be free to leave. Hospitals are legally designated 'places of safety' in which safeguarding is a priority, so sexual relationships are not appropriate and sexual activity with another person is not permitted on the premises, and staff should explain this to people in inpatient care.

There may be times where service users form romantic or intimate relationships in hospital. While staff should not promote or encourage this, they may be in a position to encourage the safety and health of relationships between legally consenting people. Staff have a duty to check with each person how they feel about the relationship, to ensure that they have capacity to consent to it, that it is mutual and that it feels safe to them (see [Section 4.3.12](#)).

A person who has been admitted to an inpatient ward has the right to fulfil their personal sexual needs alone and in the privacy of their room. Masturbation should be done discreetly, and the right to do so must be respected.

3.1. Co-producing a ward agreement

For the expectations of behaviour in the ward environment to be clear, a general ward agreement based on the sexual safety standards should be co-produced with people who have experience of inpatient care, their families and carers, and staff on the wards ([Standard 4.1](#)). The ward agreement in [Appendix A](#) was developed by the ERG and is included as an example – it is important that every ward develops their own ward agreement through discussion with staff and people on the ward, amending our example as needed or writing their own so that it is specific to their circumstances.

Each ward agreement should outline acceptable and unacceptable behaviours in intimate, emotional and sexual relationships between people on the ward and within the wider hospital environment.^k Shared understanding of the agreement means that all people who work, visit or access care on the premises can adhere to its terms. While developing this agreement, it is important to consider the specific population whose needs are being met within the service. The needs will differ depending on the type of service and the people who receive care there, so each ward agreement should reflect that. For example, it is important to take account of age, mental health needs, individual needs and characteristics, possible history of trauma, medication effects, capacity, risk profiles and possible offending profiles.

^k When considering unacceptable behaviour, all services should adhere to the legal framework set out in the [Sexual Offences Act 2003](#). Services should also co-produce local policies around consensual sexual activity or individual sexual exploration in line with the [Mental Capacity Act 2005](#) and the [Human Rights Act 1998](#). This is particularly relevant for people receiving long-term care in rehabilitation wards.

A note on children and young people

It is not permissible to allow intimate or sexual activity among children and young people under the age of 16, in children and young people's mental health or learning disability inpatient settings. This would be a violation of the trust's duty of care. It also applies to children and young people's inpatient settings that could include people up to the age of 25.

3.2. Expectations for staff

Clinical and nursing staff who work in inpatient settings have a duty of care to the people receiving care in the service. It is not acceptable for any staff member to engage in sexual or intimate activity or have a relationship with a person under their care, either on or off the hospital premises. This includes intimate emotional and physical relationships.

If a staff member does engage in such activity or relationships, they would be violating their duty of care and be at risk of being removed from the ward, being demoted, losing their job and professional registration, or facing criminal action.

See the [Royal College of Nursing's description of duty of care](#).

Each trust should have an explicit and up-to-date policy for professional boundaries that takes account of these – and also of online relationships and **online sexual activity**, for example through social media or email.

3.3. Supporting people in inpatient settings

All people who receive care have the right to engage in relationships of any kind throughout their life if they are age-appropriate and based on mutual consent. People also have the right to express their sexuality appropriately and to have their sexual needs met safely.

Staff need to understand the impact of being in an inpatient setting, especially for a long period of time, on people and the difficulties people may experience in maintaining existing relationships. People who are in a relationship when they come into inpatient care should not be prohibited from maintaining their relationship and displaying affectionate behaviours during their stay (any safeguarding concerns should be followed up). However, people still need to adhere to the co-produced agreement of the ward and not engage in sexual activity with another person on hospital premises.

People may need additional support from staff so that they can meet their sexual needs safely. This could include access to education to understand safe sex, having adequate privacy and space for masturbation, or support to use digital resources (such as video calling, messaging or email) to keep in contact with their partner. Staff will also need to help people be aware of the risks of online sexual activity and support them to engage in this behaviour safely.

Relationships can also develop between people receiving care in adult inpatient mental health and learning disability settings. Currently, there is little policy in place that seeks to advise staff on what to do when sexual or **affectionate activity** arises between people receiving care, and existing policies are inconsistent and often too restrictive.⁴ Each service should put in place a co-produced local policy to guide decision-making around this matter. Such policies should be developed with full consideration of laws pertaining to mental health, criminal law, human rights law and the duty of care.⁵

Relationships between people of legal age to consent who are receiving care can be beneficial in many ways.⁶ Should a relationship develop between two individuals who have capacity to consent, decisions around how they choose to maintain it should be made with each person on a case-by-case basis. This should be in line with local policy and the [Human Rights Act 1998](#),¹ and detailed in their care plan. In forensic psychiatric hospitals, staff should consider the value of mutual disclosure of offences between the two people.

If it becomes apparent that people have formed a relationship, it should be made clear that sexual activity on hospital premises is not allowed and that service users can choose to pursue a consensual, age-appropriate sexual relationship only off the premises. While it is not the role of staff to encourage sexual relationships between people who are receiving care, staff are advised to have separate conversations with them, to ensure that staff are doing all they can to minimise risk and ensure the safety and sexual wellbeing of both. This might include having open discussions with them about healthy relationships and sexual activity, providing information about sexual health (for example, on safe sex and contraception), ensuring that the ward agreement on appropriate behaviour is understood, and exploring whether the relationship is truly consensual.

However, a relationship may not be in a person's best interest; for example, those with a history of abuse or sexual trauma may be at risk of re-traumatisation.⁴ It is also important to consider the impact of a relationship on others in the adult inpatient setting. There could be an adverse impact on others on the ward, particularly if the relationship breaks down. If this happens, conversations should take place with the inpatient community, to gauge their feelings and ensure that they are not adversely affected.

3.3.1. Supporting autistic people or people with a learning disability

Every person must be treated as an individual, with rights to sexual health and sexual safety. The key to supporting someone with an autism diagnosis or learning disability to stay sexually safe is to take the time to understand their experience, how they express themselves, their attitudes and beliefs, and how they prefer to communicate.

For people who have a learning disability, sex and sexuality might be taboo subjects with staff in services, and also with families and carers. They might not be perceived as adults with sexual needs like other adults, and so their expressions of sexuality can be misconstrued or suppressed.

Some people may not have the verbal communication abilities to be able to express their sexuality, or sexual thoughts or feelings, or they may do so inappropriately. It is important to find other ways to understand a person's needs and wishes, tailoring communication methods to what works for them.

Service [scenario A](#) provides an example of supporting an autistic person, while [scenario B](#) outlines one example of how to support a person with a learning disability.

¹ Human Rights Act 1998 – [Article 8: Right to respect for private and family life](#).

Autistic people can have difficulties understanding social cues and responding appropriately in social interactions, which may lead to their behaviour being interpreted as sexually inappropriate or their misinterpretation of other people's actions.

Being in inpatient care for a long period of time can affect the ability of people with a learning disability or autism diagnosis to safely express their sexual thoughts and feelings, to find a way to have their sexual needs met, and to develop appropriate and healthy intimate and/or sexual relationships.

For these reasons, it is important for reasonable adjustments to be made so that their needs can be met.

Their vulnerability also puts them at higher risk of experiencing sexual abuse or a sexual safety incident. Therefore, services need robust safeguarding measures to keep people with a learning disability or autistic people sexually safe, providing the right level of support for individuals to express and communicate their sexuality and sexual needs appropriately in the inpatient environment. Regular reviews or health checks can determine any potential risks to sexual safety and whether the person has unmet needs.

Staff will need training and support to:

- better recognise subtle sexual safety incidents, especially those involving vulnerable people
- have a greater understanding of the complexity of issues that people with a learning disability and autistic people face, including their right to self-determination, their potential difficulties in identifying and raising concerns about abuse, and previous experiences of trauma
- talk sensitively and appropriately to autistic people and people with a learning disability about sexual health and their experience of sex, so they can better understand the person and their needs
- recognise and understand the nuance of trauma that people will have experienced prior to inpatient care and how it may be affecting them
- make use of available information, educational and diagnostic materials related to relationships and sexuality, sexual experiences and sexual knowledge in people with a learning disability.

Some of the available programmes and resources to support people and staff include:

- Ask, Listen, Do supports people to give feedback, express their concerns or make a complaint.
- Care, Education and Treatment Reviews help to improve care for people with a learning disability and/or an autistic diagnosis.
- Oliver McGowan Mandatory Learning Disability and Autism Training is soon to be rolled out to all health and social care staff who support people with a learning disability or autistic people
- Sexuality – research and statistics presents information and resources from Mencap on relationships and sexuality.
- Books Beyond Words provides books without written words.

3.4. Who may be involved in a sexual safety incident?

Any person in an inpatient setting may be involved in a sexual safety incident, regardless of sex, sexual orientation or gender identity. This includes people receiving care, staff, and visitors such as families, carers and staff visiting from external organisations.

A sexual safety incident or feelings of reduced sexual safety can occur between any combination of service users, staff and visitors, and none of these groups should be overlooked when assessing sexual safety and what might make a person feel unsafe. It is important to consider the use of technology in the context of personal contact – sexual harassment or reduced feelings of safety can also come about because of contact by mobile phone or other computerised technology.

It is also important to recognise that people's vulnerabilities can vary depending on the setting or which people are around. For example, someone can appear vulnerable around certain individuals, and this could reduce once they move to another area, away from the individuals. Similarly, someone who is vulnerable in one setting may exhibit behaviour that poses a sexual safety risk to others in another setting. People can express different traits depending on the environment and the dynamics inherent in it, and it is important to consider how they can be supported.

Some individuals on an inpatient ward can be especially vulnerable around those who display **disinhibited sexual behaviour**. The person who is disinhibited may not have been given adequate information and education about sexual relationships before, so may have acquired inappropriate sexual behaviours themselves. Staff need to find ways to prevent and divert these behaviours, and to educate people about healthy sexual relationships so that they have an awareness about sexual safety incidents and their likelihood of posing a sexual safety risk is reduced.

3.5. The role of the police in a sexual safety incident

Working effectively and positively engaging with the police can ensure that appropriate action is taken in a timely and person-centred way. This will encourage people to have trust and feel confident that they will be supported in investigations and court proceedings.

Sexual safety incidents may lead to the involvement of the police, who will determine whether there should be a criminal investigation and prosecution. When a person has been detained under the Mental Health Act or lacks capacity, it does not affect the need to report a sexual safety incident to the police and it does not prevent someone from being prosecuted. As such, developing and maintaining an effective working relationship with the police, and establishing agreed protocols for responding to sexual safety incidents, is key to ensuring clarity and understanding of the legal proceedings that may follow an incident.

Service policies and processes on sexual safety should include guidance on the role of the police, such as:

- the role of the dedicated sexual safety champion on each ward in relation to being a point of contact for the police (or the local dedicated police liaison officers, where available)
- how to liaise with the police during investigations
- securing and maintaining the integrity of forensic evidence related to the incident
- processes around providing support to victims who may be involved in legal proceedings.

The [National Strategy on Policing and Mental Health](#), developed by the National Police Chiefs' Council, provides further information on the role of the police in mental health.

Service [scenario C](#) and [scenario D](#) provide some examples of how the police may be involved in a sexual safety incident.

4. Implementing the standards

Approaches to implementing the standards may vary between settings because each service will tailor their work to meet their population's needs, but there are some key considerations that all services should follow.

4.1. Advancing equality

Everyone has the right to equal access to good-quality, compassionate mental health care, in line with the [Equality Act 2010](#). Alongside ensuring equality in mental health care, it is essential to advance equality in support for sexual safety. Personal and protected characteristics (such as sex, age including developmental age, cultural background, life experiences and relationships) can affect how different behaviours are perceived and interpreted. It is therefore important to acknowledge that different people will have different feelings about what is, and what is not, acceptable behaviour.

Each person should be asked about what makes them feel safe from sexual harm and whether something has made them feel unsafe. They should be allowed to define, in their own terms, what behaviours or situations they consider acceptable.

Understanding diversity and ensuring equality around support for sexual safety should be included as part of sexual safety policies and regular staff training.

All people hold unconscious biases that do not consider individual differences; if unacknowledged, these biases can lead to discrimination or inequalities in care. Staff should be trained to recognise unconscious bias and how to address it, so that it does not impact on the delivery of equal care for all. For example, sexual safety is often viewed through a heterosexual lens and thus mostly considered in the male/female context. It is important for all staff to be vigilant in single-sex environments and consider the implications of sexual safety for people from LGBTQ+ communities. Support can be tailored to ensure that their experiences are understood.

“ Staff must listen to, and take seriously, any report of a sexual safety incident made by a patient. Even if it is concluded that the alleged incident did not take place, staff must work to understand why the person made the allegation and acknowledge the distress associated with it.

Source: [Sexual safety on mental health wards](#), CQC, 2018

Service [scenario E](#) and [scenario F](#) provide examples of people with different protected characteristics being admitted to inpatient wards.

Small changes can be made to service design and delivery to make sure that support for sexual safety is accessible to all people. This could include providing: sexual safety information or contact details for independent sexual safety advisers in accessible formats for people with a learning disability or sensory impairment; in different languages for people whose first language is not English; or helping people to access sexual safety support and advocacy services that meet their needs (for example, older people, people from BAME communities and people from LGBTQ+ communities). Another change could be ensuring that the environment meets the sexual safety needs of people who have a physical disability, and that their privacy can be maintained in facilities with limited accessibility.

For more information on how to address mental health inequalities at a local level, see the [Advancing Mental Health Equality resource](#) developed by the NCCMH.⁷

Finally, it is important to remember that people admitted to hospital under the Mental Health Act should be supported and cared for with the same compassion and dignity as other service users. This also applies when supporting them following any disclosures of a sexual nature. They are entitled to the same level of support, access to advocacy and follow-up during and after investigations as any other person.

Advancing equality also involves the diversity of the workforce reflecting that of the local population.

4.2. Co-production

So that improvements to service delivery can truly meet people's needs, all approaches to embed the sexual safety standards must be co-produced with people who have experience of care in the inpatient setting, their families and carers, and staff. Representatives from each of these groups should be involved in:

- sharing the decision-making around how, and in what order, the sexual safety standards are implemented
- the co-production of ward behaviour agreements and procedures on how to raise concerns regarding sexual safety
- co-producing local policies and guidance around professional boundaries, how to prevent and respond to sexual safety incidents, how to strengthen multi-agency working and how to report incident data
- sharing the decision-making regarding changes to the physical environment and ensuring both physical and psychological safety
- co-producing values-based interview questions for incoming staff and being included in interview panels
- co-producing and co-delivering sexual safety training for staff and other stakeholder organisations
- developing resources and materials that address sexual safety.

Positive practice:

[Cheshire and Wirral Partnership NHS Foundation Trust](#)

Following extensive consultation with service users, Cheshire and Wirral Partnership NHS Foundation Trust collaboratively developed co-produced safety cards outlining what people should expect when staying on a ward, things that should not happen on the ward and how to escalate a safety concern or access advocacy services.

Because sexual safety is a highly sensitive subject, particularly if discussing situations that may bring up some difficult memories of personal experience of sexual trauma, provisions should be made so that people can receive support if they find the discussions difficult. This might include, but is not limited to:

The NCCMH has developed [Working Well Together: Evidence and tools to enable co-production in mental health commissioning](#),⁸ a guidance document outlining additional approaches and principles that can be used for co-production in mental health.

- having safe spaces away from where the meeting or discussion is taking place, so people can take a break if they need to
- having designated members of staff involved in the co-production process, so that people know there is someone specific they can talk to about any concerns
- offering one-to-one discussions, for people to talk about anything they find challenging in the meeting
- supporting people to contribute their views or experiences after the meeting if they feel uncomfortable sharing them at the time
- helping people to access alternative, independent advice from mental health or sexual support agencies if they feel it is more appropriate.

4.3. Key focus areas

4.3.1. Trauma-informed care

Many people have experienced some degree of trauma in their life, and the correlation between experience of trauma and poor mental health mean it is likely that a large number of people who receive care in mental health services have experienced trauma.⁹ A trauma-informed approach is strengths-based while aiming to acknowledge and understand any previous trauma and how it has affected the person in the past, it is also responsive to how it impacts the person in the present. This includes the impact of trauma on staff members, or the possible trauma that staff members may have experienced. Trauma may be experienced as a result of mental health problems or previous relationships, not just of significant traumatic events.

Understanding a person's mental health problems in the context of their life and relationships means that appropriate steps can be taken to ensure that care is provided in a way that does not inadvertently traumatise or re-traumatise them.

“ Trauma-informed care requires a system to make a paradigm shift from asking, ‘What is wrong with this person?’ to ‘What has happened to this person?’ ”

Source: Harris, M. & Fallot, R. D. (Eds.) (2001). *Using Trauma Theory to Design Service Systems*. New Directions for Mental Health Services. San Francisco: Jossey-Bass (as cited in *The Institute on Trauma and Trauma-Informed Care, What is Trauma-Informed Care?*, University at Buffalo, 2015).

Service [scenario G](#) provides an example of trauma-informed care in practice.

Enabling people to feel safe and in control is key in supporting someone to feel both physically and psychologically safe. It is essential to use a person-centred approach to understand how control and restriction can be harmful for a trauma survivor, what their triggers may be, and how best to increase physical and psychological safety. Person-centred approaches include:

- tailoring approaches and care to each person, their own individual needs and their culturally specific beliefs and values
- taking the time to understand the person and their experiences, not just their symptoms
- providing care with empathy
- taking everything the person says seriously, believing in their level of distress and listening without judgement.

For people to feel safe within inpatient settings, there should be a clear commitment from organisations to provide trauma-informed care within an environment that is adapted to ensure safety. For an environment to be trauma-informed, there must be an understanding that inpatient services by their very nature remove many aspects of control, while being admitted is itself a form of restriction. To facilitate feelings of safety and control, organisations are responsible for ensuring the availability of single-sex wards, while changes to the environment should be co-produced with people who have used the services and staff (see [Standard 1.6](#) for further information on safe environments).

All staff, at every level of the organisation, should be given training on trauma-informed approaches, including how to recognise and respond to different types of trauma, including **sexual abuse** and **child sexual abuse** (as well as disclosures of historical sexual abuse), and deliver trauma-informed care. They should be able to understand the importance and benefits of working in this way and recognise how their own behaviour can add to or detract from feelings of safety.

The [QI Reducing Restrictive Practice Collaborative](#) have developed a change theory and additional resources to support ward teams to reduce the use of restrictive practice on their wards.

Reducing restrictive practices promotes the delivery of trauma-informed care and improves sexual safety. Staff should be supported to reduce restrictive practices to ensure people's psychological safety (not being restrained or feeling other people are in control of your body), while balancing the need for physical safety (such as supporting someone not to harm themselves or others). It is important to acknowledge this tension and for staff and service users to consider how best to enhance safety together.

Positive practice:

[Shropshire Care Group \(Midlands Partnership NHS Foundation Trust\)](#)

Shropshire Care Group offers bi-monthly sexual safety awareness sessions to staff of any discipline. The multidisciplinary sessions inform and educate staff on the key principles of sexual safety, such as trauma-informed care and conducting risk assessments. The sessions encourage open discussion and awareness of sexual safety among staff.

4.3.2. Asset-based approach

When working with people experiencing mental health problems, it can be all too easy to offer support in a risk-averse way. This means only considering the potential difficulties and risks that they might be experiencing, and attempting to problem-solve these in isolation. Taking an asset-based approach includes considering their personal strengths, current level of resilience, abilities and resources to cope in times of adversity. It also includes recognising any helpful support structures they already have. It is important to consider the person's life, past experiences and relationships, and how these might contribute to their perception of sexual safety or to their ability to process any incidents of sexual safety.

Positive practice:

[Hertfordshire
Partnership
University NHS
Foundation Trust](#)

The trust has introduced one-to-one sexual safety conversations into the induction process for the adolescent inpatient unit. This involves staff tailoring their approach based on the young person's age, individual needs and current mental health state.

4.3.3. Access to specialised sexual safety support

All people within the inpatient environment should be given the opportunity to access an independent service or designated member of staff who can offer specialised sexual safety advice, advocacy and support in a way that is age- and culturally appropriate, and that meets the person's needs. Support might include:

- a clear route for raising concerns about sexual safety and sexual violence
- advice, guidance, advocacy and support for concerns about personal sexual safety
- advice on sexual safety and appropriate sexual behaviours
- advice on sexual violence, both physical and psychological
- consistent guidance and support through any legal proceedings, if required
- support to access sexual health screenings and SARC's, if necessary
- support when making a disclosure, followed by ongoing, consistent support throughout the processes that follow.

When needed, staff in services should help people anonymously access this support, to disclose any sexual safety concerns or incidents while receiving care, visiting or working on the ward. Services should build close relationships with local SARC's, to understand current levels of capacity, so that people can receive the right support at the right time.

This support should be extended to all service users, visitors and staff.

4.3.4. Involving and supporting family, friends and carers

Family members, carers and **support networks** should be involved in the person's support and/or care from the outset, particularly in the case of children and young people, provided the person agrees or as stated in any advance decisions.^m It is important to consider the views of family members, carers and the support network throughout, ensuring they are involved in decisions around care and informed about the person's outcomes.

Services should also consider involving family members, carers or support networks in supporting a person following a sexual safety incident. Staff should, however, be mindful that family members may be unable to provide the support the person needs for their sexual safety. This may be for a number of reasons, including social, cultural or religious concerns, or the impact the incident may have on their personal relationship.

Families and carers should be given appropriate support and guidance to ensure their needs are met following a sexual safety incident. Their own safety, protection and wellbeing should also be considered.

See [NICE guidance on supporting adult carers \(NG150\)](#) and the key elements of the Carers Trust's [Triangle of Care](#).¹⁰

Service [scenario H](#) gives an example of responding to an incident on a children and young people's ward.

4.3.5. Safeguarding

Safeguarding is an integral part of ensuring safety within healthcare. It is essential that the standards outlined in this document are integrated into local safeguarding practices and policies. To ensure that this is achieved, each ward should have more than one designated sexual safety safeguarding staff member, so that there is always at least one person with the appropriate training available to deal with any safeguarding issues relating to sexual safety, even through periods of scheduled leave. All people should know who the named safeguarding lead is on each day, so they can promptly raise and address safeguarding concerns. It is everybody's responsibility to ensure people's safeguarding and sexual safety within inpatient settings.

It is imperative that sexual safety is given as much weight as other safeguarding issues. Currently, it is often grouped together with other safeguarding issues, but because such incidents can have serious outcomes local safeguarding boards (for both children and adults) should consider having a separate category for sexual safety.

Safeguarding boards are also responsible for quality assurance of safeguarding practice. One way of achieving this is by ensuring that data are recorded, analysed and reported comprehensively and consistently, to identify key areas for improvement.

The [Making Safeguarding Personal](#) programme supports services to develop an outcomes-focused, person-centred approach to safeguarding practice. It focuses on working with people to ensure effective safeguarding is in place, to make a positive difference to their safety.

^m Parents have the right to being involved in the decision-making for their child's care if the child is under 16. If a young person, aged 16–17, has mental capacity and does not want to have their family involved in their care, the reasons for this choice should be explored with the young person and taken into account. The exception to this is if there are concerns about there being a risk of harm to self or to others.

Positive practice: Service users on acute adult and older adult mental health wards are offered personal alarms that they can carry with them at all times. If they feel unsafe, they can sound the alarm to notify staff of their whereabouts.

[Shropshire Care Group \(Midlands Partnership NHS Foundation Trust\)](#)

There may be situations where a person with a history of criminal sexual behaviour is admitted to an inpatient environment. Staff and safeguarding leads should discuss how to balance the safeguarding needs of people in the ward environment (and their visitors and members of staff) with the right to confidentiality, respect and dignity for the person who is being assessed for, or has been previously convicted of, criminal sexual behaviour. This is a complex balance to strike: safeguarding leads must be aware of potential risks and ensure that everyone's rights are respected.

4.3.6. Supervision and reflective practice

Supervision

All staff need regular supervision sessions that they can use to equip themselves with the necessary skills, tools and resources to deal with difficult situations, including sexual safety disclosures and incidents. Discussions about sexual wellbeing and safety should be embedded into these regular supervision sessions. This gives staff the time and space to raise any concerns about sexual safety on the ward, talk about possible ways to prevent future sexual safety incidents, and discuss and address anything that might be particularly challenging for them to deal with personally. Having these open discussions regularly can build a space where staff can be honest about what is happening on the wards, about any personal limitations they may have, and identify any support needs.

Positive practice: Midlands Partnership NHS Foundation Trust has introduced a weekly audit to monitor the frequency of sexual safety incidents within their inpatient mental health services. This regular review of the data has enabled early identification of common themes, and thus, quicker action.

[Shropshire Care Group \(Midlands Partnership NHS Foundation Trust\)](#)

Reflective practice

Reflective practice should be encouraged as an adjunct to supervision. It is a method by which staff can think about the care they have provided and how they could improve in the future. This is a good example of continuous learning. Team reflective practice can offer additional opportunities to learn from colleagues and support each other with decision-making.

4.3.7. Training

To ensure sexual safety, staff will need comprehensive face-to-face (or virtual, if this is not available) team training that encourages shared learning and discussion. All staff (clinical and non-clinical, and senior leaders) should receive this training so that sexual safety is well understood throughout the organisation. Training should be co-produced and include learning modules on:

- understanding sexual health and sexual safety, and how individual differences may affect how behaviours are perceived and processed (including the impact that a learning disability or autism diagnosis may have on sexual behaviours and sexual safety)
- how to talk about sexual safety, sexual violence and sexual behaviours in a way that is age appropriate and accessible to people with differing needs
- delivering trauma-informed care, and understanding and recognising several types of trauma
- mental capacity in relation to consent to sexual activity
- being aware and vigilant of high-risk areas for sexual safety incidents so that preventive action can be taken
- supporting people to be safe when using digital means to maintain relationships
- acknowledging unconscious bias and how to minimise its impact
- processes (both internal and legal) for responding to sexual safety incidents, including disclosures of historical incidents, and how to support people with differing needs throughout
- how to support a person to access a sexual health clinic or SARC
- professional boundaries, as well as how to deal with situations when staff are the subject of a sexual incident or have allegations made against them
- other areas of sexual health or abuse such as female genital mutilation, exploitation and trafficking, and what to do if concerns arise.

Positive practice:

[Nottinghamshire
Healthcare NHS
Foundation Trust](#)

Nottinghamshire Healthcare NHS Foundation Trust is in the process of developing a suite of open-access, co-produced, reusable learning objectives related to sexual safety for staff in healthcare settings. These are designed to engage practitioners in key learning around sexual safety and sexual harm to promote continuing professional development.

4.3.8. Legal frameworks

Care and support should be delivered in line with the relevant legislation for this area of work (see [Section 2.1](#)).

Services are also bound by duties under the [Convention on the Elimination of All Forms of Discrimination against Women](#), which was adopted by the United Nations General Assembly in 1979 and became an international treaty in 1981.

Because these sexual safety standards are applicable to people of all ages, it is important to be aware of crossovers in legislation. For example, there will be an overlap and differences between the Children Act, which outlines care for children up to the age of 16, and the Mental Health Act for people over 16.

It is also important to have knowledge of how the [Criminal Justice Act 2003](#) will be used when dealing with serious sexual safety incidents.

4.3.9. Promoting age- appropriate education around healthy sexual relationships

People of legal age to consent have different experiences of sexual relationships and, as such, their understanding of healthy sexual relationships may vary. If someone has been in a coercive or otherwise unhealthy relationship, or has witnessed one, they might have acquired behaviours that put themselves or others at risk of harm. The service should work to promote age-appropriate education around healthy sexual relationships at every level. This might include making accessible age-appropriate information available on wards, or staff talking with service users of legal age to consent about healthy relationships and sexual behaviours, that meets their level of understanding.

A number of existing models have been developed to assist healthcare professionals in this area. The **BETTER model**¹¹ was developed for nurses to address sexual health in the assessment and care of people receiving treatment for cancer, but its principles can be applied to a range of health care settings. The model outlines six steps, summarised here for use in mental health inpatient settings:

Bring	Bring up the topic of sexual health with the individual and identify whether they have any concerns
Explain	Explain that sexual health is an important aspect of quality of life, normalise the topic and alleviate potential embarrassment
Tell	Tell the individual that any resources or education they need to address these sexual health concerns will be provided
Time	Ensure these discussions are at an appropriate time for the individual and are considerate of the person's readiness to engage in this conversation topic
Educate	Educate the individual with regards to any sexual side-effects of their medical condition or medications they may be taking
Record accurately	Record the assessments, treatments and outcomes of interventions in the individual's patient record or care plan

The **PLISSIT model**¹² was developed to assist nurses with the assessment and management of sexual health problems, and comprises four levels, summarised here for mental health inpatient wards:

Permission	Create an appropriate environment in which the individual feels comfortable discussing sexual concerns and seek consent to discuss this topic
Limited information	Offer general, age-appropriate information and resources regarding sexual health and sexuality
Specific suggestions	Offer more specific age-appropriate information and suggestions about sexuality and sexual health interventions, tailored to the individual
Intensive therapy	Implement specialist knowledge and advanced counselling skills to tackle the specific problems the individual is experiencing

The expanded **ex-PLISSIT**¹³ model follows the same four levels, but requires consent at each level as opposed to just the first one.

4.3.10. Multi-agency support for sexual safety

Working together with all agencies that can provide support for sexual safety will ensure seamless care and support at all times. This joined-up approach should be woven into care at every level, so that there are no gaps in provision. This means that joint working should be take place at system, organisational and individual staff levels.

Agencies that should join up to provide support with sexual safety might include, but are not limited to:

- children and adult social care services
- community/outpatient mental health services
- the police
- safeguarding advisers
- sexual health and genitourinary medicine services
- specialist sexual safety advisers and SARC
- VCSEs that specialise in support following sexual safety incidents and/or trauma
- youth offending services.

It is also important to link up with other agencies that can support the person with maintaining other aspects of their life when they return to the community, such as housing, education, finances, employment, primary care and other mental health support services.

To help a person access other agencies, staff should be familiar with the referral criteria for each service. If there will be a wait to access a service because of lack of service capacity, it should be explained to the person and interim care should be offered.

Positive practice:

[Camden and Islington NHS Foundation Trust](#)

The sexual safety agenda at Camden and Islington sits within the Awareness and Response to Domestic and Sexual Abuse (AR-DSA) network, run in partnership with charities, such as Against Violence and Abuse (AVA), to draw on the expertise of specialist organisations.

Finally, multi-agency public protection arrangements (MAPPA) were established following the passing of the Criminal Justice Act. They exist in every criminal justice area in the country, to 'protect the public, including previous victims of crime, from serious harm by sexual and violent offenders'.¹⁴ Multi-agency working is critical to achieving this aim. The [MAPPA guidance](#) outlines which agencies have a duty to cooperate, the agreement that each must adhere to, guidance on information sharing and risk management, and specific mental health-related guidance. For further detail on multi-agency working, see [Domain 5](#) of the standards.

4.3.11. Information sharing

When taking a multi-agency approach to supporting a person with their sexual safety concerns or a disclosure of a sexual safety incident, their information may need to be shared with other care teams or agencies. It is important that it is clearly explained to the person who their information will be shared with, and that, wherever possible, they are given the choice to decide who it will be shared with. This conversation should take place at every stage where information could be shared, as well as during assessment and throughout care.

When information needs to be shared with another organisation and confidentiality breached in the interest of protecting either the person or the public, the purpose should be explained and the person should understand exactly what will be done with their information. While decisions about information sharing and breaching confidentiality are made on a case-by-case basis, serious sexual assault or rape allegations are examples where a breach of confidentiality may be required to properly investigate the incident.

Guidance on information sharing can be found in [NHS England's Information Sharing Policy](#), in the Caldicott Principles and in the MAPPA guidance (as regards sharing with MAPPA organisations in the interest of protecting people from harm).

The same principles apply when considering sharing information with family, carers and support networks. The person must be given the choice to involve them in their care and support, and this includes whether information is shared with them. In the case of children and young people, parents and carers should always be given information (following discussion with the child or young person), unless there are specific circumstances or concerns that indicate this should not happen, in which case social care may need to be involved. A young person with capacity may wish for their parents or carers to not be informed or involved in their care. Their choice should be respected, although services should continue to discuss the potential benefits of informing family.

There might be individual, social or cultural reasons why a person might not wish to share information with their family, and this must be respected. Relevant information should only be shared if it is in the person's best interests or if it is to keep the person and others safe, in line with the [Department of Health's consensus statement on information sharing and suicide prevention](#).¹⁵

If staff are in doubt about a person's capacity to make a decision about their information, the person should be offered support from an advocate or other appropriate person to help them decide. If all attempts to support the person to gain capacity are unsuccessful, it may be in the person's best interests for staff to make some decisions around information sharing on their behalf.

Positive practice:

[Newham Adult Mental Health Services \(East London NHS Foundation Trust\)](#)

As a component of cascading the learning from their sexual safety initiative, the Newham Directorate is sharing their work across all the adult mental health services within the East London NHS Foundation Trust. To achieve cultural change from the top-down, senior leaders from each service or directorate are required to attend these meetings. This shows staff that there is a commitment from leaders to embed these core values into the leadership of the organisation, as well as at a service level.

4.3.12. Mental capacity

The question of capacity can arise in a number of situations, such as whether the person has the capacity to make decisions about their own care, to participate in safeguarding procedures or investigations, to consent to activity or to initiate sexual activity. However, it is important that someone's capacity to consent to sexual activity is not confused with whether they have consented or not.

Whenever a person is unable to make their own choices about their care or about their safety, staff must act in the person's best interests and follow legal guidance as set out in the Mental Capacity Act, [Mental Capacity Act Code of Practice 2007](#) and professional guidance, and seek any additional specialist advice such as legal or safeguarding advice.

When responding to a sexual safety incident, the mental capacity of the person who has been directly affected and of the initiator should be assessed by an appropriate mental health professional. Staff should also consider whether either person is sexually disinhibited as a result of their mental health problems or for other reasons. This will form part of the capacity assessment that staff will need to complete. This assessment should be made before concluding whether an incident or a sexual relationship is viewed in a criminal context and the police need to be involved.

The elements and principles of mental capacity assessments are contained within the Mental Capacity Act and the Mental Capacity Act Code of Practice. There is further information on determining capacity within a criminal context in the Sexual Offences Act. The specific additional needs of people who may lack capacity should be identified through assessment and those needs should be met.

Positive practice:

[Hertfordshire Partnership University NHS Foundation Trust](#)

The trust has developed a guidance document and flow chart so that all staff know the best course of action to take when responding to disclosures of a sexual safety incident or sexual abuse.

4.3.13. Ongoing mental health support following the incident

When a person raises concerns or reports a sexual safety incident, it might be easy to focus solely on the incident and forget the effect this might have on the person, their current mental health needs and their ongoing recovery. Services must ensure that they continue to provide the mental health care that the person needs or offer it if the directly affected person is not an existing service user. Staff should discuss with the person whether they would like the frequency, type or intensity of care to change following an incident. Any changes made to their care should be reflected in their care plan.

It is also important to acknowledge that some people might need time to process or understand a sexual safety incident. They may benefit from incident-specific mental health support at a later point in time, set by the person.

4.3.14. Raising and investigating concerns within the workforce

It must be acknowledged that staff are capable of unprofessional conduct. This is a violation of professional boundaries between staff members and people under their care. There should be no exceptions to inappropriate behaviour, regardless of who it is from. Both service users and staff should be encouraged and supported to report any behaviour that concerns them, whether it is from a member of staff or another service user. The person raising concerns should be given ongoing support during and after the disclosure.

There should be explicit and up-to-date policies and guidelines around:

- professional boundaries
- the use of touch during treatment
- what constitutes acceptable and unacceptable behaviour in the inpatient environment (this should be shared with staff and service users, so everyone in the ward community knows what to expect)
- how to raise concerns.

All disclosures should be treated equally. When a person raises a concern about a member of staff, this disclosure should be validated and given the same response as any other disclosure; action should be taken immediately. A service user's family, friends or carers may wish to raise concerns about a member of staff or another service user in the ward environment. They should also be given an appropriate forum to do so in a way that does not harm their relationship with the person they care for.

Staff may find it difficult to raise concerns about other staff. There should be processes in place to support staff to raise concerns anonymously, and staff should be made aware of external organisations that can support them confidentially, such as [Protect](#).

People who make a disclosure should not face any negative consequences as a result. Some examples of negative consequences are withdrawal of provisions on the ward, unfair treatment, unfair dismissal of staff, or other restrictions on care or in carrying out job roles. Policies for raising concerns should be written in line with the [Public Interest Disclosure Act 1998](#) and people should feel comfortable making disclosures under this legislation.

When investigating reports of concerns in the inpatient environment, the local policy on internal inquiries should be followed. This includes escalating complaints or concerns from the service director to the chief executive, human resources (HR) and the trust board. There should be trust guidance on how to conduct such investigations and the person conducting the investigation should have adequate training in safeguarding and trauma-informed approaches to do so competently, especially when it comes to dealing with competing personal accounts. The lead investigator should also consider the impact that an ongoing investigation might have on the ward community and conduct the investigation with sensitivity.

Safeguarding, the police and the Crown Prosecution Service will need to work together during an investigation to ensure a comprehensive review of any allegations. When the investigation concerns a member of staff, the relevant professional regulatory bodies and the Disclosure and Barring Service might be involved, as appropriate. Any decisions around how to deal with investigations involving staff should follow the relevant organisational procedures and be in line with both national and local policies.

Any recommendations that arise as a result of an investigation must be followed up at a time set by the lead investigator, to ensure that recommended changes to service provision are being made in the best interest of service users.

Positive practice:

[Camden and Islington NHS Foundation Trust](#)

The AR-DSA network at Camden and Islington NHS Foundation Trust invite representatives from HR to attend their meetings to ensure there is an appropriate response to staff who may have been involved in an incident, either as the initiator or the person directly affected.

4.3.15. Better reporting

Sexual safety incidents are, in general, largely under-reported.^{16,17} However, with the implementation of these standards and a gradual change in organisational culture, incident reporting on the wards is expected to improve. This means that wards will likely see an increase in sexual safety incident data following implementation. It is important to remember that this does not mean that the wards are performing worse in terms of ensuring sexual safety. Therefore, QI outcome evaluations should not be based on reporting levels.

Positive practice:

[Central and North West London NHS Foundation Trust](#)

The Trust has developed a leaflet for service users and carers, [Keeping safe: Sexual safety](#). The Trust has also done work to improve the quality of data collected around an incident, to support investigations and improve learning opportunities.

The chief executive and the trust board should regularly review incident report data, as well as the number and types of complaints that are made, as a regular part of governance. Reporting data can be used to improve the delivery of care, and to plan service provision and resourcing at a local level. This involves considering the needs of the community and balancing this with locally available support, including inpatient care, community mental health support and VCSE organisations. Allocation of additional support can be reviewed in line with reporting data.

It is important to bear in mind that differences between incident reporting systems can introduce variation in records and present issues when collating records for audits or analysis. The implementation of a streamlined reporting system with consistent categories and definitions is likely to improve the quality and usability of the data.

5. Service scenarios

The fictional scenarios in this guidance were developed with people who have experience of accessing care or working in mental health and learning disability inpatient settings. Each one is an example of how care delivery and support can be modified in practice to improve overall experience on admission and in response to a sexual safety incident.

The scenarios are designed to help staff think through potential situations, to prompt problem solving in their service policies or processes, rather than to provide a definitive answer. There are many ways that sexual safety can be ensured and responses to sexual safety concerns addressed, so the appropriate approach for each person should be explored and discussed collaboratively.

A: Providing care to an autistic person

Yasmin is 42 years old and has been admitted to an acute mental health ward under the Mental Health Act after a psychotic episode. She has been diagnosed as being on the autism spectrum and experiences sensory processing sensitivities, particularly to touch. She finds light physical contact quite uncomfortable and heavier physical contact painful. She also considers skin-on-skin contact to be an intimate gesture that is only shared between close family or romantic partners. This, coupled with her displeasure about being admitted to hospital, has caused Yasmin to become extremely anxious on admission.

At the outset, a female nurse on the ward sits down with Yasmin to develop a personalised care plan with her for her time on the ward. The nurse asks Yasmin what she might need to help her to feel safe there. Yasmin becomes tearful and agitated and explains that she is very sensitive to touch and scared of people touching her. From her case notes, the nurse sees that during a previous inpatient stay Yasmin was restrained, which led to increased anxiety and distress. She is wondering whether that incident is contributing to Yasmin's current anxiety.

What could be done?

- The nurse asks Yasmin whether she can include the points from their discussion in her care plan, so that other staff members can be made aware of Yasmin's sensitivity to touch. Yasmin agrees, so the nurse passes the information on to the care team.
- The nurse explains to the care team that while others may perceive light touch as normal conduct, Yasmin may see it as sexually inappropriate. As such, staff members should not touch Yasmin without explaining the nature of the physical contact and, wherever possible, obtaining her consent.

What might happen next?

- Yasmin's welcome pack contains a co-produced agreement that details appropriate and inappropriate behaviour on the ward. She is relieved to see that the agreement has been shared with every service user and staff member, so everyone on the ward will be aware that touching another person without their consent is not appropriate.
- She is reassured to see in her welcome pack that the hospital trust is committed to reducing the use of restrictive practices on the wards. As she has been admitted under the Mental Health Act, this had been a serious concern for her.
- After a few days, Yasmin's admission becomes a voluntary admission because she feels noticeably more comfortable in the ward environment. Yasmin says that part of this is because she feels safer within this ward compared with her previous admission. She was pleased to see posters around the ward that detail how to tell someone if a person has an issue with safety.
- The nurse plans to meet with Yasmin regularly during her stay to discuss any concerns she may have about interpersonal contact or safety on the ward and to see if any of her needs have changed.

B: Responding to sexual behaviours in a learning disability setting

John has recently been admitted to an adult mixed-sex learning disability ward. He is 25 and has a severe learning disability. He has limited verbal ability and largely communicates using Makaton and visual supports. John is struggling to settle into the new environment and is particularly struggling to distinguish between appropriate and inappropriate places to explore his personal sexual needs. This has resulted in several instances of John masturbating in communal spaces, such as the lounge area on the ward. This has been upsetting for some of the other service users who share these spaces with him.

What could be done?

- Sexual behaviour is a significant issue within this local service, with incidents related to inappropriate interactions between people such as unwanted touching, comments of a sexual nature, as well as social interactions that start appropriately and lead to unwanted interactions causing people and staff to feel sexually unsafe. As a result, all staff have been provided with training on how to address challenging sexualised behaviour in the inpatient setting.
- A male nurse on the ward spends time with John to identify and communicate which areas are regarded as appropriate for masturbation (such as his own bedroom) and which areas are inappropriate (such as the corridor or lounge). The nurse ensures there is clear signage on the doors to distinguish communal and private areas.
- The nurse also logs all incidents of exposure and looks for patterns of behaviour and circumstances that may typically precede this behaviour. When John displays these signs, the nurse knows to guide him to a more private space. He also ensures that John is given appropriate time in the privacy of his own room to explore his sexual needs, and that other staff members and service users respect his privacy.

What might happen next?

- Ward staff recognise that John's behaviour may have upset those around him and so they check in with everyone who witnessed the incidents. John's nurse incorporates details of any incidents of exposure into handover notes, particularly who witnessed the incident, to ensure that staff can provide adequate follow-up to everyone who needs it.
- The team have a variety of easy read resources that detail what constitutes appropriate and inappropriate behaviour; they make them available to those involved. The team ensure there is easy read signage around the ward that makes it clear who a person can talk to if they feel unsafe.
- The team also considers whether there may be other issues underlying John's sexual behaviour, such as distress, boredom, or other family difficulties. They work with John and his family to identify any other support he might need.

What else can the team do to ensure sexual safety?

- Analyse incident data and gather feedback from people and staff about sexual safety and use this information to put in place additional measures, based on QI methodology, that can improve safeguarding, provide more timely support for people and reduce sexual safety incidents.
- Focus on improvements in day-to-day social interactions between people and with staff, particularly around helping people to maintain their personal space when interacting with others. Reflective practice can help staff respond appropriately to people who feel unsafe during social interactions.
- Use a trauma-informed approach and Positive Behavioural Support plans to understand behaviours that lead to sexual safety incidents, which can ensure a more person-centred response while maintaining boundaries.
- The psychology team works individually with people to co-produce skills to help them feel safe during wider interactions they may have with others.
- The speech and language team uses adapted materials and interventions to help people understand the concepts of sexual safety and to support communication.
- Staff use modelling of the preferred interactions throughout the day to support people to interact while maintaining personal space.
- Conversations about COVID-19 measures offer opportunities to have discussions around touching and personal space in general.



C: Responding to an incident in which a staff member is directly affected

Maria is a 34-year-old woman working as a healthcare assistant on a low-secure rehabilitation ward. She has been assigned to accompany Andrew, a long-stay service user, on escorted leave. When they return, Maria appears visibly distressed. Her manager offers to take Maria to a private, confidential space to talk, or to find an alternative female member of staff to talk with. Maria appreciates being given this option but decides to talk with her manager. She tells him that during the escorted leave Andrew touched her in a way that felt inappropriate and attempted to kiss her. The manager takes time to listen to her account of the event. He asks whether Maria believes it was an intended sexual assault or whether Andrew may have been sexually disinhibited. Maria believes Andrew was sexually disinhibited at the time, but this does not lessen the distress she is experiencing.

What could be done?

- The manager sees that Maria is shaken and asks her what can be done to improve her safety at work. Maria asks if it is okay to finish work early today and the manager agrees.
- She also says she would like to continue working on this ward, but no longer feels safe conducting one-to-one assessments with Andrew or accompanying him on escorted leave alone; the manager ensures that her caseload reflects this. He encourages her to let him know if anyone asks her to work with Andrew in this way and says he will ensure this is changed.
- The manager also asks Maria whether she would like to inform the police, and supports her to provide a statement. She is given time off work, as requested, and her manager promises to phone Maria regularly during this time to check in with her.
- The manager also reports in Andrew's care notes that there is a possibility of sexual disinhibition to make other staff members aware and checks whether this behaviour has been reported previously.
- Finally, he provides Maria with a confidential, sexual advisory helpline as well as an internal support option. He schedules a follow-up meeting with her to assess any potential delayed impact of harm.

What might happen next?

- Following their conversation, Maria's manager logs the incident on the reporting system and offers her a chance to review and amend the report.
- He schedules an appointment between Maria and someone from HR to ensure they are informed about the situation and can consider how this may affect Maria's work.
- The local mental health police liaison officerⁿ follows up with Maria to discuss the incident and her statement. They also outline the likely next steps of a police investigation to determine whether legal proceedings will occur and what that will involve.

ⁿ Or local police officer in areas that may not have mental health police liaison officers.

- He arranges a session for all staff on the ward to talk about [relational security](#) and asks Maria if she would be open to having a conversation with Andrew, to work on rebuilding their therapeutic relationship.
- Maria's manager also organises a one-to-one session with Andrew to discuss the incident and clarify the co-produced agreement on appropriate and inappropriate behaviour, and look into how they can support him further during his time on the ward.
- The manager asks a member of staff to conduct an assessment of capacity and updates Andrew's risk assessment in consideration of his increased risk of sexually disinhibited behaviour.

D: Responding to a disclosure in the context of current symptoms of mania

Riccardo is a 28-year-old man who is receiving care on a forensic mental health ward. In hospital, he has experienced one sudden-onset manic episode and is experiencing symptoms of mania again. During ward rounds, Riccardo makes a disclosure to his multidisciplinary care team that one of the female healthcare assistants entered his room and touched his crotch over his trousers when undertaking general observations. Riccardo elaborates on the incident, but he appears uncertain about what happened and provides a very inconsistent and confusing account of the incident. The team agree that the ward forensic psychiatrist will take this forward.

What could be done?

- All disclosures of this kind are taken seriously. The psychiatrist recognises that the trauma narrative can be inconsistent and explains to Riccardo that he has a duty to investigate what happened.
- The psychiatrist generates an incident report, which will be assessed by senior management and members of Riccardo's multidisciplinary team. He makes an entry on an electronic care record system.
- The psychiatrist asks if Riccardo would be comfortable if he shared this information with the hospital's safeguarding team and the ward manager as well as Riccardo's family.
- The psychiatrist explains that the trust has a responsibility to everyone in the hospital and that it actively encourages reporting of such incidents to the police and that a police investigation may follow. He explains that reporting the incident to the police can be done by a trusted member of ward staff on Riccardo's behalf, or that Riccardo can do this himself with staff support, when he feels ready. Riccardo agrees to the safeguarding team being told but does not want to involve his family or have any police investigation.

- The psychiatrist explains the situation to the safeguarding lead. They advise him to wait and see if, once his manic symptoms reduce, Riccardo feels differently about the police investigation. In the meantime, the safeguarding team speak to the healthcare assistant's line manager and HR, and arrange to hold discussions with the assistant as soon as possible to investigate what happened. They keep written records of all discussions and decide the most appropriate way to manage the situation on the ward to keep both Riccardo and the healthcare assistant safe while they investigate the incident.
- A few days later, the psychiatrist asks Riccardo again if he would like to discuss anything regarding the disclosure. Riccardo is now experiencing fewer manic symptoms and tells him that, having had some time to reflect on the situation, he feels uncomfortable and somewhat anxious about being around female staff. The psychiatrist immediately arranges with the ward manager for Riccardo's care needs to be provided by male staff members where practically possible. He asks Riccardo what else he might need to feel safe on the ward, if he would like his family involved and if he would like further investigations to be made. Riccardo agrees to further police investigations. The psychiatrist communicates this to the member of staff who is the designated police liaison worker, who informs the police of the incident.
- While the safeguarding board and police are investigating the disclosure, due process is followed, in line with local policy.
- If the investigation confirms that the allegations against the healthcare assistant are unfounded and that Riccardo's experience and disclosure of the events were due to a decline in his mental health, the care team will try to identify what else can be put in place to support him. The healthcare assistant will be supported to feel safe, which may include receiving additional supervision or support from other agencies or deciding whether she may wish to work on a different ward.
- If the investigation confirms that the incident has taken place, the healthcare assistant will be removed from her position at the trust, in line with trust policy. Police procedures will be followed and a report will be prepared by a senior staff member to establish if there were any gaps in care, lessons learned and how best practice can be cascaded to teams.
- Debriefs will be held with Riccardo and any other people who may have been affected. Additional mental health support will be offered, and access to a specialist, independent sexual safety adviser will be made available.

What might happen next?



E: Admission to an older adult mental health ward

Gino, an 84-year-old male, has been referred by the liaison mental health team for admission to an older adult mental health ward after experiencing intrusive and frequent suicidal thoughts. As a result of a stroke, Gino has some mobility problems and sometimes struggles to walk with the aid of a walking stick.

During his initial assessment conversation with a female nurse on the ward, Gino reluctantly tells her that because of the stroke, he is unable to properly wash some parts of his body, including his genitals, and usually has support from visiting care staff at home.

What could be done?

- The nurse reassures Gino that he will be able to have his personal care needs met on the ward and asks whether he would prefer a male staff member to help him.
- Gino says he would prefer to be helped by a male nurse, so she ensures that this preference is recorded in Gino's care plan and on the patient record system, and shares the information with the other members of staff.
- In light of Gino's mobility issues, she enquires about the type and extent of tactile assistance he is comfortable with when being escorted around the ward. Gino tells her that he does not like people touching him without warning and instead asks that a staff member offers him their arm to initiate the contact.
- The nurse asks what else he might need to feel safe. Gino says that he is scared about being in a setting with people he does not know and not feeling able to ask for help. The nurse escorts him around the ward, clearly indicating all the call points for staff, and explains how to summon immediate help. She ensures that Gino has access to a call bell in his room, to easily notify staff if he needs assistance. She ensures that the call bell is placed so that he can reach it from his bed.
- The nurse arranges an assessment for Gino, to check for perceptual deficits. This will ensure that she can offer a safety information and resource pack which is accessible to Gino and takes account of his needs.

What might happen next?

- These choices help Gino to feel more in control of his care and ward experience.
- As Gino receives a welcome pack and informative resources, it means he can easily access all the information he may require. These resources include a co-produced ward behaviour agreement, information on what Gino can expect from his stay and how to raise a safety concern with a member of staff, an anonymous helpline or an independent advocacy service.
- The nurse organises a regular catch-up with Gino to re-assess whether support needs to be further tailored, meaning that he has an opportunity to discuss any additional needs he may have or modify support that is already being provided.



F: Admission to an acute ward for a transgender person

Kristina, 36, is a transgender woman. She has been admitted to an acute mental health ward by the crisis team due to concerns about suicide risk. During her assessment, the nurse notices that Kristina seems very anxious. When asked if there is anything she is worried about, Kristina tells the nurse that she is scared she may be put on a male ward. She has been taking hormonal therapy and transitioning for a year.

What could be done?

- The nurse tells Kristina that they would not put her into an environment where she felt uncomfortable or unsafe and offers her the choice of the female ward or a mixed-sex ward. Kristina chooses the female ward and is noticeably happier about this. They also discuss other factors that might affect her feelings of sexual safety, such as having a private bathroom to use, interacting with or being observed by male staff, and any concerns about using common areas. The discussion around sexual safety including her preferred name and pronouns are noted in Kristina's care plan for future reference.
- Kristina receives a welcome pack on admission, with a co-produced ward agreement. She goes through it together with the nurse. She is glad to see that an agreement of non-discrimination is included, but tells the nurse that she is worried people might bully her. The nurse tells Kristina that the care team does not tolerate bullying on the ward. She explains that there might initially be increased observations, and if staff notice anything they will intervene immediately.
- The nurse explains that the care team will always be available if Kristina needs help and support, and shows her where they can be found. She explains that all staff have received awareness training to support sensitive care delivery to people from LGBTQ+ communities and been offered rainbow lanyards and badge holders to demonstrate the trust's commitment to advancing LGBTQ+ equality. Kristina feels happier knowing she can approach a member of staff, particularly one wearing a rainbow lanyard or badge holder, and be more confident that they will be understanding.
- The nurse asks Kristina if she might want to link up with external transgender support services.

What might happen next?

- The nurse confirms with Kristina that she will receive her hormonal therapy on the ward and records this in her care plan. She asks for her consent to contact her GP, but Kristina thinks it would be better for the nurse to liaise with her gender identity clinic. The nurse arranges to coordinate Kristina's hormone therapy with the gender identity clinic and endocrinology service.



G: Trauma-informed care in practice

Katherine has been admitted to an acute inpatient ward. On admission, one of the female ward nurses asks her what she needs to make her feel safe. Katherine says she would prefer to be seen by female staff but does not disclose why. When asked if she wants to involve family in her care, she strongly objects, explaining that her family are not understanding of her mental health problems. Katherine mentions that she does not like it when people stand too closely behind her and does not like being touched by someone she does not know.

What could be done?

- The nurse arranges for Katherine to receive care in a single-sex ward and for only female staff to attend to her needs.
- They make sure that all other staff are aware of Katherine's triggers so that she does not have to explain this multiple times.
- They also tell the other staff that Katherine does not wish to have her family involved in her care at this point, but encourages staff to check this at various timepoints.
- The nurse regularly reviews what helps to keep Katherine feeling safe so that they can identify any changes or new approaches to care.

What might happen next?

- Katherine says she felt that the nurse listened to her wishes and made it possible for her to receive care in a way that made her feel more comfortable. She felt that she had more control over her care and that her requests were taken seriously.



H: Responding to an incident on a children and young people's ward

Teresa is a 16-year-old girl who is currently receiving care in a children and young people's eating disorder inpatient unit. She has been there for almost 3 weeks and in that time has become close with another girl, Flora, who is 17. Flora has been in the unit for 6 weeks now. She was previously quite isolated but has shown great attachment to Teresa.

Teresa tells the ward chaplain that Flora told her to remove her clothing in front of her when they were in the garden. She says that when she refused, Flora became quite insistent and it made her feel scared and uncomfortable. She tried to run away, which made Flora angry. Flora then tried to follow her. Teresa tells the chaplain that Flora has since apologised to her for how she behaved and said that she did not mean anything, but Teresa is scared to be around her.

What could be done?

- The chaplain reassures Teresa and tells her that he has a duty to pass this information on to the care team and to safeguarding, to make sure that her time in hospital is safe. Teresa says she understands, but is scared of making Flora angry. The chaplain assures Teresa that they will be sensitive in their approach.
- The chaplain asks if he can share their discussion with Teresa's parents, so that they are aware of what has been happening. Teresa agrees and the chaplain shares this with the care team.

What might happen next?

- The care team create an incident report and escalate it to the safeguarding children lead. As part of the investigation, the care team works closely with social workers to take appropriate action to keep both Teresa and Flora safe and update their care plans.
- The team decide it is within the girls' best interests to temporarily move Flora to another ward on the premises. They pass on detailed reports to the next ward and continue to review the arrangements regularly.

6. Positive practice examples

The following entries have been recommended by people with lived experience and other stakeholders involved in the development of this guidance. These examples were selected based on their alignment with the standards outlined in this document; however, as many of these services are early on in their sexual safety improvement journey, these examples reflect work in progress.

Camden and Islington NHS Foundation Trust

Following analysis of internal incident data across their mental health services, Camden and Islington NHS Foundation Trust identified 200 sexual safety incidents across a 2-year period. Response procedures within the case reports were highly heterogeneous. These findings necessitated immediate action. In response, the Trust developed a robust sexual safety policy to be applied across all inpatient and outpatient settings and is planning a corresponding staff training programme to ensure staff adhere to this policy.

This sexual safety agenda sits within the AR-DSA network, run in partnership with charities, such as AVA, to draw on the expertise of specialist, independent organisations. AR-DSA meets bi-monthly to discuss a range of issues around sexual harm and domestic abuse in the service user population and approaches to

tackle these. This dynamic group is typically composed of health care professionals, safeguarding representatives, people who have used mental health services and people who have experienced sexual harm to ensure co-production runs throughout the initiative. The group also raises relevant equalities issues to improve care for communities that may be more vulnerable to sexual harm. Alongside policy development, the group also developed a sexual safety poster that aims to encourage people (staff and service users) to speak up about current or historical sexual safety incidents, regardless of whether it occurred on Trust premises. This poster included relevant helplines and contact information and was also closely developed with strategic communications to ensure the message was conveyed effectively.

Demonstrates positive practice in:

- ✓ multi-agency working
- ✓ co-production
- ✓ trauma-informed care

Population: inpatients and outpatients

Location: London

For further information, contact: Shirley McNicholas, Women's Lead for Camden and Islington Foundation NHS Trust: Shirley.McNicholas@candi.nhs.uk

The AR-DSA network also recognise the importance of a whole-system approach to sexual safety to ensure it is embedded throughout the Trust. A QI coach has recently joined the network to drive the initiative on the ground. HR representatives have also joined the network to ensure there is an appropriate response to staff who may have been involved in any incident as a victim or the source of harm. The Trust has developed links with external organisations and charities to improve multi-agency working; this work has enabled the engagement of Independent Sexual and

Domestic Violence Advocates through honorary contracts with the Trust as part of the Pathfinder Project. The Pathfinder Project's lead agency with the Trust, AVA, will also facilitate specialist training for staff and has provided a one-day course on trauma-informed care for practitioners and managers at Drayton Park Women's Crisis House.

This organisational approach has led to improved staff awareness and accountability, enabling further innovative and collaborative work. A junior doctor within the Trust recently worked closely with pharmacy to develop and publish a step-by-step guide for staff on how to acquire post-exposure prophylaxis immediately after an incident; this guide is given to staff during training. This demonstrates the effective and efficient approach taken by staff towards sexual safety within the Trust and this system-wide approach has fast developed the sexual safety initiative. As such, this work has had interest from many external organisations, including the CQC, and was showcased at the White Ribbon Event in November 2019. This work is part of embedding a trauma-informed approach within the Trust.

Cheshire and Wirral Partnership NHS Foundation Trust

Because the CQC report was under development, Cheshire and Wirral Partnership NHS Foundation Trust also decided to give greater priority to addressing sexual safety and have since worked on a number of the recommendations from the CQC report.¹

One key approach to addressing sexual safety and helping people to feel safe was the development of co-produced safety cards. Following extensive consultation with service users, safety cards were collaboratively developed to outline what people should expect when staying on the ward and what should not happen, so that everyone has clear expectations while on an inpatient stay. The cards took a general approach to safety and sexual safety was explicitly encompassed within

this. The cards also detailed how to escalate concerns if someone did not feel safe, including a confidential advice helpline and information for an independent advocacy service. Easy read versions of the cards were made available, to be inclusive of different needs and to make the information accessible to all. The cards have been rolled out across a variety of services, including learning disability wards, children and young people's mental health services, low-secure units and PICUs. This approach has improved awareness of sexual safety on the wards and increased discussion around how to ensure people feel safe.

Following this successful project, the Trust hope to make all their services trauma-informed and are taking the first steps to address this. The Trust recognise the importance of interacting with service users in a way that is sensitive of their previous experiences and hope to extend the same principles to its response to incidents that involve staff members. The Trust also recognise the utility of a QI approach in driving this initiative, so have recruited QI coaches to help advance sexual safety in day-to-day working practice through the development of driver diagrams and the implementation of change ideas.

Demonstrates positive practice in:

- ✓ co-production
- ✓ clear, accessible information
- ✓ QI approach

Population: inpatients

Location: Cheshire

For further information, contact: Cathy Walsh, Associate Director of Patient and Carer Experience: cathy.walsh1@nhs.net

Now that the Trust has an established working group set up to address issues around sexual safety, there are other issues on the agenda for 2020. They hope to improve the way incidents of sexual harm are reported, increase awareness of sexual harm and sexual health across the workforce, and develop an approach to support partners of people affected by a sexual safety incident while receiving inpatient care. There will be an open invitation to people who have used the services to get involved in this initiative, to ensure that co-production is embedded throughout. While this initiative is in progress, these existing and planned activities promote sexual safety as a crucial component of the wider safety agenda across the Trust.

City and Hackney Centre for Mental Health, Homerton

Provided by: East London Foundation Trust

Through a partnership with Homerton Sexual Health Service, the City and Hackney Centre for Mental Health have introduced sexual health history-taking and screening on admission. This initiative is in recognition that people with severe mental illness (SMI) are more likely to engage in high-risk sexual behaviours, including multiple partners, unprotected intercourse, and involvement in the sex trade.^{18,19} People with an SMI are at an increased risk of being a victim of sexual violence, both in the community and in the inpatient setting,¹ and have a higher prevalence of unplanned pregnancy and sexually transmitted infections.^{18,20,21} By partnering with sexual health services, the City and Hackney Centre for Mental Health proactively promote sexual health in this community. A more thorough history-taking may improve disclosures of historical or recent abuse, enabling further appropriate support provisions to be offered.

This service has also used the **STARTER model** to support staff who may feel less confident to broach this subject:

- **Start** the conversation as soon as possible: including sexual health history as part of the assessment process enables earlier identification of concerns
 - **Talk** about sexual health concerns and sexual side-effects: this may include concerns around meeting sexual needs, sexual identity and the potential impact of illness or prescribed medications on sexual wellbeing
 - **Acknowledge** your own views, biases and assumptions: staff members should reflect on how their culture, age, sex and views may influence their approach to conversations around sexual health
 - **Refer** to external services when necessary: links should be developed and maintained with external organisations, such as those offering sexual health screening or support to victims
 - **Time**: agree a schedule for when you will return to the topic; staff should respect each person's willingness to engage in the conversation and return to the subject at agreed intervals
 - **Educate** the patient and yourself: there should be opportunities for staff and service users to further educate themselves around the many aspects of sexual health and sexual safety
- **Reflect** and record: referrals, discussions and outcomes should be well documented and shared with the necessary people

Demonstrates positive practice in:

- ✓ love, sex and intimacy information programmes
- ✓ sexual health and expression care plans

Population: 18+

Location: London

For further information, contact: Rachel Luby, Senior Registered Mental Health Nurse: rachel.luby@nhs.net

Adopting this model encourages open discussion around sexual health and sexual harm, with consideration of a service user's readiness to engage, enabling a proactive approach to sexual health concerns.

Hertfordshire Partnership University NHS Foundation Trust

As a result of the publication of the CQC report on sexual safety in mental health wards,¹ Hertfordshire Partnership University NHS Foundation Trust convened a multi-agency Sexual Safety Task and Finish Group. The group was established with a view to action the recommendations that were made in the CQC report and consists of managers of the acute services, nursing leads, Hertfordshire Constabulary, Hertfordshire SARC, local sexual health services and the Trust's safeguarding leads.

The Sexual Safety Task and Finish Group have already begun a number of projects that are nearing completion, such as:

- Developing and embedding clear referral pathways from the local SARC into mental health services, so that there is a clear route for people to receive support and protection following a sexual assault
- Co-producing sexual safety awareness leaflets for adult service users and their families with people who have used services in the past. These include information on what sexual safety is, along with how people can report any concerns of a sexual nature

Demonstrates positive practice in:

- ✓ multi-agency working
- ✓ advancing equality
- ✓ trauma-informed care

Population: inpatients

Location: Hertfordshire

For further information, contact: Karen Hastings, Consultant Social Worker (Adult Safeguarding)/ Approved Mental Health Professional: karen.hastings1@nhs.net

- Including one-to-one sexual safety conversations as a part of inpatient induction for the adolescent unit. These conversations are tailored to the child or young person's age and are personalised, based on their needs
- Developing a guidance document and flowchart for all staff on adult wards so that they know how best to respond to disclosures of a sexual safety incident or sexual abuse

The group continue to meet regularly and have planned future workstreams around promoting equality in experience of inpatient care and ensuring safe environments. These future workstreams include:

- Ensuring that any advice, guidance and resources that are developed are tailored to meet the needs of people with a learning disability or other communication difficulties so that as many people have access to these resources as possible
- Enhancing staff awareness of the specific needs that LGBTQ+ patients may have regarding feeling safe from sexual harm within inpatient environments

- Strengthening and improving staff competences around how to deliver trauma-informed care
- Ensuring that current ward environments are improved so that they enhance safety for all people

By establishing this multi-agency group who can work in this collaborative manner, each agency is now able to identify gaps in the current provision for ensuring sexual safety and embed new approaches to address these as well as promoting sexual safety.

The John Howard Centre

Provided by: East London Foundation Trust

Proposed changes to the 'access to sexually explicit material' policy in a medium secure forensic setting which would allow service users to access moving images were initially met with concern within the John Howard Centre. Despite most service users being detained at a crucial period in the development of their adult sexuality, the expression of sexuality was deemed problematic and sex was generally regarded as a taboo subject. Decisions were based on risk aversion as opposed to service user need(s). This did not acknowledge that service users were sexual beings, and the evidence that shows that sexual and relationship wellbeing improves quality of life, enhances the recovery process and acts as a positive motivator against recidivism.²²

What is more, when asked what would make them more comfortable to 'talk about sex', staff indicated that they would be if patients broached the subject, and patients would be if the subject were raised by staff. Therefore, it was apparent that an improved culture around sexual discussion was required.

Demonstrates positive practice in:

- ✓ sexual health history-taking and screening on admission
- ✓ partnership with sexual health services

Population: 18+

Location: London

For further information, contact: Rachel Luby, Senior Registered Mental Health Nurse: rachel.luby@nhs.net

'Let's talk about sex(ual) health, intimacy and expression' set out to increase confidence in the discussion of sex, using QI methodology. The change ideas included staff training around sexual health with a focus on how to introduce the topic, sexual health screening, access to a condom distribution programme, sexual health and expression care plans and a 10-week programme called 'Let's talk about love, sex, intimacy'. This programme focused on topics such as consent, sex when you are single, sexual safety, sexual side-effects and dating. Patients were asked to rate their confidence to 'talk about sex' on a weekly basis and their confidence improved from an average of 3/10 to 8/10 within 6 months of the programme, reflecting a change in culture around this once taboo subject.

Throughout the project, the frequency of sexual safety incidents was also recorded. This was done both to reassure those that were reluctant to engage and to measure whether creating an atmosphere where discussions about sex were the norm resulted in an increase in sexual disinhibition or violence. Over the duration of the project, the number of incidents decreased, demonstrating the importance of facilitating open and transparent conversation around the topic of sexual health and sexual wellbeing.

Newham Adult Mental Health Services

Provided by: East London Foundation Trust

Following an incident on their premises, the Newham Directorate decided to conduct in-depth explorations of the experiences of female staff and service users in adult inpatient and community mental health settings using a range of surveys, interviews and analyses of reports. Prevalent issues with sexual harassment and inappropriate behaviour were identified, affecting staff and service users alike. In immediate response to these findings, the Newham Directorate established a Task and Finish group as part of the wider safety agenda, intended to advance sexual safety in mental health services. The first step towards this goal was to rewrite the Trust's professional boundaries policy to explicitly outline what is considered appropriate and inappropriate conduct between staff and service users, taking account of ground-level interactions, social media, and professional and personal relationships. Crucially, this document applies to all clinical or non-clinical workers who may be on the service premises, regardless of registered status, job role or banding.

Demonstrates positive practice in:

- ✓ clear and accessible information provided in services
- ✓ cultural change deriving from clinical leaders

Population: 18+

Location: London

For further information, contact: Gill Williams, Borough Director of Newham Adult Mental Health: gill.williams2@nhs.net

The working group also produced a leaflet for service users detailing clear information on 'What you can expect from our services', with contact details through which to raise queries or concerns. The leaflet takes a broader safety approach, to ensure that all service users have a clear expectation of what should and what should not happen while under the care of the Trust. Through accessing and exploring the relevant data, the Trust has been able to identify common features that have placed individuals at greater risk of abuse or exploitation, such as a diagnosis of emotionally unstable personality disorder or experience of historical sexual trauma. By identifying key risk factors and undertaking routine assessments around trauma, staff can improve vigilance and deliver more person-centred and trauma-informed care.

The Trust plans to increase awareness and accessibility of information on sexual safety by displaying informative posters in services and designating a champion on each ward to drive the sexual safety initiative at ground level. The Trust also recognises that a cultural and attitudinal shift requires top-down change from the senior level. The Newham Directorate will present their work in 2019/20 to each service in the Trust. Senior staff members will attend to ensure that core values are reflected in leadership throughout the Trust.

Newham Adult Mental Health services have taken important steps towards advancing sexual safety. Addressing this once taboo subject in a transparent manner has increased awareness and facilitated discussion of the importance of sexual safety across the Trust.

Nottinghamshire Healthcare NHS Foundation Trust

Coinciding with the publication of the CQC (2018) report,¹ Nottinghamshire Healthcare NHS Foundation Trust also began to look deeper into issues around sexual harm within their adult mental health services. As a result, an advisory group was established in January 2019 to drive this initiative in a collaborative manner between the Trust and academics with expertise in the field, facilitating an evidence-based approach to the initiative.

While sexual safety concerns can affect everyone accessing mental health services or working in these settings, this initiative is specifically focused on the experiences of women in adult inpatient units. The Trust recognise that different services have different needs and the approach to sexual safety will need to suitably differ according to the patient profile. As such, the Trust is hoping to direct and embed these changes within a focused scope of services before applying the principles to a broader range of services and patient groups. The main aim of the initiative is to develop a suite of resources to enable practitioners working in mental health services

Demonstrates positive practice in:

- ✓ co-production
- ✓ resources for staff training
- ✓ sexual safety

Population: women aged 18+

Location: Nottingham

For further information, contact: Dr Julie McGarry, Associate Professor, University of Nottingham: Julie.mcgarry@nottingham.ac.uk

to change their way of working around sexual safety and managing sexual harm. This includes the development of resources to aid with training needs to support staff to engage in this topic and feel confident in asking questions about sexual health and sexual harm. A key product of this initiative is the development of open-access, co-produced reusable learning objectives (RLOs) around sexual safety for staff in health care settings. The RLOs are web-based, multimedia learning resources that adopt a pedagogical approach. Using an interactive combination of audio, video, images and text, the RLOs are designed to offer information and reflective exercises to engage practitioners in key learning around sexual safety. There are plans to develop additional RLOs around similar topics, such as domestic abuse.

Crucially, the Trust has adopted co-production in their approach to sexual safety. Key stakeholders were recruited to the advisory group, including people who have accessed mental health services, people who have experienced sexual harm and professionals with expertise in the area. This collaborative approach is key to delivering a work package informed by expert opinion and shaped by personal experience, as well as being applicable in practical settings.

While this work is in progress within the Trust, the increased conversation around this topic has put sexual safety high on the agenda of clinical leaders within the Trust. The initiative has been welcomed by staff and has encouraged the Trust to strive for excellence in sexual safety.

Shropshire Care Group

Provided by:
Midlands
Partnership NHS
Foundation Trust

After observing an increase in sexual safety incidents, Shropshire Care Group conducted a thematic review into the incident data across their mental health wards at the Redwoods Centre. The majority of incidents related to service users engaging in consensual sexual activity, service users instigating non-consensual acts, or incidents concerning sexual disinhibition. The review outcomes were used to determine a list of priority actions, including staff education and training, changing the culture across the Shropshire Care Group, and information provisions for service users. Additionally, the creation of a male and female acute mental health ward allowed a review of a service user's presentation or history previous to admission to a ward to determine whether a single-sex or mixed-sex ward would best meet the service user's needs. It also offered choice.

The Trust first developed a privacy, dignity and respect policy to guide staff in their interactions with service users. To address awareness further, the Shropshire Care Group also offered awareness sessions to staff of any discipline; these typically last 2–3 hours and are run by a clinical matron, nurse consultant and clinical psychologist to facilitate a multidisciplinary approach to sexual safety. The sessions encompass a range of information and education around the key principles of sexual safety, such as trauma-informed care and conducting robust risk assessments. Crucially, the session leaders take a transparent approach to the topic by acknowledging current issues around sexual safety and how to address these. As such, staff have been well engaged with the sessions which has generated quality discussion and shared learning across the workforce. While the sessions have been running for a year, they are now offered bi-monthly to account for new staff intake.

Demonstrates positive practice in:

- ✓ awareness raising sessions
- ✓ weekly audits

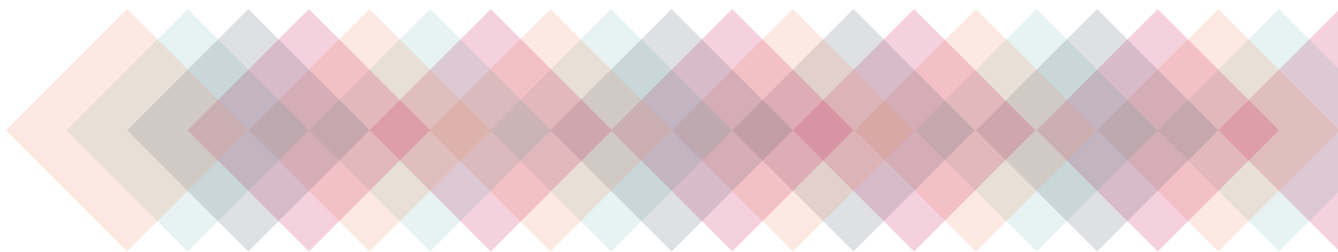
Population: inpatients aged 18+

Location: Midlands

For further information, contact: Sarah Oliver, Clinical Matron, Redwoods Centre: Sarah.Oliver@mpft.nhs.uk

The Trust recognises the importance of accurate data recording and regular data analysis. They have introduced a weekly audit to monitor the frequency of sexual safety incidents within their inpatient mental health services. This regular review of the data enables early identification of common themes, and thus, quicker action. Equally, there has been a significant increase in the use of RiO (electronic patient records); the everyday use of the alert system to log concerns has become embedded in working practice. Improving recording and communication between staff has been key to the Trust's approach to sexual safety. For example, a dementia ward within the Shropshire Care Group now incorporates sexual safety issues into their handover notes to ensure incoming staff exercise increased vigilance over their shift for those concerned.

The Trust have also taken action to improve the accessibility of information available to service users. Upon admission, service users are provided with a welcome pack that includes information about safety, including sexual safety. Service users, on acute adult and older adult mental health wards are also offered personal alarms that they can carry with them at all times; if someone feels unsafe, they can sound their alarm to notify staff of their whereabouts. There is also a sexual safety agenda within community meetings to promote an open atmosphere around the topics of sexual health and sexual safety. This has facilitated a more honest conversation with service users around sexual concerns and sexual needs. This transparent approach to the topic has contributed to a tangible change in culture across the Trust.



7. Helpful resources

- 7.1. Relevant NICE guidelines and quality standards**
- [Domestic Violence and Abuse: Multi-agency Working \(PH50\)](#)
 - [Patient Experience in Adult NHS Services: Improving the Experience of Care for People Using Adult NHS Services \(CG138\)](#)
 - [Service User Experience in Adult Mental Health: Improving the Experience of Care for People using Adult NHS Mental Health Services \(CG136\)](#)
 - [Violence and Aggression: Short-Term Management in Mental Health, Health and Community Settings \(NG10\)](#)
- 7.1.1. Additional NICE guidelines and quality standards**
- [Antisocial Personality Disorder: Prevention and Management \(CG77\)](#)
 - [Autism Spectrum Disorder in Adults: Diagnosis and Management \(CG142\)](#)
 - [Child Abuse and Neglect \(QS179\)](#)
 - [Decision Making and Mental Capacity \(QS194\)](#)
 - [Intrapartum Care for Women with Existing Medical Conditions or Obstetric Complications and Their Babies \(NG121\)](#)
 - [Learning Disability: Care and Support of People Growing Older \(QS187\)](#)
 - [People's Experience using Adult Social Care Services \(QS182\)](#)
 - [Self-Harm \(QS34\)](#)
 - [Sexual Health \(QS178\)](#)
 - [Supporting adult carers \(NG150\)](#)
- 7.1.2. NICE pathways**
- [Child abuse and neglect](#)
 - [Patient experience in adult NHS services](#)
 - [Service user experience in adult mental health services](#)

7.2. Relevant policy, legislation, regulation and commissioning documents

- [Another Assault – Mind’s campaign for equal access to justice for people with mental health problems](#)
- [Capacity to Consent to Sexual Relations](#) – British Psychological Society
- [Eliminating Mixed Sex Accommodation](#) – Department of Health
- [Learning from Patient Safety Incidents](#) – NHS Improvement
- [Multi-Agency Public Protection Arrangements \(MAPPA\)](#) – National Offender Management Service and Offender Management and Public Protection Group
- [National Strategy on Policing and Mental Health](#) – National Police Chiefs’ Council
- [Promoting Sexual Safety Through Empowerment](#) – CQC report on sexual safety and the support of people’s sexuality in adult social care
- [The Right to Be Safe – Ensuring Sexual Safety in Acute Mental Health Inpatient Units: Sexual Safety Project Report](#) – Mental Health Complaints Commissioner, State of Victoria, Australia
- [Responding to Domestic Abuse: A Resource for Health Professionals](#) – Department of Health
- [Safe and Well: Mental Health and Domestic Abuse](#) – Spotlight Report
- [Sexual Safety on Mental Health Wards](#) – CQC
- [Sexual Safety of Mental Health Consumers Guidelines](#) – Ministry of Health, New South Wales Government, Australia
- [Ward Watch – Mind’s Campaign to Improve Hospital Conditions for Mental Health Patients: Report Summary](#)
- [The Women’s Mental Health Taskforce](#) – Department of Health & Social Care

7.2.1. Sexual safety information and resources

- [Keeping Safe – Sexual Safety: Information for Patients and Carers](#) – Central and North West London NHS Foundation Trust
- [Respond’s Independent Sexual Violence Advocacy Service](#) – Support for people with learning disability, autism diagnosis or both, who are victims of sexual abuse
- [Sexuality: research and statistics](#) – Information from Mencap on sexuality and the importance of relationships to people with a learning disability
- [Sexual Safety in Mental Health](#) – a collection of resources from the Royal College of Nursing

7.2.2.

Relevant legislation and guidance

- [Care Act 2014](#)
- [Children Act 1989](#)
- [Children Act 2004](#)
- [Criminal Justice Act 2003](#)
- [Equality Act 2010](#)
- [Gender Recognition Act 2004](#)
- [Human Rights Act 1998](#)
- [Mental Capacity Act 2005](#) (including [Deprivation of Liberty Safeguards](#))
- [Mental Capacity Act Code of Practice 2007](#)
- [Mental Health Act 1983](#) (amended [2007](#))
- [Policing and Crime Act 2017](#)
- [Public Interest Disclosure Act 1998](#)
- [Safeguarding Vulnerable Groups Act 2006](#)
- [Sexual Offences Act 2003](#)

7.2.3.

Safeguarding resources

- [Adult Safeguarding: Roles and Competencies for Health Care Staff](#) – Royal College of Nursing
- [Making Safeguarding Personal: Guide 2014](#) – Local Government Association and Directors of Adult Social Services (ADASS)
- [Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff](#) – Intercollegiate document published by the Royal College of Nursing
- [Working Together to Safeguard Children: A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children](#) – HM Government

7.2.4.

Additional relevant quality standards for inpatient care

- [Accreditation for Working Age Inpatient Mental Health Services \(AIMS-WA\)](#) – College Centre for Quality Improvement (CCQI)
- [Quality Network for Eating Disorders \(QED\)](#) – CCQI
- [Quality Network for Forensic Mental Health Services \(QNFMHS\)](#) – CCQI
- [Quality Network for Inpatient CAMHS \(QNIC\)](#) – CCQI
- [Quality Network for Inpatient Learning Disability \(QNLD\)](#) – CCQI
- [Quality Network for Inpatient Mental Health Services for Deaf People \(QNMHD\)](#) – CCQI

7.3. Commissioning guidance

- [Quality Network for Mental Health Rehabilitation Services \(AIMS Rehab\)](#) – CCQI
- [Quality Network for Older Adults Mental Health Services \(QNOAMHS\)](#) – CCQI
- [Quality Network for Perinatal Mental Health Services \(PQN\)](#) – CCQI
- [Quality Network for Psychiatric Intensive Care Units](#) – CCQI
- [Commissioning Framework for Adult and Paediatric Sexual Assault Referral Centres \(SARC\) Services](#) – NHS England
- [Guidance for Commissioners of Acute Care](#) – Inpatient and Crisis Home Treatment – Joint Commissioning Panel for Mental Health
- [Guidance for Commissioners of Child and Adolescent Mental Health Services](#) – Joint Commissioning Panel for Mental Health
- [Guidance for Commissioners of Eating Disorder Services](#) – Joint Commissioning Panel for Mental Health
- [Guidance for Commissioners of Forensic Mental Health Services](#) – Joint Commissioning Panel for Mental Health
- [Guidance for Commissioners of Mental Health Services for People from Black and Minority Ethnic Communities](#) – Joint Commissioning Panel for Mental Health
- [Guidance for Commissioners of Mental Health Services for People with Learning Disabilities](#) – Joint Commissioning Panel for Mental Health
- [Guidance for Commissioners of Mental Health Services for Young People Making the Transition from Child and Adolescent to Adult Services](#) – Joint Commissioning Panel for Mental Health
- [Guidance for Commissioners of Older People’s Mental Health Services](#) – Joint Commissioning Panel for Mental Health
- [Guidance for Commissioners of Perinatal Mental Health Services](#) – Joint Commissioning Panel for Mental Health
- [Guidance for Commissioners of Rehabilitation Services for People with Complex Mental Health Needs](#) – Joint Commissioning Panel for Mental Health
- [Guidance on Values-Based Commissioning in Mental Health](#) – Joint Commissioning Panel for Mental Health

7.4. Resources for co-production in mental health care

- [Co-production](#) – Social Care Institute for Excellence
- [Co-production in Mental Health](#) – Skills for Care
- [Co-production resources](#) – NHS England
- [Ladder of co-production](#) – Think Local Act Personal
- [Working Well Together: Evidence and Tools to Enable Co-Production in Mental Health Commissioning](#) – NCCMH

7.5. Other resources

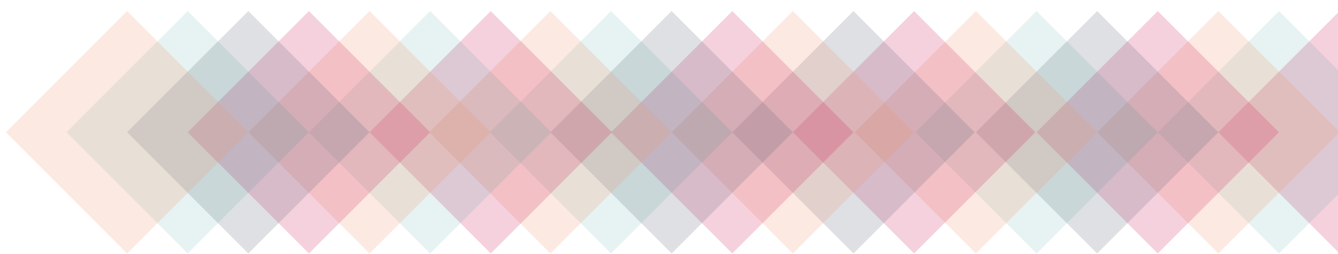
[Agenda](#) – Alliance for Women & Girls at Risk

[Protect](#) – organisation providing independent confidential advice around raising concerns about the workplace

[Respond](#) – Young People’s Sexually Harmful Behaviour Service

[Safe Lives](#) – help for victims of domestic abuse

[Stonewall: Unhealthy Attitudes](#) – the treatment of LGBTQ+ people within health and social care services



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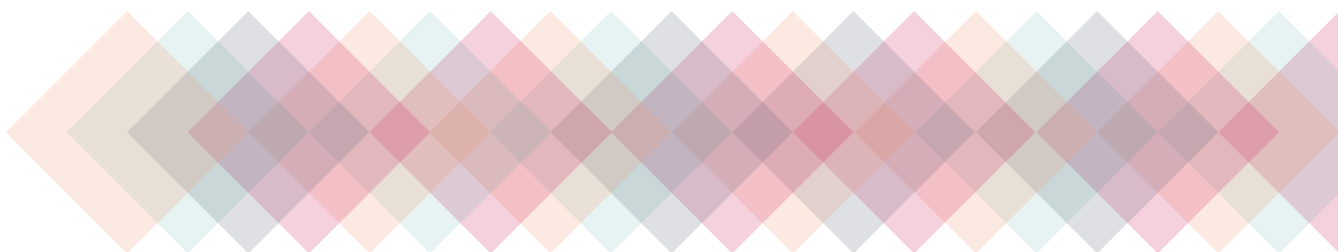
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9. Abbreviations and glossary

Abbreviations

AR-DSA	Awareness and Response to Domestic and Sexual Abuse
AVA	Against Violence and Abuse
BAME	Black, Asian and Minority Ethnic
CQC	Care Quality Commission
EFG	equalities focus group
ERG	expert reference group
HR	human resources
LGBTQ+	lesbian, gay, bisexual, transgender, queer and others
MAPPA	Multi-Agency Public Protection Arrangements
MHSIP	Mental Health Safety Improvement Programme
NCCMH	National Collaborating Centre for Mental Health
NHSE/I	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
PEP	post-exposure prophylaxis
PICU	psychiatric intensive care unit
QI	quality improvement
RLO	reusable learning objectives
SARC	sexual assault referral centre
VCSE	voluntary, community and social enterprise

Glossary

Where legal definitions are used in this glossary, they are applicable to England only. While these standards and guidance can be used by other UK nations, it is important to consider how differences in legal definitions may alter the interpretation of the standards. Legal definitions are clearly labelled; the remainder have been agreed by consensus with the ERG.

Affectionate activity

Acts of physical intimacy with another person that are intended to display affection, such as kissing, hugging, hand-holding or non-sexual touching. A recipient of these affectionate behaviours may or may not have consented to these acts of intimacy. Affectionate activity is not always sexually motivated, but people can still feel uncomfortable if they have not consented.

Age appropriate

Age appropriateness in legal relationships varies and there is no widely accepted definition. Staff should be mindful of power imbalances caused by large but legal age gaps in people's relationships, and when talking with a person in their care they should consider and be sensitive to the person's age and level of understanding.

All staff

All staff working in an inpatient setting – of all bands, job roles (including clinical and non-clinical) and registration status. It includes domestic staff, administrative staff, service leads and directors, staff from external organisations, peer support workers, volunteers, students on placement and religious leaders, contracted, temporary, visiting or bank staff.

Carer

Any person who cares for a partner, family member, friend or other person in need of support and assistance with activities of daily living. Carers are usually unpaid and includes those who care for people with mental health problems, long-term physical health conditions and disabilities, with their physical and/or emotional needs. A carer can be anyone of any age, including a child, young person and older adult. They also do not need to be a designated carer to have caring responsibilities.

Child sexual abuse

'Child sexual abuse involves forcing or inciting a child to take part in sexual activity, whether or not the child is aware of what is happening and not necessarily involving a high level of violence.

'This may involve physical contact including **rape** or oral sex, or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or exploiting or grooming a child in preparation for abuse (including via the Internet) or prostitution. Child sexual abuse can be committed by both men and women, or other children.' ([Crown Prosecution Service](#))

Co-production

Co-production is an ongoing partnership between people in a community, including people who design, deliver and commission services, people who use the services and people who need the services but may not be currently accessing them.

Culturally appropriate	Having discussions or presenting information in a way that considers and is sensitive to the person's cultural background and beliefs.
Initiator	The person who carries out the behaviour (verbal, non-verbal or physical contact) that makes another person feel uncomfortable, unsafe or that contributes to feelings of lack of sexual safety .
Intersectionality	<p>The interaction and overlap between multiple protected characteristics or social identities (such as class, sex, race and sexuality) which may contribute towards an individual's experience of discrimination.</p> <p>'Intersectionality is a lens through which you can see where power comes and collides, where it interlocks and intersects. It's not simply that there's a race problem here, a gender problem here, and a class or LGBTQ problem there. Many times that framework erases what happens to people who are subject to all of these things.'¹⁸</p>
Near-miss	An event which could have resulted in subsequent harm but is not deemed to be a sexual safety incident. Services should still assess whether any psychological harm is experienced by people on the ward who have been affected. All near-misses should be recorded, to provide opportunities for learning.
Online sexual activity	'Online sexual activity is defined as use of the Internet (via text, audio, video and graphic files) for any activity that involves human sexuality. These activities include, but are not limited to, casual encounters for recreation, exploration, and entertainment purposes, seeking education or support around sexual concerns, purchasing sexual materials, trying to find sexual partners, and so forth.' ¹⁹
Person or people	This generally refers to anyone who might have been affected by a sexual safety incident, unless otherwise specified. This includes people who receive care, staff members and visitors to a ward. These standards also apply to people directly affected by an incident, as well as to the initiator or accused person(s) and any witnesses or bystanders.
Psychological safety	Feeling safe from any instances of traumatisation and re-traumatisation; feeling able to express thoughts, feelings and opinions without fear of consequences; feeling safe from any situations or behaviours that might negatively affect a person's wellbeing. These feelings of harm might arise from the physical space, other people or from the person's own mental state.
Rape	<p>'A rape is when a person uses their penis without consent to penetrate the vagina, mouth, or anus of another person. Legally, a person without a penis cannot commit rape, but a female may be guilty of rape if they assist a male perpetrator in an attack.'^o (Crown Prosecution Service)</p> <p>The full legal definition can be found in Section 1 of the Sexual Offences Act 2003^o</p>

^o Legal definitions are used to ensure consistency in response and approach between all agencies involved, including mental health services, the police and the Crown Prosecution Service. Any changes to legislation should be reflected in the working definitions used by all agencies.

<p>Re-traumatisation</p>	<p>Symptoms related to a past traumatic experience that have had a delayed onset or have reactivated.</p>
<p>Routine enquiry</p>	<p>Staff with appropriate training routinely ask adult service users about their past or current experiences of violence and abuse. The enquiry should be made on an individual basis, in an environment where the person feels safe, and in a kind, sensitive manner. Staff are supported to respond to disclosures of violence or abuse in a safe and appropriate way, to ensure people can access the proper pathways into support. (NICE guidance on Domestic Violence and Abuse: Multi-agency Working [PH50])</p>
<p>Sexual abuse</p>	<p>Unwanted sexual activity or non-contact sexual abuse (such as sexually inappropriate comments or sharing nude pictures without consent) that has usually been initiated by force or coercion, through making threats, or by taking advantage of a person who is unable to give consent or does not fully understand the situation. Sexual abuse is often experienced as a series of events, but it might be limited to one event.</p>
<p>Sexual activity</p>	<p>Any physical behaviours of a sexual nature that are carried out with another person, regardless of whether this activity was consented to or not. This includes touching in a sexual way (including above clothing) and intercourse/penetration.</p>
<p>Sexual assault</p>	<p>See also online sexual activity.</p> <p>‘Sexual assault is when a person is coerced or physically forced to engage against their will, or when a person, male or female, touches another person sexually without their consent. Touching can be done with any part of the body or with an object.’ (Crown Prosecution Service)</p> <p>Sexual assault refers to a single event, so if unwanted sexual acts of a physical nature are experienced multiple times, these will be seen as multiple sexual assaults. Sexual assault does not always involve violence, so physical injuries or visible marks may not be seen.</p> <p>The full legal definition can be found in Section 3 of the Sexual Offences Act 2003.</p>
<p>Sexual behaviours</p>	<p>A very broad term to describe any physical behaviours of a sexual nature. These may be solitary behaviours (such as self-stimulation), non-contact behaviours (such as watching sexually explicit materials) or they may involve sexual activity with another person(s) (such as intercourse or penetration).</p>
<p>Sexual disinhibition</p>	<p>Any behaviours (physical, verbal, non-verbal) of a sexual nature which are regarded as socially, culturally or contextually inappropriate. They can happen as a result of illness, neurological damage, effects of medications or other factors.</p>
<p>Sexual harassment</p>	<p>Unwanted behaviour of a sexual nature which has the purpose or effect of violating a person’s dignity, or creating an intimidating, hostile, degrading, humiliating or offensive environment.</p> <p>‘Of a sexual nature’ may refer to verbal, non-verbal or physical advances including unwelcome sexual advances, sexual jokes, displaying pornographic photographs or drawings, or sending communication via any means with material of a sexual nature. This definition has been adapted from the full legal definition, which can be found in Section 26 of the Equality Act 2010.</p>

Sexual relationships

A relationship between people in which any form of **sexual activity** occurs. Where the relationship appears consensual, it might still be important to consider whether coercion has been used to establish the relationship. If one or both of the people lack mental capacity, the sexual relationship could be seen by the law as non-consensual.

Sexual safety

Feeling safe from any behaviours, circumstances or environments that a person might perceive to be a sexual harm to themselves. Feelings of sexual safety are individualised and each person will have different situations that may cause them to feel greater or lesser safety from sexual harm.

Sexual safety incident

Any sexual behaviour that is unwanted or makes a person feel uncomfortable or unsafe. This includes rape, sexual assault, sexual harassment, being spoken to with language of a sexual nature, or observing sexual behaviour, including exposure to nakedness. The person who is directly affected by the behaviour will define whether this is categorised as a sexual safety incident or not.

Sexual violence

Coercion (physical, using threats, psychological) used to obtain sexual acts, including when the person is unable to consent (because of age, capacity, because they are unconscious), and making unwanted sexual comments. Sexual violence includes rape, sexual assault, sexual harassment, domestic violence, sexual abuse of children, sexual abuse of children and people with mentally stalking, acts of trafficking, sharing of sexual imagery (including digitally). See also the [World Health Organisation's definition](#), upon which this was based.

Support network

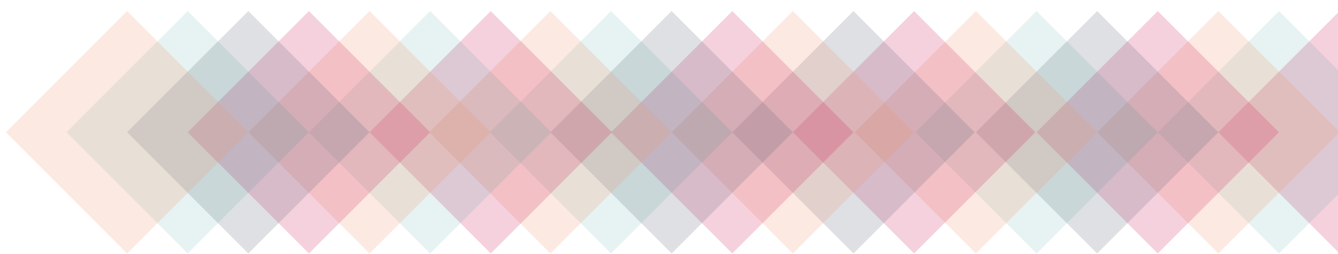
A person, group of people, community or organisation that provides emotional and/or practical support to someone in need. A support network can be made up of friends, family members, colleagues, peers, volunteers, health and social care professionals or supportive online forums and social networking sites.

Trauma-informed care

An approach to care which acknowledges that most people will have experienced some form of trauma in their lifetime, and considers how that trauma might continue to impact their life. By acknowledging a person's trauma and understanding what the person may continue to find traumatising, care can be delivered in a way that minimises the possibility of inadvertently re-traumatising the person.

Unconscious bias

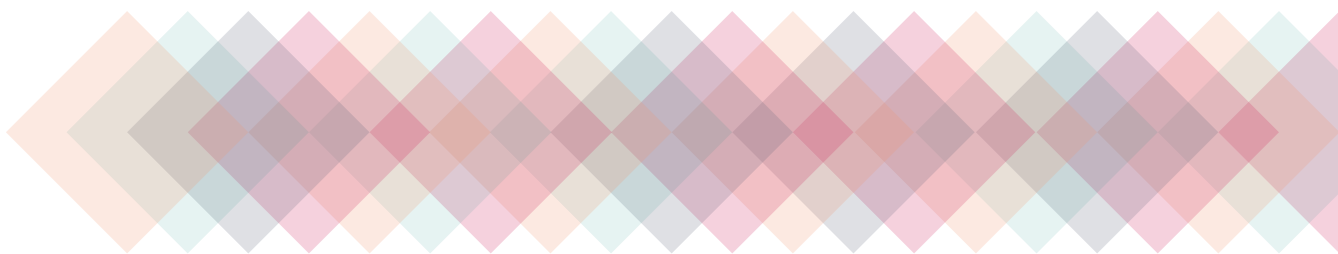
Prejudice or judgements that are held about other people or situations without the person realising that they are present. These biases are often unfounded stereotypes that have developed from a person's individual background, experiences and culture. They are so deeply ingrained that they lead to automatic judgements of or responses to situations or people. Unconscious bias may lead to changes in behaviour that the person is not acutely aware of.



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Appendix A: Example ward agreement

As mentioned in [Standard 4.1](#), each ward should have a clear, co-produced agreement outlining what is acceptable and unacceptable behaviour for all people in the ward environment. This includes those receiving care, staff of any job role, and visitors.

The following page contains an example of a 'Ward Charter' that the Sexual Safety Collaborative are using with wards who are involved in the QI programme. The charter is based on standards developed in Australia (see Appendix A of the New South Wales Government report on [Sexual Safety of Mental Health Consumers Guidelines](#)).

Wards are encouraged to co-produce and develop their own ward agreements based on the standards, especially children and young people's wards, which may require more age-appropriate language.

When co-producing the ward agreement, the following aspects should be discussed and developed for inclusion:

- introductory paragraph about what safety is, a person's right to feel safe from harm and a statement of intent to promote safety on the ward; our example focuses on sexual safety, but a ward working group may come to the co-produced decision that they want a general ward agreement that focuses on general expected behaviour
- standards of expected behaviour for everyone on the ward
- contact details for independent support or advocacy.

Each co-produced ward agreement is a living document that should be reviewed regularly and updated in line with the principles of co-production, as the views and experiences of those in the ward environment change.

Ward agreements should be displayed in plain sight for everyone on the ward and can also be printed and included in induction packs. They must be accessible and available in a range of formats, such as easy read, Braille, audio or foreign language versions.

[Replace with Trust logo]



**IMPROVING MENTAL
HEALTH SAFETY**
Sexual Safety Collaborative

Ward charter

Sexual safety

Everyone has the right to feel safe from sexual harm. On this ward, we do not want you to feel uncomfortable, frightened or intimidated in a sexual way by service users or staff. We will work to promote everyone's sexual safety. Everyone should behave in a way that meets the following standards.

Expected standards of behaviour on [insert ward name]

1	I respect myself.
2	I treat others with respect and dignity.
3	I understand that sexual activity with another person should be for mutual pleasure and never used for punishment or through coercion.
4	I do not try to talk someone else into engaging in sexual activity or harass another person sexually.
5	I try to be aware of how my behaviour makes others feel. I will change my behaviour if someone tells me it makes them uncomfortable and I will ask for help with this if I need to.
6	I respect the rights of others to space and privacy to fulfil their sexual needs through masturbation.
7	I understand that fulfilling my own sexual needs through masturbation must be conducted privately and discreetly.
8	I will speak up if I have been hurt, harassed or assaulted physically or sexually.
9	I will speak up if I see or hear about someone else being hurt, harassed or assaulted either physically or sexually.

If you feel too frightened or upset to speak to a member of staff, you can get independent advice or support by calling [insert organisation name] on [insert telephone number].

