Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 5588

Please reply to:
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Trust Management
Maidstone Hospital
Hermitage Lane
Maidstone
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ME16 9QQ
Email: mtw-tr.foiadmin@nhs.net

16 July 2019

Freedom of Information Act 2000

I am writing in response to your request for information made under the Freedom of Information Act 2000 in relation to Domestic abuse.

You asked:
1. Do you have a domestic abuse policy or something equivalent that applies to employees experiencing domestic abuse? If so, please provide a copy of the applicable policy.
2. Do you have other policy/policies which provide for support for employees experiencing domestic abuse (for example, as part of a leave policy)? If so, please provide a copy/copies of the relevant policy/policies.
3. Please inform us when each of the policies caught by the above questions ('the relevant policies') were first created and, if applicable, subsequently reviewed and updated?
4. Do you have a dedicated point of contact staff member who is trained to provide information and support to employees experiencing domestic abuse? When was that role created and first made active?
5. How are HR staff and managers made aware of the existence of the relevant policies?
6. How are general staff made aware of the existence of the relevant policies?

Trust response:
1. Yes attached
2. Yes attached
3. All dates on the first page of the policies
4. Safeguarding team
5. HR Staff and managers are made aware during the induction process and regular training is provided
6. During the induction process

Please see the following documentation.

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Domestic abuse / violence policy and procedure, for patients and for staff

Requested/ Required by:	Chief Nurse
Main authors:	Matron Safeguarding Adults, and Named Nurse Safeguarding Children
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Directorate:	Corporate Nursing
Specialty:	Safeguarding Adults and Safeguarding Children
Supersedes:	n/a
Approved by:	Safeguarding Adults Committee, 29th April 2014 Safeguarding Children Committee, 10th April 2014
Ratified by:	Quality and Safety Committee, 7th May 2014
Review date:	May 2017

Document history

Requirement for	• *Compliance with CQC Outcome 7* • *To be compliant with Domestic Homicide Review recommendations*

document:	
Cross references:	• Unison. (2010). *Agreement on Domestic Abuse* • RCN • Ashford Domestic Abuse Forum • Department of Health. (2006). *Responding to Domestic Abuse: a handbook for health professionals* • DASH Tool: Domestic Abuse Stalking Honour Based Violence and Harassment Checklist, Laura Richards CAADA • Foreign and Commonwealth Office - Forced Marriage Unit. (2007). *Dealing with cases of forced marriage: practice guidance for health professionals* • Home Office. (2012). *Domestic violence disclosure scheme guidance* • Home Office. (2013). *Domestic violence disclosure scheme (DVDS) pilot assessment* • Home Office. (2013). *Domestic violence disclosure scheme impact assessment* • http://www.domesticabuseservices.org.uk/victims/where-can-i-get-help/ • http://www.domesticabuseservices.org.uk/
Associated documents:	• Maidstone and Tunbridge Wells NHS Trust. *Safeguarding Adults: Protection and Support of Vulnerable Adults Policy and Procedure* [RWF-OPPPCS-C-NUR5] • Maidstone and Tunbridge Wells NHS Trust. *Safeguarding Children Policy and Practice Guidelines* [RWF-OPPPCS-C-NUR6] • Maidstone and Tunbridge Wells NHS Trust. *Safeguarding Children Supervision Policy and Procedure* [RWF-OPPPCS-NC-NUR5] • Maidstone and Tunbridge Wells NHS Trust. *Social Services referral form for child in need and child at risk of significant harm* [RWF-OPF-CS-C-NUR5] • Maidstone and Tunbridge Wells NHS Trust. *SVA referral flow chart: incident occurring outside hospital* [RWF-OPPM-CORP85] • Maidstone and Tunbridge Wells NHS Trust. *Standards of Conduct Policy and Procedure* [RWF-OPPPCS-NC-WF32] • Maidstone and Tunbridge Wells NHS Trust. *Standards of Conduct at Work [Disciplinary]* [RWF-OPG-CORP32] • Maidstone and Tunbridge Wells NHS Trust. *Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure* [RWF-OPPPCS-C-NUR1] • Maidstone and Tunbridge Wells NHS Trust. *Memo + AP1 form, to refer abuse* [RWF-OWP-APP112] • Maidstone and Tunbridge Wells NHS Trust. *Statutory and Mandatory Training Policy and Procedure* [RWF-OPPPCS-NC-WF22]

Version Control: *Details of approved versions*		
Issue:	**Description of changes:**	**Date:**
1.0	First iteration of policy/procedure	May 2014

Policy statement for

Domestic abuse / violence, for patients and for staff

Maidstone and Tunbridge Wells NHS Trust (The Trust) recognises that its patients and employees will be amongst those affected by domestic abuse, for example as a survivor, an individual living with domestic abuse, or as a perpetrator of domestic abuse / violence.

The Trust is committed to developing a culture in which there is zero tolerance for abuse in any form and which recognises that the responsibility for domestic abuse lies with the perpetrator. The Trust is committed to ensuring that any person who is the victim of domestic abuse has the right to raise the issue in the knowledge that they will receive appropriate support and assistance.

This policy and procedure covers the responses staff will need to take when disclosures are made that they are in an abusive relationship. It will also identify the tools available for staff to use to enable and empower a patient to make that disclosure. The *risk assessment tool* for assessing the seriousness of the abuse and potential harm to a victim is also included in this policy and procedure.

By developing an effective domestic violence and abuse policy and working to reduce the risks related to domestic abuse, we will create a safer environment for patients and colleagues and we will also send out a strong message that domestic abuse and violence is unacceptable.

The Trust recognises that domestic abuse is an equalities issue and undertakes not to discriminate against anyone who has been subjected to domestic violence and abuse both in terms of patient experience, current employment or future development.

Domestic abuse / violence procedure, for patients and for staff

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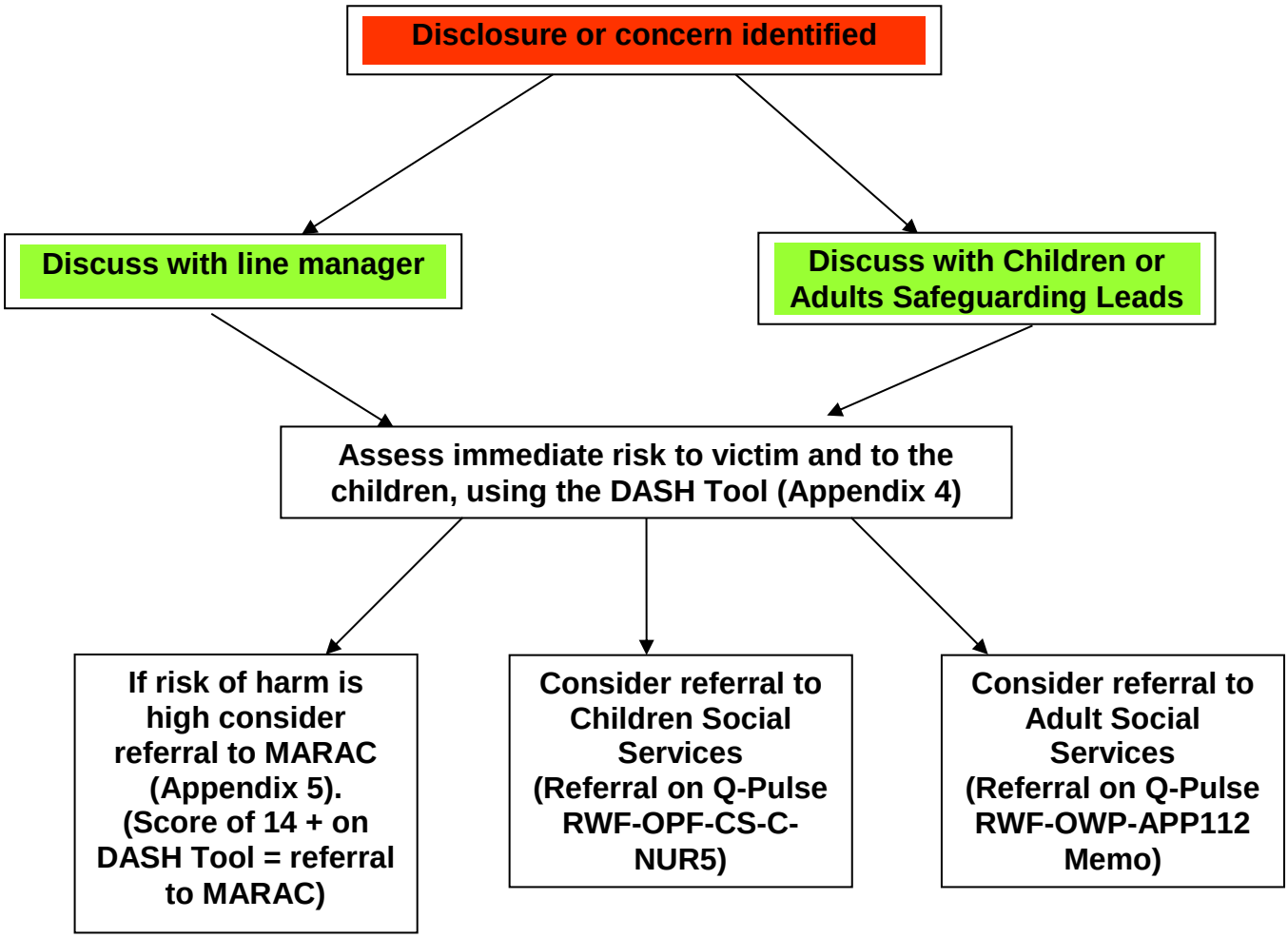


Offer support services to all victims using local resources that can be found on the Kent County Council website:
http://www.kent.gov.uk/community_and_living/community_safety/domestic_abuse.aspx

Document clearly all concerns raised and actions taken

1.0 Introduction and scope

- This policy and procedure covers anyone who discloses that they are a victim of domestic abuse.
- This policy and procedure is intended to ensure the correct support and advice is given to a victim of domestic abuse.
- This policy and procedure is intended to ensure that staff who are in a position to support patients or colleagues who have disclosed information about their situation have the knowledge and skills about local resources and referral routes to appropriately support the victim of domestic abuse.
- This policy and procedure is intended to ensure that the appropriate referrals are made in response to disclosures of domestic abuse.

2.0 Definitions

- **Home Office definition of domestic abuse**
  Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:
  - *psychological*
  - *physical*
  - *sexual*
  - *financial*
  - *emotional*

  Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

  *Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."**

  **This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.*

  (Home Office 2013)

  Whilst this is not a legislative change, the definition will send a clear message to victims about what does constitute domestic violence and abuse.

- **Domestic abuse and young people**
  The changes to the definition of domestic abuse raises awareness that young people in the 16 -17 age group can also be victims of domestic abuse and violence. By including this age group the government hopes to encourage young people to come forward and get the support they need, through a helpline or specialist service.

- Domestic abuse is not just about actual physical violence. It can also involve emotional abuse, the destruction of a spouse's or partner's property, their isolation from friends, family or other potential sources of support, control over access to money, personal items, food, transportation and the telephone, and stalking. It can also include abuse inflicted on, witnessed by or threatened against, children.
  - Domestic abuse occurs in all social classes, cultures, and age groups whatever the sexual orientation, mental or physical ability.
  - Once it has started it often becomes more frequent and more violent.
  - It can severely affect children emotionally and physically.
  - Victims are sometimes beaten or harassed by members of their immediate or extended family.
  - Domestic abuse is gendered – the majority of perpetrators are men and between 80-95% of those who experience it are women, although it does also occur against men in heterosexual relationships, in same sex relationships and against bisexual and transgender people.
  - Domestic violence/abuse is not a 'one off' occurrence but is frequent and persistent, aimed at instilling fear into, and compliance from, the victim. On average a victim of domestic violence/abuse is assaulted 35 times before they report the matter to the police.
- **Domestic violence disclosure scheme**
  On 25 November 2013, it was announced that the domestic violence disclosure scheme would be rolled out across England and Wales from March 2014. This followed a successful 1-year pilot across 4 police force areas.

  - **Right to ask**
    Under the scheme an individual can ask police to check whether a new or existing partner has a violent past. This is the 'right to ask'. If records show that an individual may be at risk of domestic violence from a partner, the police will consider disclosing the information. A disclosure can be made if it is legal, proportionate and necessary to do so.
  - **Right to know**
    This enables an agency to apply for a disclosure if the agency believes that an individual is at risk of domestic violence from their partner. Again, the police can release information if it is lawful, necessary and proportionate to do so.

  The pilot assessment report and the impact assessment on the disclosure scheme are available. You can also read the domestic violence disclosure scheme guidance.

  (Home Office 2013)

3.0 Duties

A member of staff may make disclosures that they are a victim of domestic abuse, they may make disclosures to their colleagues or line managers.

If they are a patient they may make this disclosure to the nurse, doctor or anyone who they feel that they can trust.

Very often victims of domestic abuse will not recognise that they are in a domestic abuse relationship.

- **The Trust:** must encourage staff to respond sympathetically, confidentially and effectively to any patient or member of staff who discloses that they are experiencing domestic abuse.
- **Line managers:** must listen effectively and empathetically to members of staff who disclose they are living in a domestic abuse relationship; they must enquire sensitively about the disclosure and know to whom and when to refer onwards.
- **Trust staff:** must listen effectively and empathetically to patients or colleagues who disclose they are living in a domestic abuse relationship and know to whom and when to refer onwards to services that will support the victim.
- **HR Business Partners:** must support managers in managing and handling these situations.
- **Staff members:** doctors, nurses, porters, domestic staff (any member of staff that a patient or member of staff chooses to disclose to) must listen empathetically, document appropriately and refer on where necessary with the permission of the victim of abuse or must know in what situation a referral ***without their permission*** is warranted and supported.

4.0 Training / competency requirements

The Trust is committed to ensuring all staff and line managers are aware of domestic abuse/violence and its implications. From a variety of learning experiences staff will be able to:

- Identify signs of domestic abuse
- Respond to disclosures in a sensitive and non-judgemental manner
- Provide initial support – be clear about available support from external sources and from in-house specialist staff where applicable
- Support the victim to report incidents of violence to the police
- Identify when a referral to Social Services is required
- Understand how the person can be enabled to contribute to their own safety plans.
- Discuss how the organisation can contribute to safety planning, if it is a member of staff affected.
- Signpost to other organisations and sources of support.
- Understand that Trust staff are not counsellors.

Raising awareness of domestic abuse is covered in:

- Trust induction
- Non-clinical update
- Clinical update
- Level 2 Safeguarding Children Training – in more detail – resources available locally, when to refer.
- Level 3 Safeguarding Children Training – in more detail, MARAC and use of the DASH Tool

5.0 Procedure

5.1 Victims of domestic abuse / violence

There are signs which may indicate a patient or employee may be a victim of domestic abuse. These may include:

- Attendances at A&E where the history is not consistent with the mechanism of injury
- Situations where a suspected perpetrator attends with the victim and will not allow privacy for consultation
- Disclosure by the victim of abuse
- Third party disclosure may happen
- There may be obvious effects of physical abuse (it is important here, not to make assumptions)

It is essential to understand that any of the above may arise from a range of circumstances of which domestic abuse may be one.

Victims should be treated empathetically and offered support and referrals should be made to agencies that are equipped to assist with their situation.

Managers / supervisors who have to talk with victims about such matters should address the issue positively and sympathetically ensuring that the victim is aware that support and assistance can be provided, or is available to them from external sources.

Victims who disclose experiencing abuse can be assured that the information they provide is confidential and will not be shared with other members of staff or their families, without their permission.

There are, however, some circumstances in which confidentiality cannot be assured. These is when there are concerns about children or vulnerable adults or where the risk of harm is assessed to be so severe that you will need to act to protect the safety of the victim.

In circumstances where the Trust has to breach confidentiality it will seek specialist advice from the Trust's Safeguarding Leads or Social Services before doing so. If it decides to proceed in breaching confidentiality after having taken advice, it will discuss with the victim why it is doing so and it will seek their agreement where possible.

As far as possible, information will only be shared on a need-to-know basis.

All records concerning domestic abuse will be kept strictly confidential.

Where the victim is a member of staff no local records will be kept of absences related to domestic abuse and there will be no adverse impact on the employment records of victims of domestic abuse.

Improper disclosure of information i.e. breaches of confidentiality by any member of staff will be taken seriously and may be subject to disciplinary action.

The Trust recognises that developing a life free from abuse is a process not an event for all victims of abuse and the Trust will provide ongoing appropriate support, signposting victims to appropriate agencies or support services, for victims who disclose abuse.

Remember to:

- Listen empathetically
- Create a safe environment, remove the suspected perpetrator if possible
- Ask if there are children in the same household, their names / date of births and which schools they attend
- Give reassurances that referrals that are required will be handled sensitively to promote the safety of the victim and any children involved
- Explain about the local resources that can be sourced
- Referral to specialist Domestic Abuse Services
- Assess the risk to the victim and children involved **see 5.6 below**
- Make appropriate referral to the Multi-Agency Risk Assessment Conference (MARAC) (**Appendix 5**) dependent upon the outcome of the DASH Risk Assessment
- Staff members will use their professional judgement when making a referral to MARAC without the permission of the patient

If the victim is a staff member consider:

- Special paid leave for relevant appointments, including with support agencies, solicitors, to rearrange housing or childcare, and for court appointments
- Temporary or permanent changes to working times and patterns
- Changes to specific duties, for example to avoid potential contact with an abuser in a customer facing role
- Redeployment or relocation
- Measures to ensure a safe working environment, for example changing a telephone number to avoid harassing phone calls
- Using other existing policies, including flexible working
- Access to counselling/support services
- An advance of pay
- Access to courses developed to support female survivors of domestic abuse, for example The Freedom Programme (www.freedomprogrammeco.uk) or assertiveness training

5.2 How to enquire sensitively – some tips

When enquiring it is important to:

- Never ask about domestic abuse when anybody else is present – including partners, children or any other family members. The only exception to this is when you need to use a professional interpreter. Do not use family members to interpret.
- Avoid interruptions – the victim must feel it is important to you too.
- Be patient – this may be the first time the victim has spoken to anybody about their experience; they may be embarrassed or ashamed.
- Be supportive – this may seem obvious but the victim may feel that you are making judgements about them. The biggest fear for women with children is that telling you will result in her children going into care; this is very unlikely to happen particularly if she has disclosed this to you.
- Remember and acknowledge your own limitations – the victim may want to talk to someone who can offer specific specialist advice. Consider using an advocate from a Domestic Abuse Advisory Service. (Links are included in this document and Kent.gov.uk publicise these resources available in your locale).

Always check if the victim has children who live with them – you must consider the needs of any children as paramount. Even when the victim refuses support you have to consider their ability to protect the children from abuse. It should be made clear at the outset that if you have any concerns about the welfare of children you have a duty to share that information to protect them. It may be necessary to contact someone who may have more information about the family such as the GP, health visitor, school nurse or Social Services.

Evidence suggests that some victims minimise or deny domestic abuse as a way of coping. Victims have also said that they found the subject difficult to bring up themselves and are in some way relieved when someone else does it for them.

The most appropriate time to enquire is when taking a social history or as part of a wider assessment. Health professionals carry out some form of assessment with clients/patients, usually at first contact. Asking patients, at these times, helps avoid stigma and inappropriate judgements.

It is essential that health professionals who are carrying out these enquiries always have up to date information, such as leaflets or telephone numbers, available to them to offer the opportunity of alternative or more specialised support.
Each situation is different, therefore there is no script that fits all occasions, however direct questioning is always best practice. If your messages are unclear then the victim of abuse may misinterpret your message and an opportunity for them to disclose to you may be lost. Confident questioning is key, if you do not feel confident about what to ask, discuss with a more experienced colleague and ask what they may do or say in these situations, or consider some of the examples listed here:

Suggested methods of enquiry:

- Because domestic abuse is so common for women, we ask about abuse in relationships, so that we can give all women information about agencies that can help.
- ”How is your relationship?”
- ”Do you ever feel unsafe at home?”
- ”Have you ever been afraid of your partner’s or a family member’s behaviour – are they verbally abusive?”
- ”Has your husband / partner or anyone else at home threatened you?”

Depending on the response a health professional receives, they may go on to ask:

- ”Have you ever been hurt by your partner or anyone else at home –perhaps slapped, kicked or punched?”
- ”Have you ever been forced to do something sexual that you didn’t want to do”?
- “Has your partner ever withheld money from you, leaving you unable to buy the necessities for you or your children”?
- “Have you ever been prevented from leaving the house, or locked in a room”?

These questions can be tailored to reflect the types of issues with which victims present, but whatever the response the individual should be offered domestic abuse information. If individuals decline the information this should be followed with a question such as:

“Perhaps you can keep this information so that if a family member, friend or neighbour talks to you about this, then you could pass them on?”

Remember, although a victim may not disclose anything the first time they are asked, it shows that you understand the issues and it may give them confidence to disclose to you at a later date.

It is best to be honest. If you think a victim has been abused, tell them that you are concerned for them and want to help.

5.3 Honour based violence, forced marriage and young people

Honour based violence and/or forced marriage may be identified through recognition of some of the warning signs. For example, health professionals should consider the use of this type of enquiry for young people from black and minority ethnic communities; here are some of the questions that may focus on the family relationship:

- "How are things at home – do you get on with your parents"?
- "Are your parents supportive of your aspirations – what do they hope for you"?
- "Do your parents have similar aspirations for all your brothers and sisters"?
- "Apart from school, do you get out much"?
- "What do you do at the weekends"?

Again, depending on the answer, the health professional may go on to ask more in depth questions – for example around gender roles within the family or questions around the marriage of older siblings and the circumstances.

Where a health professional does elicit information that suggests a woman is at risk of honour based violence or facing a forced marriage advice can be sought from Named Nurse/Named Midwife Safeguarding Children, Matron Safeguarding Adults and/or Social Services.

Further information on honour based violence and forced marriage can be found by referring to: *Dealing with cases of forced marriage: practice guidance for health professionals (2007).*

In cases where there are concerns that a young person under 18 years may be at risk of forced marriage, a referral **must** be made to Social Services at the Central Referral Unit.

Do not inform the family of your intention to refer to social care.

5.4 Vulnerable adults

This policy applies to Vulnerable Adults however, you should also consider raising an Adult Protection Referral AP1, with the Social Services Central Referral Unit if they are a vulnerable adult living in a domestic abuse situation. (Refer to the Trust's *Safeguarding Adults: Protection and Support of Vulnerable Adults Policy and Procedure* for further information and advice).

Consideration will need to be given to the victim's ability to make decisions with regards to onward referral for support or for immediate or long term protection. (Refer to the *Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure* for further advice).

5.5 Responding to a disclosure

If a victim discloses that they are being abused it is important to know what to do next. As a health professional your role is to:

- Provide support and information to help the victim decide what to do next
- Encourage the victim to have a safety plan
- Help assess the risk to the victim and any children they have

Never advise a victim to leave their partner. For women especially the risk of serious injury or murder escalates dramatically when a woman leaves an abusive relationship or is planning to leave an abusive relationship.

Leaving immediately may not be the best option.

5.6 Support and information

Information should be given on local and national help lines whether or not domestic abuse is disclosed.

- Do not try to make decisions for the victim. It is crucial the victim decides for themselves what to do next. It might be better for the victim to talk to a worker from a local specialist Domestic Abuse Service
- Ensure the victim feels that you believe them, make it clear that the abuse is not their fault and that they have the right to be safe.
- Let the victim know that they are not alone - a quarter of all women will experience abuse at some time in their lives.
- Explain confidentiality – but be clear if you are worried about the risk of harm to the victim, their children or to others, then you will need to share that information.
- Do not act as a mediator between the victim and the abuser– this requires specialist assessment and skills and can be very dangerous to all concerned.
- Do not discuss the disclosure with the abuser or other family members.

5.7 Assessing risk

It is important to determine the level of risk and danger faced by the victim and any children involved. You do not have to assume full responsibility for this but you do play an important part, particularly when assessing if someone is at immediate risk of harm.

Never take on lone responsibility for dealing with high risk situations.

The victim experiencing abuse will usually be able to predict the risks they face and the likelihood of further abuse. However, health professionals should also be aware that victims will often underestimate or minimise the risk of harm to themselves and their children. Where the risks are considered to be less immediate use of a formal assessment tool is advised.

Use the DASH (Domestic Abuse Stalking Harassment and Honour Based Violence) (**Appendix 4**) risk assessment to assess the level of actual risk and this will inform you as to whether a referral onwards to Multi Agency Risk Assessment Conference (MARAC) is required (**Appendix 5**).

A multi agency response

MTW NHS Trust is developing strong local partnerships to tackle domestic abuse. The DASH risk assessment is used to provide information and gives access to more specialist domestic abuse support services which includes the **Multi Agency Risk Assessment Conference** (MARAC) in both Maidstone and West Kent.

MARAC – Kent operate successful MARAC's in each of the Kent Police Districts. In West Kent and in Maidstone they are held every month, a number of key services are represented who gather and share information on 'high risk' domestic abuse cases. Action plans are formulated with the view to improving the safety of victims, pursuing arrest and prosecution of perpetrators and reducing repeat offences.

Anyone can refer a case to MARAC, however all referrals must be sent to the Safeguarding Leads for the Trust for quality assurance.

How to refer to MARAC and referral criteria

When the DASH risk assessment has been completed and it shows that a victim is at high risk of harm you will be required to send in the MARAC referral form and risk assessment to the local MARAC Co-ordinator. (**Appendix 5**)

Local specialist services are available to refer victims of abuse to, offering a range of support including such things as:

- Face to face support services, meeting the victim at safe locations near them
- Helping the victim to identify the risks in their situation
- Working with the victim to produce a safety plan so that they feel safer
- Suggesting choices and practical options tailored to the victims situation
- Offering to accompany the victim to court or attending meetings with them
- Putting the victim in touch with other agencies that can help them
- Assisting with paperwork for people with language or literacy difficulties
- Listening without bias or judgement.

They can also provide health professionals with practical advice and support.

Use the link to the kent.gov.uk domestic abuse page to find out which services can be accessed in the victims area.

5.8 Safety planning

Domestic abuse is significant in that it occurs repeatedly and can be cyclical in nature, often with periods of calm interspersed with abusive behaviour. It is important that the victim who discloses abuse is encouraged to have a safety plan of what to do when the abuse starts. Many victims will know when abuse is likely to occur and can, to some degree, predict it. If victims are able to do this they can be helped to think about what they can do to reduce the risks in emergency situations.

Safety planning needs to begin with an understanding of the victim's view on the risks to themselves and the children involved and the strategies they have in place to address them. A key question is whether they intend to remain in the relationship with the abusive partner.

It is important that the plan is based on the victim's needs and predominantly the needs of any children and it may be more appropriate for workers from specialist domestic abuse services to help the victim do this.

Recognise and acknowledge the extent and limitations of your role. You may need to refer to a more specialist service for support.

Please seek advice in relation to this from the Safeguarding Leads.

5.9 What should a safety plan cover

Safety in the relationship

- Places to avoid when the abuse starts e.g. the kitchen, where there is access to potential weapons
- People a victim can turn to for help or to let know they are in danger
- Asking friends or neighbours to call 999 if they hear anything that worries them
- Places to hide important phone numbers
- How to keep children safe when the abuse starts
- Teaching children to find safety or get help, perhaps by calling 999
- Keeping important documents in one place so they can be taken together in case they need to leave suddenly
- Letting someone know about the abuse so that it can be recorded.

Leaving in an emergency

- Packing an emergency bag and hiding it in a safe place
- Plans for who to call and where to go
- Remember to take: documents, medication, keys
- Access to a phone
- Access to money
- Plans for transport
- Plans for taking clothes, toiletries and toys for the children
- Taking proof of abuse

Safety when a relationship is over

- Contact details for professionals
- Changing landline and/or mobile telephone numbers
- How to keep current location a secret from the abuser
- Getting non-molestation, exclusion or restraining order
- Talk to children about staying safe
- Talk to employer for help with staying safe at work

http://www.domesticabuseservices.org.uk/victims/where-can-i-get-help/

and

http://www.domesticabuseservices.org.uk/

5.10 Perpetrators of domestic abuse / violence

Domestic abuse and violence perpetrated by employees will not be condoned under any circumstances nor will it be treated as a purely private matter. The Trust recognises that it has a role in encouraging and supporting employees to address violent and abusive behaviour of all kinds.

The Trust will treat any allegation, disclosure or conviction of domestic abuse related offence on a case-by-case basis with the aim of reducing risk and supporting change.

Bear in mind that it is a requirement to disclose any such non-molestation orders, injunctions or County Court Orders, cautions and convictions to your line manager as soon as this occurs. Breach of this requirement will place the employee at risk of disciplinary processes being used.

Refer to the Trust's *Standards of Conduct Policy and Procedure* and *Standards of Conduct at Work [Disciplinary]*

5.11 Role of colleagues

The Trust encourages all employees to report if they suspect a colleague is experiencing or perpetrating abuse. Employees should speak to their line manager about their concerns in confidence. In dealing with a disclosure from a colleague, employers should ensure that the person with concerns is made aware of the existence of this policy.

5.12 Domestic Homicide Review processes

The Domestic Violence, Crime and Victims Act 2004 Section 9 establishes a Domestic Homicide Review (DHR) process. This amounts to a review of the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by:

a) A person to whom he was related or with whom he was or had been in an intimate personal relationship with, or
b) A member of the same household as himself

The review will be held with a view to identifying the lessons to be learnt from the death. If the Trust is asked to contribute to a Domestic Homicide Review (DHR) it will be for the Chief Executive and/or the Chief Nurse to identify the most appropriate practitioner to complete the required investigation and report.

6.0 Monitoring and audit

- Referrals received in to the Safeguarding Leads will be monitored.

  The Chief Nurse and Director of Workforce and Planning, as Chairperson's of the Safeguarding Adults and Children's Committees and Workforce and Planning Committee, and the main author will be responsible for monitoring compliance with this policy and procedure on behalf of the Trust.

  Compliance with the following will be monitored thus:

- Training will be audited through compliance with the *Statutory and Mandatory Training Policy and Procedure* by the Workforce Development and Learning Committee.
- Bi-monthly reviews and reports on all domestic abuse referrals will be undertaken by the Trust Safeguarding Leads and reported to the appropriate Safeguarding Committees and quarterly to the Quality and Safety Committee.

APPENDIX ONE

Process requirements

1.0 Implementation and awareness

- The Trust will advertise that this policy and procedure is in place via the Chief Executives newsletter and global emails to all staff.
- Trust training will refer to this policy and procedure to ensure that staff know of its existence and are reminded of their duties when disclosures are made.
- All staff will need a basic understanding of this policy and procedure and so understand where to escalate their concerns if and when a colleague discloses that they are in a domestic abuse / violent relationship.
- All staff to receive basic awareness of domestic abuse within the core mandatory training on offer.
- Line managers to receive more in depth training with regards to referral mechanisms, support services available in their community and use of the DASH tool.
- Implementation of training will be via the Trust induction and mandatory updates and additional safeguarding children and safeguarding adults training for identified clinical staff.
- Once approved the document lead or author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust approved document management database on the intranet, under 'Trust polices, procedures and leaflets'.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Bulletin Board (Trust intranet) under "Trust Publications"; notification of the posting is included on a bi-weekly Bulletin Board round-up email, circulated Trust wide by the Communications team.
- On receipt of the Trust wide Bulletin Board notification all managers should ensure that their staff members are aware of the new publications.

2.0 Review

This policy will be reviewed jointly every three years unless there are changes in legislation, best practice or other organisation policies impact on its effectiveness.

3.0 Archiving

The Trust intranet retains all superseded files in an archive directory in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Domestic abuse / violence policy and procedure, for patients and for staff
Please return comments to: Matron Safeguarding Adults ext 24821
By date: 21.03.2014

Job title	Date sent 2nd Draft	Date reply received	Modification suggested? Y/N	Modification made? Y/N
The following staff MUST be included in ALL consultations:				
Local Counter Fraud Specialist	07.03.14			
Clinical Governance Assistant	07.03.14	09.04.14	Y	Y
Head of Information Governance	07.03.14			
Please list key staff whose reply is compulsory before approval can be granted:				
Chief Executive	07.03.14			
Non-executive Directors	07.03.14			
Executive Directors	07.03.14			
Head of Workforce and Planning	07.03.14			
Head of Occupational Health	07.03.14			
Clinical Directors and Medical Director	07.03.14	09.03.2014		
Directorate Matrons	07.03.14			
Safeguarding Children Committee	07.03.14		Yes (1st Draft)	Yes
Safeguarding Adults Committee	07.03.14		Yes (1st Draft)	Yes
Please list other staff to be included in the consultation but whose reply is not compulsory:				
Ward Managers	07.03.14			
General Managers	07.03.14			
Assistant General Managers	07.03.14			
Chief Nurse	07.03.14		Yes (1st Draft)	
Deputy Chief Nurse	07.03.14			
Risk Manager	07.03.14			
Head of Estates	07.03.14			
ADNS'	07.03.14			
Staff Side Chair	07.03.14			
HR Business Managers	07.03.14			
CCG Safeguarding Lead	07.03.14		Yes (1st Draft)	Yes
Safeguarding Co-ordinators West Kent	07.03.14			
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Title of policy or practice	Domestic abuse / violence policy and procedure, for patients and for staff
What are the aims of the policy or practice?	To inform staff about what their expected responses should be if a staff member discloses that they are in a Domestic Abuse relationship or situation.
Identify the data and research used to assist the analysis and assessment	
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups	Is there an adverse impact or potential discrimination YES If yes give details.
Males or Females	The majority of victims who disclose that they are in a Domestic Abusive relationship are women, with the perpetrators being men, however it is recognised that this can occur in ALL relationships.
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak English as a first language	No
People who have a physical disability	No
People who have a mental disability	No
Women who are pregnant or on maternity leave	Risks of escalating violence are heightened for women living in a domestic abusive relationship and who become pregnant.
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix Three of this policy/procedure on the Trust Intranet.

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet (Trust policies, procedures and leaflets):

No.	Title	Unique ID
4	Domestic abuse, stalking, harassment and honour based risk assessment (DASH tool)	RWF-OWP-APP620
5	Kent & Medway MARAC referral form	RWF-OPF-CS-NC-NUR8

Safeguarding Adults at Risk Policy and Procedure

Target audience: All Trust staff and volunteers

Author: Matron for Safeguarding Adults Ext. 24821
Contact details: mtw-tr.saar.dols@nhs.net

Other contributors: n/a

Executive lead: Chief Nurse

Directorate: Nursing

Specialty: Nursing

Supersedes: Safeguarding Adults at Risk of Harm Policy and Procedure (Version 6.0: August 2015)
(Version 6.1: May 2017)

Approved by: Safeguarding Adults Committee, 11th April 2018

Ratified by: Policy Ratification Committee, 14th September 2018

Review date: September 2022

Document history

Requirement for document:	• Local process for implementing Kent & Medway Multi-agency Safeguarding Adults Policy, Protocols and Guidance • Implementation of the Care Act 2014 • Incidents indicate a need to strengthen the Trust's response to Safeguarding Adults
Cross references (external):	1. Care Act 2014 2. Care Act Guidance, Chapter 14, *Department of Health and Social Care,* updated 1st October 2018 3. Kent and Medway Multi-Agency Safeguarding Adults Policy Protocols and Practitioner Guidance (September 2017) 4. Data Protection Act 2018 – the UKs implementation of the General Data Protection Regulation (GDPR) 5. Mental Capacity Act 2005 6. Deprivation of Liberty Safeguards April 2009 - *introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007 (which received Royal Assent in July 2007).* 7. Domestic Violence, Crime and Victims Act (2004). 8. Serious Crime Act 2015, Part 5, Domestic Abuse 9. Kent and Medway Multi-Agency protocol for dealing with cases of domestic abuse to safeguarding adults with care and support needs, July 2018 10. Domestic abuse support services in Kent & Medway, http://www.domesticabuseservices.org.uk/ 11. Department of Health. (2005). Responding to Domestic Abuse: a Handbook for Health Professionals. London: Department of Health. 12. Revised Prevent Duty Guidance for England and Wales (2015) 13. Care Quality Commission – Statement on CQC's roles and responsibilities for safeguarding children and adults, June 2015 14. Guidance for providers on meeting the fundamental standards and on CQC's enforcement powers 15. NHS England: Safeguarding Policy updated 29th June 2015 16. Disclosure and Barring Service: gov.uk – Referral Guidance updated 2017 17. CONTEST The United Kingdom's Strategy for Countering Terrorism, Home Office June 2018 18. Safeguarding Adults: The Role of Health Service Practitioners DoH March 2011 19. KMSAB Resolving Practitioner Differences; Escalation Policy
Associated documents (internal):	• Consent to Examination or Treatment Policy and Procedure for [RWF-OPPPES-C-SM5] • Disciplinary Policy and Procedure [RWF-OPPPCS-NC-WF10] • Domestic abuse / violence Policy and procedure [RWF-OPPPCS-NC-NUR7] • Equality and diversity (incorporating Single Equality Scheme (SES)) Policy and procedure [RWF-OPPPCS-NC-WF70] • Grievance and Disputes Policy and Procedure [RWF-OPPPCS-NC-WF27]

	• Guidance Document for Making Reasonable Adjustments to Provide Individualised Care to Patients [RWF-OPPM-CORP113] • Health and Safety Policy and Procedure [RWF-OPPPCS-NC-CG1] • Hospital Passport an information booklet to help nurses and me complete my care plan when I come / go into hospital [RWF-OPF-CS-NC-NUR1] • Incident Management Policy and Procedure [RWF-OPPPCS-NC-CG22] • Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure [RWF-OPPPCS-C-NUR1] • Policy and Procedure for the Prevention and Treatment of Pressure Ulcers [RWF-OPPPCS-C-NUR9] • Policy and procedure for the provision of enhanced care to adult inpatients (use of Nurse 'Specials' 1:1 nursing) [RWF-OPPPCS-NC-NUR4] • Protected Mealtimes and Red Tray Policy and Procedure [RWF-OPPPCS-C-NUR3] • Restraint Policy and Procedure [RWF-OPPPCS-C-NUR4] • Serious Incidents (SI) Policy and Procedure [RWF-OPPPCS-NC-CG23] • Single Equality Scheme [RWF-OPPPCS-NC-WF14] • Speak Out Safely (SOS) Policy and Procedure (formerly Whistle Blowing) [RWF-OPPPCS-NC-WF33] • Supporting Staff involved in Traumatic and Stressful Incidents, Complaints or Claims Policy and Procedure [RWF-OPPPCS-NC-WF59] • This is me: this leaflet will help you support me in an unfamiliar place [RWF-OPF-CS-NC-NUR2] • Use of cameras, video and audio recorders (including the use of smart phone and other mobile devices with recording functionality) on Trust premises Policy and procedure [RWF-OPPPCS-NC-CG8]

Keywords:	Safeguarding adults	Safeguarding	Prevent
	KASAF		

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	Initial Document	October 2007
2.0	Update of Initial Document	July 2008
3.0	Update for NHSLA Standards	October 2009
3.1	Appendix 10 and Appendix 11 under review	October 2010
4.0	Review of previous document and amendments	May 2012
5.0	Review of previous document and amendments	April 2013
5.1	Appendix forms revised.	August 2015
6.0	Total redraft of the Policy and Procedure in line with the Care Act 2014 that came into full force in April 2015.	August 2015
6.1	Updated KASAF (appendix 4a) now has guidance on completing the form in a separate document. An additional appendix has been created to accommodate this (4b). The form is in appendix 4a.	May 2017
7.0	• Review of policy to remove Patient Experience Matron Role and also to strengthen the role of directorate matrons and line managers.	September 2018

Version control:		
Issue:	**Description of changes:**	**Date:**
	• Review to clarify Site Report reporting mechanisms and expected responses. • Changes to flowchart. • Insertion in section 12 about responsibilities in relation to Duty of Candour and giving feedback to referrers and adult at risk. • Insertion of Allegations Management - Local Authority Designated Officer Role (LADO) into 14.0 • Clarified the role of Bank and Agency Manager in relation to safeguarding investigations involving a Bank or Agency member of staff • Referred to the Enhanced Care to Adult Inpatients Policy and Procedure • Deleted the words 'of harm' from the title and definition of who we should be concerned about • Included new definitions of abuse such as Cuckooing and Mate Crime. Change the Public Protection Units to Vulnerable Investigation Teams (VITs) • Included information about the Trust's Safeguarding Panel	

Summary for

Safeguarding Adults at Risk Policy

As a partner agency with the Local Authority (LA), the Trust agrees to follow the Kent and Medway policy so as to ensure that staff work within the Care Act 2014.

Guidance states that safeguarding is defined as:

"Protecting an adult's right to live in safety, free from abuse and neglect"

There is a clear duty for the Safeguarding Adults Board members to co-operate in order to:

- **Prevent abuse and neglect**
- **Promote an adult's well-being**
- **Take into account, where appropriate, the adult's views, wishes, feelings and beliefs in deciding what action to take, if any.**

The LA now has a requirement to make or cause safeguarding enquiries to occur, if there is concern that an adult with care and support needs (met or unmet) is experiencing, or is at risk of abuse or neglect. This applies regardless of mental capacity or incapacity and setting (other than in a prison or approved premises).

When an adult has substantial difficulty in being involved in the safeguarding process and when they do not have an appropriate representative the LA will have to arrange an independent advocate.

The LA also has a statutory duty to set up Safeguarding Adults Boards and these Boards have a legal requirement to ensure that Safeguarding Adult Reviews take place if an adult at risk dies as a result of abuse or neglect, where agencies felt that opportunities were missed to effectively safeguard the adult. Partner agencies such as the Trust have a duty to co-operate with these reviews if requested by the Safeguarding Adults Board.

The six key principles that underpin all adult safeguarding work

1. Empowerment	People being supported and encouraged to make their own decisions and informed consent. *"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."*
2. Prevention	It is better to take action before harm occurs. *"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."*
3. Proportionality	The least intrusive response appropriate to the risk presented. *"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."*
4. Protection	Support and representation for those in greatest need. *"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."*
5. Partnership	Local solutions through services working with their communities. Communities have a part to play in Preventing, detecting and reporting neglect and abuse. *"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me*
6. Accountability	Accountability and transparency in delivering safeguarding. *"I understand the role of everyone involved in my life and so do they."*

Safeguarding Adults at Risk of Harm Procedure

Safeguarding Adults Referral Flowchart

For when an 'Adult at Risk' has been abused, neglected or been left at risk of any of these, in the acute hospital.

Is a crime suspected to have been committed? →

If you are unsure consult with the local Kent Police Vulnerable Investigation Team (VITs) for the area the abuse is alleged to have occurred

No

Yes

No further action from p[illegible]ocument ratio[illegible] outcome of consultation with

If emergency action is required to safeguard patients or to safeguard evidence you should call the Police on 999 immediately.
Senior Manager to consider if suspension of staff is necessary at the outset.
Complete KASAF – copy to Matron for SA and Directorate Matron
Send to the CRU
Liaise with local VIT Kent Police – document outcome of consultation
Electronically copy Matron for SA into KASAF.
Directorate Matron to inform the Chief Nurse
Out of Hours Clinical Site Manager to use escalation processes.

The Police will decide if a crime is to be investigated
Police investigation will take precedence
Staff will assist police with their inquiries
If staff are unsure about complying with Police requests for information or copies of documents take advice from Head of Information Governance or Clinical Site Manager

Safeguarding concerns indicate abuse is suspected and there is a need for further assessment, but no crime suspected

Consult your line manager, Directorate Matron or Matron for SA for advice. (**Out of Hours escalate to Clinical Site Manager)**
Directorate Matron to inform DDNQ of issue of concern.
Reporter to complete KASAF electronically and send to CRU copying in Matron for SA

Initial assessment suggests **no** abuse.
Record your rationale for decision; providing evidence and send outcome of assessment to Matron for SA for consideration of closure with the LA

Information suggests that abuse has occurred.
DDNQ or Directorate Matron to appoint an Investigating Officer (IO)
Matron for SA is the Designated Senior Manager (DSM) and will offer guidance to IO, if requested.
Report of investigation must be shared with the DSM within 6 weeks

Trust disciplinary investigation will run alongside the safeguarding investigation where staff are implicated
HR and Disciplining Manager will be responsible for referring onto the appropriate professional bodies and/ or the Disclosure and Barring Scheme. **The Chief Nurse must be informed of any referral on to professional bodies.**

Send investigation report to Matron for SA

Outcomes of police investigation and disciplinary process will be shared by Matron for SA with the DSO for the LA

The outcome of investigation will be shared with the DSO for the LA at the Trust's Safeguarding Panel, chaired by the Deputy Chief Nurse
A decision will be made at this meeting whether further investigation is required.
If the investigation is deemed complete a decision as to whether or not the allegation is upheld will be made at this meeting.

It is the responsibility of the Local Authority to decide whether or not the investigation carried out is complete and whether or not the allegation is upheld.
They will close the referral down on their systems once all paperwork has been received and outcomes agreed.

KASAF	**= Kent Adult Safeguarding Alert Form (Appendix 4a)**
VIT	**= Vulnerable Investigation Team – Kent Police**
CRU	**= Central Referral Unit**
DDNQ	**= Divisional Director of Nursing & Quality**
LA	**= Local Authority**
DSO	**= Designated Senior Officer (LA)**
DSM	**= Designated Senior Manager (Trust)**
Matron for SA	**= Matron for Safeguarding Adults**

1.0 Introduction, purpose and scope

The Care Act 2014 came in to full force in April 2015. The Care Act Guidance; Chapter 14 concentrates on Safeguarding Adults, providing guidance on Sections 42 – 46 of the Care Act 2014.

Chapter 14 of the Care Act Guidance replaces the Department of Health's (DH) Guidance 'No Secrets'. This Act places safeguarding adult's duties onto a statutory footing.

As a result, the definitions, responsibilities and terminologies used have changed considerably. The Kent and Medway Safeguarding Adults Board have reviewed and revised the Kent wide Safeguarding Adults Policy, Protocols and Guidance.

The Trust endorses the Kent and Medway Multi-Agency Safeguarding Adults Policy, Procedure Protocols and Practice Guidance which can be found at: –

http://www.kent.gov.uk/__data/assets/pdf_file/0018/11574/Multi-Agency-Safeguarding-Adults-Policy,-Protocols-and-Guidance-for-Kent-and-Medway.pdf

This document describes the internal process for implementing the Trust's procedure for Safeguarding Adults at Risk.

This document applies to all staff within the Trust and especially those who will come into direct contact with adult patients who may either be at risk of harm or who have already been harmed. This document gives staff clear guidance about who might be considered an 'adult at risk' and when to refer safeguarding adults concerns to the Local Authority (LA).

Trust staff have the responsibility for the protection and safety of all patients being cared for by the Trust, and as such are expected to comply with this policy.

2.0 Definitions / glossary

Term	Definition
Adult at risk	An adult (a person 18 years or over) who: • Has needs for care and support (whether or not the Local Authority is meeting any of those needs) and • Is experiencing, or at risk of, abuse or neglect and • Due to those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect Abuse or neglect may be deliberate, or the result of negligence or ignorance. Unintentional abuse or neglect may occur owing to life pressures or as a result of challenging behaviour which is not being properly addressed. It is the intent of the abuse or neglect which is therefore likely to inform the type of response. It is irrelevant who is supplying support for the adults care needs or indeed whether or not their care needs are being met or not.
Deprivation of Liberty Safeguards (DoLS)	If all alternatives have been explored and the hospital or care home believes that it is necessary to deprive someone of their liberty to deliver the care or treatment they need, then there is a standard process they must follow to ensure that the deprivation of liberty is lawful and that the person is protected with the appropriate

Term	Definition
	safeguards in place.
Designated Adult Safeguarding Manager (DASM)	The Senior Manager in the Trust overseeing the hospital safeguarding investigation – usually the Matron for Safeguarding Adults.
Designated Senior Officer (DSO)	The LA practitioner allocated to oversee the Safeguarding Adult Section 42 Enquiry.
Disclosure and Barring Service (DBS)	The DBS was established in 2012 and carries out the functions previously undertaken by the Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA). They help to prevent unsuitable people from working with vulnerable groups, including children.
The Domestic Violence, Crime and Victims Act 2004	Established within this Act that the definition of domestic abuse is: *''Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are of who have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:* • *Psychological* • *Physical* • *Sexual* • *Financial* • *Emotional"*
Investigating Officer (IO)	The person appointed from the Trust to carry out the Section 42 Enquiry
Kent Adult Safeguarding Alert Form (KASAF)	(Refer to Appendix 4a; guidance in Appendix 4b) – This is the LA's form for raising a safeguarding concern to them. This is the only mechanism to use to make the referral.
Making safeguarding personal	The Care Act introduces this idea into the safeguarding adults processes to ensure that enquiries: • are person-led • are outcome-focused • engages the person and enhances involvement, choice and control • improves quality of life, wellbeing and safety
Non-statutory safeguarding enquiry	LAs may decide to make a safeguarding enquiry for an adult who does not meet the Section 42 criteria. These enquiries are not required by law and will therefore be referred to as 'non-statutory enquiries'.
Safeguarding concern	The first contact made between a person concerned about the abuse or neglect and the LA
Section 42 statutory safeguarding enquiry	This refers to any enquiries made, or instigated by the LA after receiving a safeguarding concern or referral. If the adult fits the criteria as an adult at risk as defined in Section 42 of the Care Act, then the LA is required by law to conduct enquiries or ensure that

Term	Definition
	enquiries are made.

2.1 Definitions of types of abuse (taken from the Care Act Guidance 2014 and Kent & Medway Adult Safeguarding Policy)

Care Act Guidance

Term	Definition – lists are not exhaustive lists
Discriminatory abuse	Including forms of harassment, slurs or similar treatment; because of race, culture, gender and gender identity, age, disability, sexual orientation or religion.
Domestic abuse and violence	Including psychological, controlling or coercive behaviour, physical, sexual, financial, emotional abuse; so called 'honour' based violence.
Financial or material abuse	Including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.
Modern slavery	Encompasses slavery, human trafficking, and forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.
Neglect and acts of omission	Including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.
Organisational abuse	Including neglect and poor care practice within an institution or specific care setting such as a hospital or care home (for example) or in relation to care provided in one's own home. This may range from one-off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.
Physical abuse	Including assault, hitting, slapping, pushing, misuse of medication, inappropriate restraint or inappropriate physical sanctions.
Psychological abuse	Including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, (including swearing at a patient and name-calling), cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.
Self-neglect	This covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.
Sexual abuse	Including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented to or was pressured into consenting,

Term	Definition – lists are not exhaustive lists
	voyeurism.

2.2 In addition to these, Kent and Medway Adult Safeguarding Policy also include the following:

Term	Definition
Cuckooing	This is a form of crime in which drug dealers or gangs take over the home of a vulnerable person in order to use it as a base for drug dealing or as a sex den, or for other criminal activity. Often associated with 'mate crime'.
Exploitation	Opportunistically or premeditated, unfairly manipulating someone for profit or personal gain, modern slavery, human trafficking, radicalisation
Female genital mutilation (FGM)	Is the partial or total removal of external female genitalia for non-medical reasons and it can be known as female circumcision, cutting or Sunna. This must be reported and is a criminal offence.
Forced marriage	Is when physical threats or abuse, or emotional pressure (e.g. the person is made to feel like they are bringing shame on the family) is brought to bear to make one person marry another.
Hate crimes	These can be against the person or their property. Hate crimes hurt and they can be motivated by the offender's hatred of people who are seen as being different. An adult or a child may be the victim because of race, religion, age, disability, sexuality or gender.
Inappropriate restraint	Staff must not restrain a person in a way that restricts their breathing, it must not include deliberate use of pain, it must be clearly documented and agreed by the care team (follow the Trust's Restraint Policy and Procedure to avoid inappropriate restraint).
Mate crime	Occurs when someone 'makes friends' with a person and goes on to abuse or exploit their relationship. The founding intention of the relationship, from the point of view of the perpetrator, is likely to be criminal. The relationship is likely to be of some duration and, if unchecked, may lead to a repeat and worsening abuse. Mate crime can happen to anyone, but children and adults with learning disabilities are especially vulnerable to this type of abuse. This could include cuckooing (see above).
Multiple forms of abuse	An individual or a group of individuals can carry out abuse or neglect. Patterns of harm may emerge and may include multiple forms of abuse, which can occur in an ongoing relationship, or in a service setting, or to several people at any one time. Patterns should be recorded and professionally shared, as repeated instances of poor care may for example, be an indication of organisational abuse. It is very important to look beyond single incidents or breaches in standards, to underlying dynamics and patterns of harm. Any or all of these types of abuse may be perpetrated as the result of deliberate intent and targeting of adults at risk, negligence or ignorance.

3.0 Duties

Duty of care: all Trust staff have responsibility for the protection and safety of all patients being cared for by the Trust.

Person/Group	Duties
The Chief Executive	• Has overall responsibility for safeguarding adults and must ensure that the Trust has appropriate staff to manage safeguarding adults concerns and processes. • Ensures safeguarding adults is embedded within the Trust's culture which endeavours to recognise the link between quality, Clinical Governance and safeguarding in order to reduce the risks of harm.
The Chief Nurse	• Is the nominated Trust Executive lead for safeguarding both adults and children and will ensure that the Trust has in place a robust governance, assurance and training framework to ensure all staff have the knowledge and competence to enable the protection of adults and ensure a high standard of care is delivered. • Is accountable for reporting on safeguarding governance to the Trust Board and its regulators and will: ○ Report any key issues to the Quality Committee throughout the year ○ Submit an annual report collating the years' work streams, successes and challenges in relation to adult safeguarding to the Trust Management Executive, Quality Committee and Trust Board.
Managers (including HR Business Partners)	• Ensure that the Trust's recruitment processes are adhered to in relation to the Disclosure and Barring Scheme and ensure that relevant references are gained and checked. • Ensure that referrals of safeguarding concerns are referred to the Disclosure and Barring Service (DBS) if allegations of abuse are upheld against a member of staff. • Ensure that all new members of staff are booked onto the Trust Induction so that they are aware of their duties and responsibilities for Preventing harm and know how to respond positively when a concern or allegation is raised.
Matron for Safeguarding Adults (SA) (designated Trust lead)	• Develop a training strategy to ensure that staff are appropriately trained to a level to have the confidence to respond to, and manage, safeguarding referrals and concerns in line with the Trust's policy and Kent & Medway's Policy, Protocols and Guidelines for Safeguarding Adults. • Design the Trust's safeguarding adults training presentations. • Is available to consult with and offer advice in the most complex cases. • Develop systems to effectively co-ordinate the Trust's responses to safeguarding referrals. • With Directorate Matrons, develop, co-ordinate and implement Trust-wide action plans to ensure that lessons are shared within our multi-disciplinary environment. • Audit the effectiveness of safeguarding reviews, referrals and investigations so that practices can be improved Trust wide. • Provide reports to the Safeguarding Adults Committee with a report with regards to progress on active hospital investigations. • Provide a summary of any Kent & Medway Safeguarding Adults

Person/Group	Duties
	Reviews, Domestic Homicide Reviews and Mental Health Mortality Reviews, and develops a Trust-wide action plan for implementing recommendations from such reviews. • Ensure that the Trust Safeguarding Adults Committee continues to deliver appropriate information for the Chief Executive, Chief Nurse, Trust Clinical Governance Committee and Quality Committee to inform them of the progress of the Safeguarding Agenda within the Trust and within the local safeguarding economy. • Foster close partnerships working with colleagues in the local multi-disciplinary agencies who have a responsibility for facilitating the Safeguarding Adults agenda. • As far as is possible, attend and participate in the sub-groups to the Kent and Medway Safeguarding Adults Board (KMSAB), giving feedback that is pertinent to the Trust, to the Trust's Safeguarding Adults Committee. • Attend the Kent Mental Capacity Act Local Implementation Network Meeting, giving feedback that is pertinent to the Trust's Safeguarding Adults Committee. • Line manage the Learning Disability Liaison Nurse • Ensures systems are in place to capture data in relation to KASAFs raised by staff and DoLS applied for by the organisation.
Trust Safeguarding Medical Leads	• Offer expert advice in relation to complex cases being investigated or reviewed to medical and nursing colleagues. • Take a lead responsibility for ensuring safeguarding awareness, inclusive of mental capacity and DoLS training for medical staff is delivered.
Directorate Matrons	• Support their ward staff with investigations when issues of safeguarding concerns are raised about care delivery in their area, or allegations of abuse have been made. • Ensure that their staff are aware of the outcomes of investigations and the actions required to improve responses and care in the future. • Ensure that learning from safeguarding investigations are shared at Clinical Site Meetings. • Audit whether or not learning from investigations has been embedded into practice. • Review patients who are identified on the site report in their areas as an adult at risk (formerly known as a vulnerable adult). Where there are issues of concern, contention or complexity the Directorate Matron should gain advice from the Matron for SA or from Legal Services.
Safeguarding Champions	• Named practitioners who will give assistance/advice with the assessment and delivery of a patient's care needs. • Have a central role in their area, in promoting 'best practice' in relation to the care and treatment of patients who are assessed as being an adult at risk. • Act as a resource of expertise in safeguarding processes for their health colleagues. • Are invited to participate in additional training half days up to 3 times

Person/Group	Duties
	per year. (See Role and responsibilities of the Safeguarding Adults Champions (Appendix 5)
Ward Managers	• To identify a Safeguarding Champion to the Matron for SA (This includes paediatric departments). • Other duties in accordance with ensuring that this policy and procedure is adhered to in their area.
All staff	• Must report all cases of suspected abuse of adults in line with the Kent & Medway protocol: ○ If this occurred in the hospital setting, staff must report to either their line manager or Directorate Matron, for assessment and referral onto Kent Central Referral Unit, using the KASAF. It will be the responsibility of Trust practitioners (as opposed to LA practitioners) to ensure that investigations are carried out into these allegations into the Trust's care and practice, unless a crime is suspected, then it will be the police who are responsible. The alert forms and the outcome of the investigation must be copied into the Matron for SA electronically. ○ If abuse is suspected to have occurred prior to the patient's admission to hospital this must be referred to the Kent Central Referral Unit (CRU) using the KASAF. (see **Appendix 4a; guidance is given in Appendix 4b**) and staff **must** copy this form electronically to the Matron for SA ○ Staff must complete incident forms for any cases of suspected abuse ***that is alleged to have occurred in the hospital*** and report this to their line manager. ○ Staff must report adults identified as at risk who are now under their care on the daily site report. If they are concerned about care delivery or complexity of the patient they should seek advice from their Directorate Matron in the first instance. Specialist, more complex advice can be sought from the Matron for SA ○ Staff must provide additional advice and support for adults who are at risk or who are suffering from harm to safeguard them from being abused in any way. ○ Staff must appropriately maintain the confidentiality of anyone involved in a safeguarding case by only discussing details with those staff and agencies on a need to know basis.

4.0 Training / competency requirements

A suite of training programmes has been developed to ensure that a range of staff have access to appropriate training commensurate with their level of need.

All staff are required to refresh this training every three years.

In addition, the Kent & Medway Safeguarding Adults Board delivers multi-agency training in Safeguarding Adults at Risk of Harm, the Mental Capacity Act and DoLS. This can be accessed by searching the following link and booking on to the course of preference.

https://www.kent.gov.uk/social-care-and-health/information-for-professionals/training-and-development

Also refer to Appendix 14 - Training needs analysis (but please note that this appendix remains under review as the publication of the Safeguarding Adults Intercollegiate document is still awaited as at September 2018).

5.0 Procedure

It is for the local authority (LA) to decide whether the concern that has been raised to them about an adult safeguarding concern/ issue amounts to a Statutory Safeguarding Enquiry (Section 42 enquiry) being initiated. After risk assessing the information, the LA will decide the level of enquiry to be undertaken.

The LA are the lead agency for Section 42 Safeguarding Enquiries and will decide when the Section 42 duty is satisfied.

If a referrer is unhappy with the Local Authority's decision with regards to level of enquiry or the closure of a case they should use the Local Authority's escalation policy to express their concerns. The Matron for SA should be notified if the Local Authority Escalation Policy is used.

The link to the KMSAB Resolving Practitioner Differences; Escalation Policy is as follows:

https://www.kent.gov.uk/__data/assets/pdf_file/0019/56107/Kent-and-Medway-Multi-Agency-escalation-policy-for-adult-safeguarding-resolving-practitioner-differences.pdf

Please refer to the flowchart for a summary of the process.

If the person is assessed as lacking mental capacity, then a decision whether to invoke the safeguarding procedures must be made by the LA in the adult's Best Interests in terms of the Mental Capacity Act 2005. Therefore, Trust staff must make a KASAF referral for patients who they are concerned about, who lack capacity, in the patient's best interests, for the LA to consider.

If a crime is suspected to have occurred in the community the LA will notify the Police and it will be a Police responsibility to lead a criminal investigation.

If an incident of alleged abuse occurs in the hospital setting and it is either clear that a crime is suspected or where there is doubt as to whether or not the alleged incident constitutes a crime, a senior staff member (Ward Manager and above) should consult with the local Vulnerability Investigation Team (VIT) via the national number 101. For the Maidstone Hospital this will be the Maidstone VIT and for Tunbridge Wells Hospital this will be the Tunbridge Wells VIT. If there is an immediate risk of serious injury or someone is in danger of being attacked 999 should be called for an immediate response.

All conversations with Kent Police must be documented and you must take note of the Officer's name and number and request a reference number from Kent Police. The outcome of your conversation with Kent Police should be clearly documented.

If an allegation of abuse or neglect occurs within the Acute Hospital this must be reported to the LA using a KASAF referral form and if the LA assesses that a Section 42 Enquiry is warranted the LA will request the hospital Matron for SA to ensure an enquiry is undertaken (the LA retains responsibility for reviewing investigation processes at the Trust's Safeguarding Panel and will be responsible for deciding

whether the level of enquiry undertaken satisfies the Section 42 Safeguarding Adults Enquiry that was required).

The LA Safeguarding Practitioners have a responsibility to challenge the Trust if they believe that the Section 42 duties to carry out an appropriate enquiry/ investigation have not been met.

When enquiries are completed the Investigating Officer for the Trust must present this to the Safeguarding Panel (Appendix 15 Information on the Trust Safeguarding Panel) and copy the Matron for SA into the report and outcome with evidence attached. The Safeguarding Panel is chaired by the Deputy Chief Nurse and panel members will review the investigation report/evidence supplied and to decide upon the outcome of the investigation.

For more complex issues (where more than one agency is carrying out an investigation) a multi-agency strategy meeting and case conference can be convened by the Local Authority.

If staff are concerned that an adult at risk has been abused or neglected prior to coming into hospital, they should raise a Safeguarding Concern with the LA by completing the KASAF. The KASAF needs to be completed electronically and **must** be copied into the Matron for SA. There is no need to raise an e-reporting form (Datix) for these community cases.

It will be for the LA to decide whether or not a Section 42 Enquiry is required and the level of enquiry needed.

When completing the KASAF staff must include as much information as can be gathered – this will enable the LA to risk assess appropriately.

The LA should give the referrer feedback in relation to the concerns that have been raised and the outcome of the enquiry where possible.

If staff are unsure if concerns reach the threshold for raising a KASAF they should contact:

- The Matron for SA
- The Directorate Matron or line manager
- The Central Referral Unit, (CRU) on 03000 416161 for a consultation to discuss the presenting issues of concern.

5.1 Hospital concerns (see also Appendix 6)

If a patient is an inpatient, and it is suspected that they have been abused whilst in the Trust's care setting either by family, friends or staff, this will need to be raised with the Directorate Matron, or line manager **and** the Matron for SA for consideration of the best protective measures to put into place. An e-reporting form (Datix) must be completed if this occurred on Trust property.

A KASAF will need to be completed by the person who has either witnessed the abuse, the abuse has been disclosed to, or who suspects that the abuse is occurring, or has occurred. This referral should be copied into the Directorate Matron, Matron for SA and Divisional Director of Nursing & Quality (DDNQ).

If the matter is assessed as not warranting a Safeguarding Adults Referral the rationale for this decision will be recorded by the decision maker. If a KASAF referral is completed then it will be for Kent Local Authority to decide upon the level of the Section 42 enquiry or safeguarding investigation to be carried out.

It will be the responsibility of the referrer to escalate the referral information to the Matron for SA and to the Directorate Matron.

In exceptional circumstances, i.e. if there is a reason to believe that a line manager is colluding in the abuse of an adult patient who is deemed at risk, the notifying member of staff should contact any of the following for advice, guidance and support:

- Clinical Site Manager (out of hours) or Directorate Matron,
- The Directorate Lead
- The Matron for SA
- The Deputy Chief Nurse or Chief Nurse, or
- The Medical Director

When it is an alleged incident of abuse in the hospital it is the responsibility of the Directorate Matron or Head of Department, to ensure that a KASAF is completed by the person reporting the alleged abuse. If it is a family member reporting the abuse to staff, or a patient reporting such abuse, then the practitioner to whom it is reported to **must** complete the KASAF and also an e-reporting form for incidents that have occurred in the hospital.

6.0 Response to disclosures of abuse

If someone is informed about an act of abuse or staff witness an abusive act, the immediate response must be to ensure that the person is safe and that no other adult or child is at immediate risk or imminent risk in light of the content of the disclosure or the act witnessed. All staff members are to respond sensitively to the disclosure and to ensure the safety of the alleged victim and all other adults in their care.

Staff should explain to the patient or victim that it is the staff member's duty to report the matter to the Local Authority and ask them what outcome they would like. Staff must record that conversation and what the person said, on the KASAF.

As the situation might require suspension of staff member/s or Preventing the alleged abuser from visiting the patient, this information needs to be passed on to a senior manager **within 2 hours.**

The information must be passed on to the immediate line manager or, if this line manager is implicated in the abuse, staff should report it to a more senior member of staff, or Matron for SA. If the immediate line manager is not available speak to either their line manager or the Matron for SA within this timescale. If the disclosure or witnessed event happens outside of office hours, staff should inform the Clinical Site Manager, on duty, within this timescale **of 2 hours, who will in turn escalate the concerns to the On-Call manager.**

If it is considered that the matter is potentially a crime staff should inform the immediate line manager, or if they are implicated, a more Senior Manager. A KASAF should be completed and sent to the Central Referral Unit (CRU). Liaise with the local VIT at Kent Police – via 101.

In normal working hours staff must ensure that the Directorate Matron, Associate Directors of Nursing (DDNQ), Matron for SA, Deputy Chief Nurse and Chief Nurse are informed so that they are able to assist with onward safeguarding decision making.

Outside of office hours the referrer must liaise with the Clinical Site Manager who must contact the On-call Manager and then the Executive Director on Call. The Serious Incident Reporting mechanism should be considered at this point by Senior Management Team.

If a decision has been made not to contact Kent Police (where a crime is suspected) the rationale for this decision and who made this decision must be clearly documented. **(See Appendix7: Crime Scenarios 'What is a Crime' this is not an exhaustive list of crimes**)

The Ward Manager, Senior Manager or Doctor must:
Ensure any medical examinations required are undertaken and outcomes documented and evidenced appropriately. Consent must be sought prior to any examination being undertaken. If consent is not possible staff members must work in the patient's 'Best Interests'.

7.0 Documentation and recording disclosures

Good documentation will assist the Local Authority to make decisions with regards to the level of safeguarding enquiry or investigation that is required. Staff must:

- note what the person has said that they want to happen as a result of the referral being made – 'Making Safeguarding Personal'
- note what the person actually said, using their own words and phrases within the healthcare records (patient's notes) and on the KASAF
- describe the circumstances in which the disclosure came about
- note the settings and anyone else there at the time
- include only factual information
- consider use of photographic evidence (please ensure that consent is obtained prior to any use of photographic evidence)
- use body maps and wound charts as appropriate
- write in black ink or electronically
- be aware the report may be used later as part of legal or disciplinary action
- date and sign the healthcare record
- preserve any evidence

Practitioners may need to be careful with regards to ***where*** this information is documented and staff will need to consider documenting the finer details separate from the contemporaneous healthcare records. This will be the case where the alleged perpetrator still has access to the healthcare records; and until such time as a decision is made to proceed to investigation the alleged perpetrator should **not** be alerted to the concerns raised about them.

If the alleged perpetrator is a member of staff and they need to be suspended from duty they should **just** be informed that a safeguarding concern has been raised about their practice and that whilst an investigation is underway they are not to make any contact with members of staff within the Trust.

It is only at the point of interviewing the member of staff either by way of Police, or disciplinary investigation that the member of staff should be alerted to the finer detail of the allegations made against them.

Kent & Medway Safeguarding processes use Protocol 15, a procedure for investigating and determining neglect in the incidence of acquisition of pressure ulcers. This will give practitioners guidance about when to raise a safeguarding alert in these instances **(see Appendix 8: Safeguarding Adults Protocol: pressure ulcers and the interface with a safeguarding enquiry).**

The Trust has developed a Root Cause Analysis (RCA) Tool to determine the causation of a hospital acquired pressure ulcer grade 3 and 4s. These RCAs are routinely examined by a Pressure Ulcer Learning and Improvement Panel in order for the Trust leads to determine whether or not the acquisition of a pressure ulcer was avoidable and whether or not this potentially constitutes a safeguarding concern. The outcomes of these investigations are shared with the Clinical Commissioning Group as the Trust's external scrutinisers. Where this has been used there will be no requirement for raising a safeguarding alert unless it is found that a practitioner has been wilfully neglectful.

With regards to medication errors there is a useful protocol (Protocol 15) to guide practitioners about what should be considered as to when to raise a safeguarding referral. **(Appendix 9: Kent & Medway Adult Safeguarding Protocols: Medication errors)**

8.0 Referring to external agencies

All KASAF referrals must be copied in to the Matron for SA and the Directorate Matron for that area. The Matron for SA will alert the Deputy Chief Nurse of all Hospital related safeguarding alerts who will in turn copy in the Chief Nurse, Executive Lead.

All KASAFs are sent to the Central Referral Unit (CRU). If it is alleged abuse within the community setting it will be for the CRU to manage the first stage of the enquiry, this is when the person is not known on the Social Care Systems to any practitioners. If the person has a known practitioner in Social Services the KASAF will be forwarded on to them by CRU, for their management.

If a hospital incident is alleged, the Associate Director of Nursing Services or Directorate Matron will appoint a suitable Investigating Officer (IO) who will have responsibility to investigate the matter and to compile a report of the outcome of their investigation. Even if this also constitutes a Serious Incident investigation, Complaints Investigation or disciplinary investigation the report **must** be copied to the Safeguarding Matron within **6 weeks** of the request for the investigation to be commenced. In cases that are very complex an extension to this time limit can be requested and granted by the Matron for SA.

If a crime is alleged to have occurred within the hospital, the most senior nurse for that Directorate on duty (or Matron for SA) will be required to liaise with the appropriate Kent Police Vulnerable Investigation Team for advice **before** any internal investigation is commenced. This is so that clear guidance can be gained from Kent Police as to what should be done initially to safeguard the victim, without contaminating a Police Investigation. The outcome of that initial consultation must be recorded, and staff must note the Police Officer's name and number and Police Reference Number given.

If a crime is suspected to have occurred Kent Police will be invited to lead the investigation - please also see Appendix 7: Crime scenarios

It is the duty of the referrer to Kent Police to inform:

In working hours	Out of working hours
Chief Nurse – as Executive Lead **and**	Clinical Site Manager – who will in turn inform…
Medical Director – if a doctor is implicated	The Manager on call – who will in turn

and	inform…
DDNQ – for Directorate involved	The Executive Director on call

It is the Executive level within the organisation that a decision will be made with regards to declaring a Serious Incident or not.

Precautions should be taken to protect any objects or items which may be of forensic value to the Police. In cases where it is unclear as to whether an act of abuse constitutes a crime the Police should be consulted with, for their advice.

The purpose of a safeguarding adult process is to secure or return the adult's autonomy as far as possible. If the adult has capacity **and** they are not being unduly pressurised or intimidated they may ask staff not to intervene. Their wishes should be respected, but this does not remove the staff member's responsibility to report any concerns and, where appropriate, for an enquiry/investigation to be carried out. The concerns must be documented alongside the outcome of the conversation with the patient about this referral on the KASAF.

In situations where other adults are at risk or where children may be at risk an enquiry is likely to proceed.

In order to be sure that the adult is deciding for themselves it may be necessary to create a safe place in which to consult the adult about their wishes. If a patient states they do not wish for the Police to be informed or a referral made consideration will need to be given to:

- Whether or not the person has mental capacity to make that decision or not
- Whether or not undue pressure is being brought to bear on them to not make a referral.
- Whether other patients are at risk from harm from the alleged perpetrator (if they are, a referral must be made and the Police informed)
- Whether there are children at risk of harm – if so a referral to CRU and Kent Police needs to be made.

If no crime is suspected

The Local Authority will ensure that if an allegation of abuse is received they will notify the Designated Safeguarding Manager (DSM). The Social Services Manager or Designated Senior Officer (DSO) is responsible for considering the information available and for agreeing that the statutory duty is met and must contact the DSM to determine the most appropriate course of action to take.

It is the Trust's responsibility to co-ordinate the responses to concerns raised about practices within the acute hospital setting in line with the Kent and Medway Adult Safeguarding Protocol - ***13: Guidance Notes for Adult Safeguarding between the Local Authorities in Kent and Medway and Acute Hospitals*** **(Appendix 6).** The DSM (Matron for SA) will assess the information received and determine the level of further investigation, under SAs policy and procedures, in consultation with the DDNQ and Directorate Matron. The Directorate Matron will identify a suitable Investigating Officer to carry out the investigation and compile a safeguarding report.

This referral might also require consultation with our partner agencies. The Trust will take the lead in cases of suspected abuse that occurred on Trust premises, unless it is established or suspected that a crime has been committed, whereby the Police take the lead.

In complex cases a Safeguarding Meeting will be convened so that all relevant information can be assessed and clarity of roles, responsibilities and investigative process can be agreed. These strategy meetings will be formally documented. (**Appendix 10: Template for safeguarding adults strategy meeting**).

Kent Adult Social Services may be approached for advice on the safeguarding process and for ongoing support for the victim of abuse.

Where Bank or Agency staff are implicated in a safeguarding issue the Bank and Agency Staff Manager must be informed. They will be the conduit between the ward and the agency in relation to sharing information or chasing up statements from the Agency and/or agency staff. They will not be responsible for carrying out the investigation. It will be for the allocated Investigating Officer to carry out the investigation and produce a report and action plan.

9.0 Potential outcomes: Learning outcomes for the Trust

Action plans to improve services and/or individual staff skills will be developed from safeguarding investigations where a need has been identified.

The Directorate Matrons will be responsible for development and implementation of these action plans jointly with the Ward Managers. The Matron for SA will provide support and assistance with the development of these action plans if required. If it is in relation to an area in Allied Health Professionals (AHP) the AHP Manager will be responsible for ensuring the implementation and progress of the action plan.

It will be the responsibility of the Directorate Matron, AHP Manager, or speciality manager to ensure proactive progress is made on each action plan developed and they will be responsible for auditing and signing off that the action plan has been completed.

Learning outcomes, recommendations and improvements will also be reported to the Safeguarding Adults Committee every 2 months by the Directorate Matrons.

Kent Serious Adult Review/Domestic Homicide Review/Serious Incident Processes

On occasions the Trust will participate in the Kent Multi-Agency Serious Adult Review or Domestic Homicide Review processes. Learning outcomes that are specific to the Acute Hospital Trust will be shared with the Safeguarding Adults Committee, Trust Board (via the Annual SA Report), DDNQs, Chief Nurse and Allied Health Professionals (AHPs), Senior Managers for learning and improvements to be made.

All serious incidents that have been reported as such, that are of a safeguarding nature, will still need to be managed through the Serious Incident Policy and Procedure alongside use of this procedure. Outcomes and reports must be shared with the Matron for SA.

Potential outcomes for staff implicated in a referral

Disciplinary processes

Allegations of abuse of an adult by a member of staff may lead to disciplinary action being taken against that individual, in accordance with the Trust's Disciplinary Policy and Procedure. Prior to this the staff member may be removed from duty or suspended from work pending the completion of the investigation. Whatever the circumstances; all staff must ensure that the details of the incident or suspicion are documented on the KASAF and an e-reporting form completed.

If documenting in the patient's healthcare records, care should be taken not to identify the alleged perpetrator so as to safeguard the potential criminal or disciplinary investigation.

The finer detail of the allegation should not be shared with the alleged perpetrator at this stage. It is at the point of calling the alleged perpetrator in for an interview that

they should be made aware of the finer detail. The interviewer should be asking open questions about the incident and care delivery episode and should not show the alleged perpetrator any complaint letter or witness statements gathered at this stage.

An interview schedule should be developed taking into account all the information gathered thus far as part of the investigative process.

If the allegation of abuse is proven or that on the balance of probability the act of abuse had occurred via the Trust investigatory process, the staff member may be disciplined up to and including dismissal. Acts of abuse, proven on the balance of probability should be considered against the Trust's gross misconduct guidance, within the Trust's Disciplinary Policy and Procedure, this will be dependent upon the severity of the act.

If a Police investigation has been commenced, then the Trust will work in partnership with the Police during the investigation, However, the Trust will conduct its own investigation under the Trust Disciplinary Policy and Procedure and disciplinary action may be taken up to dismissal, at the point of or before the completion of the Police investigation.

If after the investigation the case is unfounded. and can not be proven, then it will be noted as such and the alleged perpetrator will be informed in writing, by their line manager.

10.0 Police action

The Crown Prosecution Service will decide whether the offence under investigation warrants a Police Caution or referral to a court process. It is the Court process that will prove or disprove 'beyond reasonable doubt' the alleged perpetrator's guilt.

If a staff member accepts a Police Caution this is evidence that the incident of abuse occurred and that they are admitting that they were the person responsible for that abuse, therefore it is an admission of guilt.

11.0 Referral to professional body and Disclosure and Barring Scheme

If a professionally registered person is found to be guilty (this can be either on the balance of probability or beyond reasonable doubt) as the perpetrator they will be referred to their registering body i.e. the NMC, GMC etc. (this list is not exhaustive). It will be the Trust's responsibility to report matters to the appropriate professional bodies. This will usually sit with the disciplining manager and the HR Business Partner. The Chief Nurse **and** the Medical Director **must** be informed of all referrals to a professional body of a Trust member of staff. The Matron for SA will be informed by HR Business Partner when the referral is completed.

Any member of staff (qualified and unqualified) with direct patient contact will be referred to the DBS scheme if found guilty (either on the balance of probability or beyond reasonable doubt) of abusing an adult at risk. It will be the responsibility of the HR Business Partner and Senior Manager hearing the case to make decisions about onward referrals. When referrals are made of individuals to professional bodies and the DBS, they **must** inform the Chief Nurse that this is being done. They must also inform the Matron for SA when the referral is completed.

If the worker is not professionally qualified and is found guilty of an abusive act (either on the balance of probability or beyond reasonable doubt) against an adult at risk they will be referred to the DBS in conjunction with National Guidance. It will be the HR Business Partner's responsibility to assess this requirement with the Disciplining Senior Manager and complete the necessary referral forms with the disciplining manager, if deemed appropriate to refer. ***This must also be considered***

for those staff already referred to a professional body. The Chief Nurse **must** be informed if referral is completed, along with the Matron for SA.

It is for the DBS to decide whether or not to place the worker on a barring list. If the worker is barred from working with adults at risk of harm and/or children it will be a criminal offence for them to seek work with these adults at risk or children.

12.0 Outcomes for the adult at risk and our duty to give feedback about outcomes of investigations

If the allegation of abuse was proven (either on the balance of probability or beyond reasonable doubt) this could lead to:

- The lead agency enabling a change of care provider for the adult.
- Additional support being provided to the adult to ensure their ongoing safety and protection.
- Training needs being identified for either the adult or their family/carers to ensure that they have the ability to safeguard themselves.
- A change of accommodation either for the adult or for the alleged perpetrator
- Counselling services for the victim and their family.
- Referral to an Advocacy Service

The adult at risk may be required to give evidence in a court case and may need additional support to enable this to occur. Kent Adult Social Services and Kent Police are able to assist with these processes.

When a report is finalised and the outcome agreed at the Safeguarding Panel, then a letter giving feedback will need to be compiled and sent to the alleged victim and/or their representative. The Matron for that Directorate or the head of service will be responsible for compiling this letter giving the outcomes of the investigation and action plan developed.

If a safeguarding referral is declared by members of the Executive Team as a Serious Incident (SI) it will be the duty of the Patient Safety Team to compile the Duty of Candour letter and send this, with a copy of an anonymised safeguarding investigation report to the alleged victim and/or their representative. The Patient Safety Team must copy the Matron for SA into these documents.

If a safeguarding referral does not reach the threshold of being declared a Serious Incident then it will be for the Directorate Matron to compile and send the letter giving feedback and outcomes to the referrer and the alleged victim, along with an anonymised version of the Safeguarding Investigation Report. These documents must be copied to the Matron for SA for evidence that this feedback has been given to the alleged victim and/or their representative.

13.0 Local arrangements for managing a safeguarding alert

In complex cases the Matron for SA or Directorate Matrons will review the care of the Adult and offer advice to the Ward Manager and staff as to any additional assistance required to meet the person's needs appropriately and safely. Use of the 'Policy and procedure for the provision of enhanced care to adult inpatients (use of Nurse 'Specials' 1:1 nursing)' should be considered.

In complex cases the Matron for SA will visit the ward, upon the ward managers or Directorate Matrons' request, and review the management of adults at risk of harm as required and provide advice with regards to implementation of care plans, risk assessments, applying the Mental Capacity Act, liaising with external agencies, etc. It will be for Ward Managers and Directorate Matrons to ask Matron for SA to visit the ward to see a particular patient.

Ward Managers and/or Directorate Matrons will ensure that:

- Adults at risk of harm have a written care plan which details the specific care requirements according to their needs
- A Clinical Risk Assessment is undertaken by ward staff to understand all the risks associated with safeguarding the adult at risk of harm
- Will ensure that the ward has sufficient resources to meet the patient's care needs including nutrition and hydration of the adult at risk of harm as well as the other patients on the ward during their stay in hospital.

14.0 Supporting staff

14.1 Individual staff alleged to have abused an Adult at Risk of Harm

Caring for patients who have been abused, or for staff who have been involved in the investigation of cases of a safeguarding nature, can be stressful. Line managers must provide their staff with the following as needed:

- Stress counselling though occupational health
- Support for statement writing or attendance at court proceedings.

The Matron for SA or Directorate Matrons are available to provide information and support for any staff involved in cases of safeguarding.

Further support for staff involved in stressful incidents can be found in the Supporting Staff involved in Traumatic and Stressful Incidents, Complaints or Claims Policy and Procedure.

If a member of staff is suspended from duty pending the outcome of an investigation the Directorate Matron will be responsible to identify a Ward Manager or Matron who is **not** involved in the investigation to provide ongoing support for the staff member who has been suspended. The level and frequency of contact will be negotiated, agreed and documented on an individual case by case basis.

14.2 Staff involved in safeguarding processes

The Directorate Matron will ensure that their staff are supported throughout the safeguarding process. It may be that staff will require additional time to write statements. They may need referral to the Occupational Health Department to look at ways of managing the stress and emotion that contributing to an investigation can cause.

The Matron for SA and/or the Directorate Matrons can offer a debriefing session to staff groups so that the safeguarding processes can be explored and so that staff can be listened to with regards to their own experiences. Learning outcomes from these sessions will be shared on a Trust wide basis to ensure that practices throughout investigations can be improved.

14.3 Allegations management – Local Authority Designated Officer (LADO) functions

Under the Care Act 2014 and Children Act 2004 everyone within Adult Services has responsibility to carry out their normal functions having regard to the need to safeguard and promote the welfare of adults at risk, children, and young people and for ensuring their wellbeing whilst protecting them from harm.

The allegation management process relates to addressing concerns that come to the attention of the authority that may call into question a person's suitability, in a paid or unpaid capacity, to work with adults or children.

Where there is no ongoing safeguarding enquiry, the Allegation Management Referral Form should be completed and sent to the Central Referral Unit (CRU) for Kent or the Access and Information Service for Medway, where it will be recorded and passed to the appropriate Local Authority Designated Officer (LADO) for adult or children's services, who will be responsible for addressing any reported concerns raised. However, if a crime is believed to have been committed, the Police must be contacted immediately.

Information regarding individuals who may pose a risk to adults or children can be received through a number of sources. The following are some examples:

- Police referral
- Information from a member of the public
- Referral from children's services
- Referral from health colleagues
- Information resulting from a safeguarding enquiry

Guidance from the Care Act 2014: 14.123 - Allegations against people in positions of trust.

Examples of such concerns could include allegations that relate to a person who works with adults with care and support needs who has:

- behaved in a way that has harmed, or may have harmed an adult or child
- possibly committed a criminal offence against, or related to, an adult or child
- behaved towards an adult or child in a way that indicates they may pose a risk of harm to adults with care and support needs

14.4 Investigation Officers

Investigation Officers will be supported to complete their investigation and to write their report by the Matron for SA or the Directorate Matron, when this is requested. (**See Appendix 11: Safeguarding Adult Investigation Report Template**).

15.0 Prevent

Prevent is part of a national programme aimed at identifying where people are possibly becoming indoctrinated into radical and extremist thoughts that could lead onto terrorist or extreme activity. Adults at risk may be more susceptible to being drawn into such ideas and actions by being befriended by extremists. Staff need to be aware of adults at risk who are expressing such ideas or who may have entered our service with unexplained and unusual injuries.

If a staff member encounters an adult at risk who appears to have been radicalised or appears to be within the process of being radicalised this needs to be reported to the Matron for SA whereby a plan of action will be developed and agreed with our partner agencies.

For adult patients referrals will be made by the Matron for SA to the Kent Channel Panel. (see **Appendix 12: Prevent referral routes**)

Occasionally members of staff might be drawn into being radicalised by extremist organisations. If colleagues become concerned about an individual staff member having extreme thoughts and ideation then this will also need to be referred to the Matron for SA who will in turn seek advice from the Director of Workforce. The Chief Nurse and/or the Medical Director will be informed and involved in the decision making to refer to external agencies. It will be the responsibility of the Director of Workforce to refer out to Kent Channel Panel for a staff member.

If this matter is referred to the agreed partner agencies they will consider an appropriate course of action and will build a plan of support for the individual at risk if it is assessed as being required.

It is recognised that this type of radicalisation of thought occurs in the pre-criminal arena and if we are able to identify these concerns and refer on appropriately to gain support for individuals vulnerable to this, then there is an opportunity created to PREVENT these ideas turning into criminal actions.

16.0 Notifications to the Care Quality Commission (CQC)

All allegations of abuse that are alleged to have occurred in the hospital setting are reported to CQC via raising a KASAF with Kent Social Services as the CRU will automatically share this with CQC.

17.0 Datix

When the Datix Incident Report is completed staff will be required to identify that the patient is an adult at risk *(still vulnerable adult on the form)* on the Datix Incident Report so that the appropriate personnel are notified as soon as this type of incident is alleged to have occurred.

18.0 Notifications within the Trust

It is essential that the Divisional Director of Nursing & Quality, Directorate Matrons, Matron for SA and Patient Safety and Risk Manager are notified when an alert is raised pertaining to incidents of alleged abuse in the Trust so that consideration can be given to whether or not it reaches the threshold for raising a serious incident.

19.0 Domestic abuse and safeguarding adults

It is important to recognise that any adult may become a victim of domestic abuse/violence or be affected by the level of violence occurring in their home or between family members. This is likely to have a serious effect on their physical and mental well-being. Where adults at risk of harm are victims of domestic violence or abuse they may need extra support to plan their future and keep themselves safe. The violence or threat of violence may continue after they have moved away from the abuser. It is important to ensure that all people in this situation have appropriate support to enable them to maintain their personal safety.

A separate domestic abuse protocol is in place between Kent Police, Social Services and Health. This can be found on the Kent County Council Safeguarding Adults website at:

http://www.kent.gov.uk/__data/assets/pdf_file/0005/14000/Joint-Police-Social-Services-and-Health-Protocol-for-dealing-with-cases-of-Domestic-Abuse-where-adults-at-risk-are-involved-April-2016.pdf

Incidents reported to the police through these domestic abuse protocols will be addressed under the Safeguarding Adults processes if it is considered that an adult at risk is at risk of abuse.

If a patient or another family member discloses to staff that they are the victim of domestic violence/abuse staff should assess if they have mental capacity to make decisions for themselves and then gain an understanding as to how they wish the information disclosed to be used.

The Safe Lives Domestic Abuse Stalking and Honour Based Violence (DASH) Risk Identification and Assessment Checklist **(see Appendix 13: Safe Lives DASH tool)** will assist staff to ask the most appropriate questions to assess the level of risk for each individual victim and plan a way forward for onward referrals with the victim or in their best interests. If the victim scores 14 or more on the DASH Risk Assessment this should be referred to the Multi-Agency Risk Assessment Conference (MARAC) refer to the Trust's Domestic Abuse Policy.

The Domestic Violence, Crime and Victims Act 2004 creates a new offence of 'Causing or allowing the death of a Child or an Adult at Risk of Harm'.

It makes common assault an arrestable offence.

Section 9 of the Act establishes a Domestic Homicide Review (DHR) process. This amounts to a review of the circumstances in which the death of a person aged 16 years or over has, or appears to have, resulted from violence, abuse or neglect by

c) A person to whom he was related or with whom he was or had been in an intimate personal relationship with, or
d) A member of the same household as himself

The review will be held with a view to identifying the lessons to be learnt from the death. If the Trust is asked to contribute to a Domestic Homicide Review (DHR) it will be for the Chief Executive and/or the Chief Nurse to identify the most appropriate practitioner to complete the required investigation and report **(please refer to the Trust's Domestic Abuse / Violence Policy and Procedure).**

20.0 Self neglect

Where a patient is assessed as neglecting themselves to the extent that this is potentially causing, or going to cause significant harm or injury staff must liaise with the Local Authority where the person lives. Staff should document who was spoken to along with their role, and the agreed outcome of that conversation.

If the patient's care ends at the Emergency Department (ED) then ED practitioners should alert the Local Authority about their concerns and level of risk of harm to the patient due to their self-neglect, and use a KASAF referral form to do this

If the patient is going to be admitted to one of the Trust's hospitals it would be reasonable to convene a multi-agency meeting to discuss the level of self-neglect, how that is impacting upon the patients health and whether or not community resources can be used to improve the situation prior to discharge.

If it is considered that the individual is likely to need care and support the Local Authority will determine if a Section 42 enquiry is required under the Care Act 2014.

If the self-neglect is as a result of care provision failures then a KASAF should be raised so that the Local Authority can make enquiries into the situation.

Not every case of self neglect will result in a KASAF being raised.

The Kent & Medway Policy, Protocol and Guidance has a stand alone self neglect policy which can be accessed at

http://www.kent.gov.uk/__data/assets/pdf_file/0012/16140/Self-neglect-policy-and-procedures.pdf

21.0 Information sharing

Whether or not planning a response to a safeguarding adult concern is through formal or informal consultations staff are likely to be sharing information that would normally be considered to be confidential.

Each agency holds information, which in the normal course of events is considered as confidential and will have their own safeguards and procedures for sharing this with other related agencies. Some information will be subject to the Data Protection legislation.

Concern about abuse of an adult at risk of harm provides sufficient grounds to warrant sharing information on a 'need to know' basis and/or 'in the public interest' and unnecessary delays in sharing that information should be avoided. Staff must ask the patient what they want to happen as a result of the concern being shared and their wishes must be documented on the KASAF.

If the alleged perpetrator has access to other adults at risk of harm a Safeguarding Referral **must** be made so that consideration can be given to protecting all adults at risk in the care of this person.

APPENDIX 1

Process requirements

4.0 Implementation and awareness

- Once ratified, the Chair of the Policy Ratification Committee (PRC) will email this policy/procedural document to the Corporate Governance Assistant (CGA) who will upload it to the Trust Policy database on the intranet, under “Policies & guidelines”.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under “Policies & guidelines”. Notification of the posting is included on the intranet “News Feed” and in the Chief Executive’s newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- Following a completed staff training needs analysis the Matron for SA will source and identify different levels of training for staff to attend so that this policy is embedded into best practice in relation to the Safeguarding of Adults at Risk and Prevention of abuse.
- Notification of the updated policy and procedure will be highlighted to all staff following formal approval of the policy.
- All nursing, midwifery, medical and Allied Health Professional [AHP] staff will be made aware of the policy as part of the clinical mandatory update training delivered by Matron for SA
- The Safeguarding Medical Lead will present the policy to the Trust Medical Committee and Clinical Directors meeting following approval.
- The Safeguarding Medical Lead will, with the Director of Medical Education, agree and implement a programme of training and induction for junior medical staff.

2.0 Monitoring compliance with this document

2.1 Audit plan

- Training attendance is audited through compliance with the Statutory and Mandatory Training Policy and Procedure by the Workforce Committee.
- A review of the identification and reporting of Adults at Risk of Harm reported by ward staff on the site reports is undertaken as part of the Nursing Management audits undertaken by the Ward Managers, Directorate Matrons and at Key Performance Indicator (KPI) meetings.
- Once every two months reviews and reports on all safeguarding activities, incidents and management are undertaken by the Trust Safeguarding leads and reported to the Safeguarding Adults Committee.

2.2 Monitoring compliance

Trust performance with regards to compliance with the published “Safeguarding Adults at Risk of Harm’ are monitored by the Safeguarding Adults Committee.

The Matron for SA ensures compliance with the CQC’s minimum requirements, which are detailed in Outcome 7, however it is noted that most CQC Outcomes have a bearing on safeguarding issues.

The Matron for SA monitors compliance through:

- Monitoring staff SA referrals against the concerns, complaints and incidents received into the Patient Safety Department.
- Compiling quarterly reports to the Safeguarding Adults Committee about SA referral activity about Trust practices
- Reviewing the Training Database for SA to ensure that staff are trained to the level determined in the policy and procedure.
- Ensure that suitably qualified personnel are tasked to initiate and complete SA Investigations.
- Highlighting any organisational risks with regards to safeguarding adults and ensuring that the risk register is populated accordingly and action plans developed and progressed.

The Deputy Chief Nurse will compile periodic reports to the Safeguarding Committee to include:

- Summarising the Kent wide SA Multi-agency Executive Board meeting with particular emphasis on the pertinent issues for the Trust.
- Summarising any gaps or risks with regards to trends of incidents and reporting.

The reports listed above and the minutes of the Safeguarding Adults Committee will be used as evidence of monitoring compliance for the CQC Outcomes.

The training database for SA will also provide evidence of monitoring compliance with the policy and procedure.

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every 4 years.

4.0 Archiving

The Trust approved document management database on the intranet, under '"Policies & guidelines", retains all superseded files in an archive directory in order to maintain document history.

APPENDIX 2

CONSULTATION ON: Safeguarding Adults at Risk Policy and Procedure

Please return comments to: Karen Davies Matron for SA kdavies7@nhs.net

By date: 25th May 2017

Job title:	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff must be included in all consultations:				
Corporate Governance Assistant	18/04/18	25/04/18	Y	Y
Chief Pharmacist and Formulary Pharmacist	18/04/18	N		
Formulary Pharmacist	N/A	N		
Staff-Side Chair	18/04/18	N		
Complaints & PALS Manager	18/04/18	N		
Emergency Planning Team	18/04/18	19/04/18	N	
Head of Staff Engagement and Equality	18/04/18	N		
Health Records Manager	18/04/18			
All individuals listed on the front page				
All members of the approving committee: Safeguarding Adults Committee	18/04/18			
Other individuals the author believes should be consulted				
Chief Executive	18/04/18			
Executive Lead for Workforce and planning	18/04/18			
Chief Nurse	18/04/18			
Deputy Chief Nurses	18/04/18			
Assistant Deputy Chief Nurse	18/04/18			
DDNQ'	18/04/18			
Head of Legal Services	18/04/18			
Head of Learning and Development	18/04/18			
Matrons	18/04/18			
Ward Managers	18/04/18			
Learning Disability Liaison Nurse	18/04/18			
Clinical Directors	18/04/18			
Medical Director	18/04/18			
Clinical Lead	18/04/18	16/05/18	N	N
Head of Governance	18/04/18			
Head of Therapies	18/04/18			
Named Nurse Safeguarding Children	18/04/18			
Chief Operations Manager	18/04/18			
General Managers	18/04/18			
Lead Nurse Dementia	18/04/18	10/04/18	Y	Y
Head of Information Governance	18/04/18			
The following staff have given consent for their names to be included in this policy and its appendices: Karen Davies				

APPENDIX 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development, approval and ratification process.

Title of document	Safeguarding Adults at Risk Policy and Procedure
What are the aims of the policy?	To ensure all patients, visitors who are adults at risk of harm are treated with dignity and respect and appropriate safeguarding referrals are competed on their behalf.
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Gender identity	No
People of different ages	Applies to people 18 years and over
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	No
People who have a physical or mental disability or care for people with disabilities	No
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	
When will you monitor and review your EqIA?	Alongside this document when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this document

FURTHER APPENDICES

The following appendices are published as related links to the main policy/procedure on the Trust approved document management database on the intranet, under 'Policies & guidelines':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4a	Kent Adult Safeguarding Alert Form (KASAF) Stage 1	RWF-OPF-CS-C-NUR1	This policy
4b	Guidance to completing a Kent Adult Safeguarding Alert Form – KASAF	RWF-NUR-NUR-GUI-11	This policy
5	Roles and Responsibilities of the Safeguarding Adults Champions	RWF-OWP-APP109	This policy
6	Kent & Medway Guidance Notes for Adult Protection Protocol between Adult Social Services and Acute Trusts	RWF-OPPM-CORP83	This policy
7	Crime scenarios: "What is a crime"?	RWF-OWP-APP617	This policy
8	Safeguarding Adults Protocol: Pressure Ulcers and the interface with a Safeguarding Enquiry	RWF-OPPM-CORP303	This policy
9	Kent & Medway Adult Safeguarding Protocols: medication errors	RWF-OPPM-CORP304	This policy
10	Template for Safeguarding Adults Strategy Meeting	RWF-OWP-APP110	This policy
11	Safeguarding Adult Investigation Report Template	RWF-OWP-APP111	This policy
12	Prevent Referral Routes	RWF-OPPM-CORP86	This policy
13	Safe Lives - Domestic Abuse Stalking and Honour Based Violence (DASH) Tool	RWF-OWP-APP620	This policy
14	Training needs analysis	Please note this remains under review	This policy
15	Information on the Trust Safeguarding Review Panel	RWF-NUR-NUR-APP-2	This Policy

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Maidstone and Tunbridge Wells NHS
NHS Trust

Safeguarding Children Policy and Procedure

Target audience:	All Trust Staff
Main author:	Named Nurse for Safeguarding Children **Contact details:** 01892 638178
Other contributors:	None
Executive lead:	Chief Nurse
Directorates:	Women, Children and Sexual Health
Specialty:	Paediatrics (Safeguarding Children)
Supersedes:	Safeguarding Children Policy and Practice Guidance, October 2013 (Version 3.4: October 2013)
Approved by:	Safeguarding Children Committee, 25th May 2017
Ratified by:	Policy Ratification Committee**,** 7th July 2017
Review date:	July 2020

Document history

Requirement for document:	• To ensure that the safety and welfare of all children is paramount • To ensure the processes for management of safeguarding children are robust and consistent • To comply with organisational, local and national guidelines
Cross references (external):	1. Working Together to Safeguard Children (HM Government 2018) https://www.gov.uk/government/publications/working-together-to-safeguard-children--2 2. What to do if you're worried a child is being abused: advice for practitioners (HM Government 2015) https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2 3. Kent & Medway Safeguarding Children Procedures (Kent Safeguarding Children Board 2018) http://www.proceduresonline.com/kentandmedway/ 4. Laming Report (2003, 2009) https://www.gov.uk/government/publications/the-victoria-climbie-inquiry-report-of-an-inquiry-by-lord-laming ; https://www.gov.uk/government/publications/the-protection-of-children-in-england-a-progress-report 5. Safeguarding Children in whom Illness is Fabricated or Induced (HM Government 2009) https://www.gov.uk/government/publications/safeguarding-children-in-whom-illness-is-fabricated-or-induced 6. Intercollegiate Document on Safeguarding Competencies (Royal College Paediatrics and Child Health [RCPCH] 2014) www.rcpch.ac.uk 7. Children Act 1989 and 2004 www.legislation.gov.uk 8. Safeguarding Practitioners Information Sharing Guidance (HM Government 2018) https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice 9. Multi-Agency Statutory Guidance on Female Genital Mutilation (HM Government 2018) https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation 10. Mental Capacity Act Code of Practice (HM Government 2007) 11. Kent Safeguarding Children Board website – www.kscb.org.uk 12. Kent Safeguarding Children Board Child Sexual Exploitation Toolkit - www.kscb.org.uk/guidance/sexual-abuse-and-exploitation 13. When to Suspect Child Maltreatment – https://www.nice.org.uk/guidance/cg89 14. The NSPCC guide to spotting signs and symptoms of abuse - https://www.nspcc.org.uk/preventing-abuse/signs-symptoms-effects/ 15. Kent and Medway Child Sexual Abuse Pathway http://www.kscb.org.uk/procedures/sexual-abuse2 16. Domestic Abuse and Violence: multi-agency working https://www.nice.org.uk/guidance/ph50 17. Domestic Abuse Support Services in Kent and Medway http://www.domesticabuseservices.org.uk/professionals/promotional-material/ 18. Safe Lives website - www.safelives.org.uk 19. Multi-Agency Guidelines Honour Based Abuse and Forced Marriage (www.gov.uk) https://www.gov.uk/guidance/forced-marriage 20. World Health Organisation FGM Factsheet (2017) http://www.who.int/mediacentre/factsheets/fs241/en/ 21. Channel Duty Guidance (HM Government 2015) https://www.gov.uk/government/publications/channel-guidance 22. Kent Safeguarding Children Board Missing Children Procedures http://www.kscb.org.uk/procedures/missing-children 23. Kent Safeguarding Children Board Child Death Procedures www.kscb.org.uk https://www.kscb.org.uk/procedures/child-death 24. Kent County Council : A Guide to Managing Allegations against Members of Staff (2017)

	http://www.kscb.org.uk/__data/assets/pdf_file/0008/72944/01.03.2017-Managing-Allegations-Against-Staff-Practice-Guidance-FINAL.pdf 25. Kent Safeguarding Children Board Guidance – On-line Safety http://www.kscb.org.uk/guidance/online-safety 26. Kent Safeguarding Children Board Request for Support Form and Support Level Guidance – http://www.kscb.org.uk/procedures/child-in-need-chin
Associated documents (internal):	• Safeguarding Children Supervision Policy and Procedure [RWF-OPPPCS-NC-NUR5] • Speak Out Safely (SOS) Policy and Procedure (formerly Whistle Blowing) [RWF-OPPPCS-NC-WF33] • Female Genital Mutilation Policy and Procedure [RWF-PAE-POL-1] • Learning and Development Policy and Procedure [RWF-OPPPCS-NC-WF20] • Domestic abuse / violence policy and procedure [RWF-OPPPCS-NC-NUR7] • Missing Children Policy and Procedure [RWF-OPPPWC-NC-PD1] • Traumatic and Stressful Incidents, Complaints or Claims Policy and Procedure, Supporting Staff involved in [RWF-OPPPCS-NC-WF59]

Keywords:	concern	vulnerability	children
	safeguarding		

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	Original document	November 2007
2.0	Reviewed and new format to comply with Trust template	June 2010
2.1	Minor amendments	December 2010
2.2	Minor amendments	March 2011
2.3	Minor amendments	July 2011
2.4	Minor amendments	August 2012
2.5	No amendments – Safeguarding Children Committee agreed to extend review date to 31.9.13	February 2013
3.0	Reviewed	October 2013
3.1	Page 15: Flagging system; 3rd paragraph change of telephone number; Appendix 11, updated CAF form	January 2014
3.2	New appendices 12 and 13 added	April 2014
3.3	Page 16, 5.15, Female Genital Mutilation – Appendix 14, 15, 16, 17 Page 16, 5.4.3, Link renamed to http://www.kelsi.org.uk/earlyhelp and CAF has been renamed 'Early Help'. Page 18, 8.1.2 new link http://www.proceduresonline.com/kentandmedway/	August 2014
3.4	Page 3 – 2nd Para, (DFE 2015) Page 4 – 5.0 Add CSE on end of list, 5.15 FGM Page 5 – Change of layout for Advice & Support Page 9 – 5.1 Additional information Page 11 – 5.7 Additional information Page 14 – 5.10 Additional information Page 16. 5.14 & 5.14.1 – CAF replaced with Early Help Page 17 – 5.16 Child Sexual Exploitation Page 17 – 5.16 Add Appendix 7 Page 19 – section 9.0/9.1 expanded	April 2016
4.0	Document reviewed and updated to take into account changes to legislation, national and local guidance, and Kent Safeguarding Children procedures	July 2017
4.1	Page 2 – new links to Request for Support forms (previously known as Threshold Guidance and the Interagency Referral Form)	October 2018

Version control:		
Issue:	**Description of changes:**	**Date:**
	Throughout the document Working Together Guidelines (2015) now changed to Working Together Guidelines (2018) Page 9 – new definition of abuse and neglect (from Working Together Guidelines (2018)) Page 11 – updated definition of Sexual Abuse – (section 2.5.3) Page 13 – section 2.8 & 2.9 – changes to terminology and referral process to Children's Social Care – now known as a Request for Support; new processes for Early Help service – updated links Page 15 – updated link to Child Sexual Exploitation guidelines Page 20 –updated Safeguarding Flowcharts Page 21 – updated link to new Working Together Guidelines (2018) Pages 31-32 – updated advice and links on new Request for Support process Page 33 – updated details on CP-IS Page 37 – updated advice on information sharing Page 39 – updated links and guidance on Serious Case Reviews	

Policy statement for:

Safeguarding Children

Maidstone and Tunbridge Wells NHS Trust places the highest priority on safeguarding all children who come into contact with the Trust. The Trust expects all staff to meet their statutory responsibilities and comply with best practice guidance. The child's welfare is paramount and staff will ensure the child's safety and welfare is their first concern.

Statutory guidance is identified in Working Together to Safeguard Children (HM Government 2018) and is applicable when working with all children up to their 18th birthday, including unborn children, and their families / carers.

This policy provides guidance for local procedures and establishes the appropriate professional response to concerns about a vulnerable child, a child in need or a child at risk of, or who has suffered significant harm.

This policy is to be used in conjunction with the Kent and Medway Safeguarding Children Procedures 2018.

Effective safeguarding arrangements should be underpinned by two key principles –

- Safeguarding is everyone's responsibility
- A child-centred approach

Staff will work in partnership and collaboratively with other agencies involved in safeguarding children.

All staff will comply with mandatory training requirements applicable to their role within the Trust.

Safeguarding children supervision will be available for staff regularly or as required depending on role.

The key message: *"SAFEGUARDING IS EVERYONE'S RESPONSIBILITY"*

Safeguarding Children Practice Guidance

Contents

1.0 Introduction and scope

It is expected that all staff will be able to recognise concerns about a child, to understand what they need to do to safeguard children, and to share information appropriately.

All staff that are in contact with children and their families should be able to:

- Understand risk factors that can make a child vulnerable
- Recognise when a child is in need of safeguarding or support and know where to refer for support
- Recognise the needs of parents/carers who may need extra support in parenting and know where to refer for this support
- Recognise the risks of abuse to the unborn child
- Assess the needs of children and the ability of their parents/carers to meet those needs
- Recognise the needs of children who live in households characterised by domestic abuse and where to refer for advice/support
- Understand the concept of the '*toxic trio'* (domestic abuse, mental health and substance abuse) and the combined effects of this on a child's health and development
- Assess the needs of children and young people who display harmful sexual behaviour
- Understand the concepts of child in need and significant harm
- Understand the risk factors associated with child sexual exploitation, female genital mutilation and child trafficking and the mandatory reporting procedures
- Share information lawfully and appropriately
- Work in partnership with other professionals, organisations and agencies to safeguard children and young people
- Contribute to strategy meetings, child protection conferences and family group conferences
- Contribute to developing and reviewing Child Protection Plans through attendance at core groups
- Understand the current child death procedures, reporting measures and contribute to any response meetings or strategy meetings held
- Contribute to Serious Case Reviews or Kent Safeguarding Children Board (KSCB) internal reviews and implement 'lessons learnt' from these reviews
- All clinical staff working with children, young people and their families should access safeguarding supervision as applicable to their role, in accordance with the Trust Safeguarding Children Supervision Policy and Procedure. This policy lays out the Trust procedures for accessing Safeguarding supervision.

2.0 Definitions / glossary

2.1 Child- a child is defined as anyone who has not yet reached their 18th birthday

Young Person/People – a child aged 16 - 17

NAI – Non-Accidental Injury - any abuse purposefully inflicted on a person; this abuse can be physical or emotional

MARAC – Multi-Agency Risk Assessment Conference - a multi-agency meeting where information is shared on the highest risk domestic abuse cases

Emergency Protection Order (EPO) - Under Section 44 of the Children Act 1989, a local authority can apply for an **Emergency Protection Order** (EPO) where there are reasonable grounds for believing there is an immediate risk of Significant Harm to a child. Applications will usually be made to the Family Proceedings Court.

Honour Based Abuse/Violence (HBV) - a form of domestic abuse which is perpetrated in the name of so called '**honour**'. The **honour** code which it refers to is set at the discretion of male relatives and women who do not abide by the 'rules' are then punished for bringing shame on the family.

Safeguarding team – led by the Named Nurse Safeguarding Children. The Safeguarding Children team is made up of Safeguarding Children Nurse and Midwife specialists who provide advice and support to all staff where they have concerns about a child. The Safeguarding Children team also provides mandatory and bespoke Safeguarding Children training to staff.

2.2 The Children Act 1989

- **Section 1 –** The welfare of the child is paramount. A child is defined as being any person who has not yet reached their eighteenth birthday
- **Section 17 –** a Child is defined as being in need when they are unlikely to achieve or maintain a reasonable standard of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled
- **Section 47 –** Introduces the concept of '*Significant Harm'* as the threshold for compulsory intervention in a child's life; it establishes a duty on local authorities to make enquiries regarding a child once significant harm is suspected and for agencies (including Maidstone and Tunbridge Wells NHS Trust) to 'cooperate' with these enquiries

2.3 The Children Act 2004 – establishes duties on all agencies to cooperate with any investigation and to share information to safeguard the welfare of a child or children[1]

2.4 Safeguarding – this is the action taken to promote the welfare of children and protect them from harm; it is everyone's responsibility and everyone has a duty to cooperate (HM Government 2018).

[1] **Section 10 –** establishes a duty to cooperate and share information with Local Authorities to improve the well-being of children
Section 11 – the duty of Maidstone and Tunbridge Wells NHS Trust to safeguard and promote the welfare of children whilst exercising its functions
Section 13 – Maidstone and Tunbridge Wells NHS Trust is a statutory partner of KSCB and other Local Safeguarding Children Boards for the areas for which it provides services

2.4.1 Safeguarding and promoting the welfare of children is defined as:

- Protecting children from maltreatment
- Preventing the impairment of their health and development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes[2]

2.4.2 Child protection is a part of safeguarding and promoting welfare. This refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm as a result of abuse or neglect.

2.4.3 Abuse and neglect: a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children (Working Together Guidelines 2018)

2.5 Categories of abuse

2.5.1 Physical abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

2.5.2 Emotional abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.

- It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person
- It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate
- It may feature age or developmentally inappropriate expectations being imposed on children
- These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction
- It may involve seeing or hearing the ill-treatment of another
- It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children
- Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone

[2] Working Together to Safeguard Children (HM Government 2015)

2.5.3 Sexual abuse

- Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, 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 grooming a child in preparation for abuse. Sexual abuse can take place online, and technology can be used to facilitate offline abuse.
- Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children
- Children who are victims of child sexual exploitation are also suffering sexual abuse and require careful assessment of their needs. Staff should refer to the Kent Safeguarding Children Board policies and procedures; in particular the use of the KSCB Vulnerability Checklist and the KSCB Child Sexual Exploitation Toolkit

2.5.4 Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse.

Once a child is born, neglect may involve a parent or carer failing to -

- provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (including the use of inadequate care-givers)
- ensure access to appropriate medical care or treatment

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

2.6 Child in need

A child is defined as being in need when they are unlikely to achieve or maintain a reasonable standard of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled[3]

2.7 Significant harm

This is the threshold that justifies compulsory intervention in a child's life[4].
When this threshold has been reached the Local Authority is under a duty to investigate, or make enquiries when it has reasonable cause to suspect that a child is suffering, or at risk of suffering significant harm[5].
Harm is defined as the ill treatment of a child or the impairment of their health and development[6].

[3] Section 17 Children Act 1989
[4] Section 31 (2) Children Act 1989
[5] Section 47 Children Act 1989
[6] Section 31(9) Children Act 1989

2.8 Early Help and Preventative Service

- The aim of the Early Help and Preventative Service is to help identify and address, at the earliest opportunity, the risks and needs of children and young adults (from pre-birth to age 25) and their family to improve the outcomes for these children, young people and their families. The aim is to provide timely and co-ordinated support to meet those needs so that they are safeguarded, their educational, social and emotional needs are met and they achieve good outcomes so as to reduce the demand for social care services.
- It provides a consistent approach throughout Kent so as to ensure effective decision making and allocation to appropriate advice and support – the right support at the right time
- It reduces the workload of statutory services and can help to step down services from Children's Specialist Services[7]
- Advice can be sought from the Early Help service as to where to refer children and families to: https://www.kelsi.org.uk/special-education-needs/integrated-childrens-services/early-help-contacts

2.9 Request For Support Guidance (previously referred to as Threshold Guidance)

Kent County Council (the Local Authority) provides guidance to practitioners to clarify when a Request for Support (previously referred to as a referral to Children's Social Care) should be made. The key principle is that children and families get the right support at the right time. Additional needs should be identified as early as possible and intervention should be where the child or young person feels most comfortable.

If the concern does not reach level 3 and above the expectation is that the practitioner will identify appropriate services to refer the child/family to or will signpost the child/family to appropriate agencies or professionals. The Request for Support Guidance can be found via the following link: http://www.kscb.org.uk/procedures/kent-support-levels-guidance

2.10 Child Sexual Exploitation

Child sexual exploitation is defined as –

Child Sexual Exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.[8]

Children and young people who are sexually exploited are the victims of child sexual abuse, and their needs require careful assessment. They are likely to be in need of welfare services and - in many cases - protection under the Children Act 1989.

[7] http://www.kscb.org.uk/procedures/child-in-need-chin
[8] https://www.gov.uk/government/publications/child-sexual-exploitation-definition-and-guide-for-practitioners

This group may include children who have been sexually abused through the misuse of technology, coerced into sexual activity by criminal gangs or the victims of trafficking. Any child who discloses, or where there are suspicions that they may be a victim of child sexual exploitation, should have a risk assessment completed using the Kent Safeguarding Children Board Child Sexual Exploitation toolkit. This will act as an aide memoire for staff and provide guidance as to whether a referral to the Child Sexual Exploitation team is appropriate; if in doubt contact the Safeguarding Team[9].

Kent has a dedicated Child Sexual Exploitation Team (CSET) based at Kent Police HQ. Any intelligence around Child Sexual Exploitation can be shared with CSET via the Safeguarding Team. Please contact the Named Nurse for Safeguarding Children for advice and support or use the following link to share information: http://www.kscb.org.uk/guidance/sexual-abuse-and-exploitation

[9] http://www.kscb.org.uk/__data/assets/word_doc/0012/53112/CSE-Toolkit-Kent-and-Medway-V5-August-2015.doc or http://www.kscb.org.uk/guidance/sexual-abuse-and-exploitation

3.0 Duties

3.1 **Under Section 11** of the Children Act 2004 all healthcare organisations have a duty to make arrangements to safeguard and promote the welfare of children and young people, and to cooperate with other agencies to protect individual children and young people from harm. This duty means that healthcare organisations must ensure that they discharge their functions with regard to the need to safeguard and promote the welfare of children and young people.

The Trust must ensure that there are clear lines of accountability for the provision of services designed to safeguard and promote the welfare of children. This is achieved by:

- Promoting a culture of listening to children, taking into account their wishes and feelings both in individual decisions and in the development of services
- Ensuring that there are clear whistle blowing procedures and a culture that enables safeguarding and promoting the welfare of children to be addressed (Francis Report 2014)
- Having clear information sharing procedures with other professionals and with Kent Safeguarding Children Board and East Sussex Safeguarding Children Board
- Ensuring that there are safe recruitment practices for all staff who have contact with both children and parents/carers, including procedures for obtaining a DBS check where appropriate
- Ensuring that there is appropriate supervision and training for staff (including Safeguarding Training) in accordance with the current Intercollegiate Document (2014); all staff must have mandatory safeguarding children training at induction
- Ensuring all staff feel competent to carry out their responsibilities and duties and the Trust will create an environment where staff feel able to raise concerns and feel supported in their safeguarding responsibilities
- Ensuring that there are a Named Doctor, Named Nurse and Named Midwife in post commensurate with the Intercollegiate Document (2014); Named staff will have sufficient time, funding and supervision to fulfil their safeguarding responsibilities effectively

3.2 **The Chief Executive** has a responsibility to ensure that all staff are able to meet the above duties

3.3 **The Chief Nurse** is responsible for:

- Safeguarding children practice, and will take responsibility as the strategic lead on all aspects of the Trust's contribution to safeguarding children
- Representing the Trust on the Health Safeguarding Group a sub-committee of the Kent Safeguarding Children Board;
- Ensuring that all appropriate safeguarding processes are in place, including compliance with all legal and statutory requirements

3.4 **Safeguarding Children Committee**

The Safeguarding Children Committee forms an integral part of the Governance system in the Trust and is chaired by the Chief Nurse.

The purpose of the committee is to provide strategic direction for all safeguarding children activities across the Trust, to ensure engagement of all agencies and to gain assurance that the Trust is compliant with all local and statutory requirements.

3.5 Named professionals

The named professionals have expertise in child health and development, the types of child maltreatment and the local arrangements for Safeguarding and promoting the welfare of children.

The posts of Named Doctor, Named Nurse and Named Midwife are statutory requirements under the Working Together (2015) document.

They have joint responsibility for –

- Promoting good professional practice, providing advice and expertise to fellow professionals
- Taking a lead in the provision of safeguarding training and supervision, working closely with the Trust Safeguarding Lead, Designated Professionals and the Local Safeguarding Children Board

3.6 Clinical Directors are responsible for ensuring through their Governance leads that:

- All staff - existing and new – are aware of the procedural arrangements for Safeguarding Children and that their mandatory training is up to date
- All appropriate staff access Safeguarding Supervision as per the current policy

3.7 The policy author (Named Nurse Safeguarding Children) is responsible for:

Updating the policy as necessary, to reflect changes in practice or legislation and ensuring there are clear procedures for disseminating updated information to all staff in a timely manner

3.8 All Trust employees are to:

- Familiarise themselves with the Safeguarding Children Policy and Practice Guidance
- Ensure that safeguarding children forms an integral part of all aspects of the care they provide and to use a child centred approach when working with children and their families
- Understand their responsibilities in relation to safeguarding children;
- Identify their development and training needs in relation to safeguarding children
- Maintain records in accordance with Trust policy and professional body guidelines

Staff working in adult areas must be aware of the potential link between domestic abuse, mental health and substance misuse (the ‘Toxic Trio’) in parents/carers and potential child protection issues.

4.0 Training / competency requirements

4.1 **Competency** – all staff require a level of competency to enable them to carry out their statutory responsibilities to safeguard children. The Trust expects that training will be in accordance with the Intercollegiate Document (2014). This document sets out the level of skills, knowledge and competencies for staff depending on their role and degree of contact with children, young people and families, the nature of their work, and their level of their responsibility.

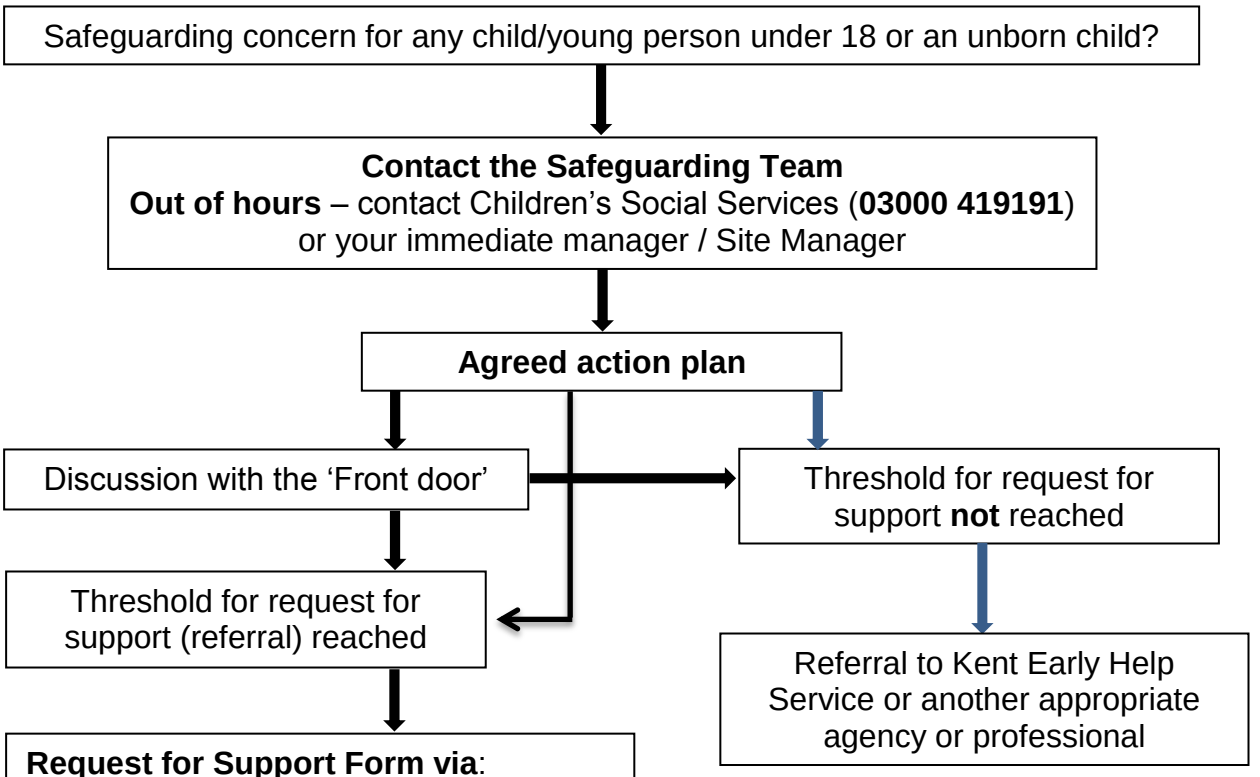
4.2 **Compliance** for training is reported through the Learning and Development Department and monitoring is in place via the Trust Safeguarding Children Committee.

4.3 **Supervision** - The Trust Safeguarding Children team provides Safeguarding Children Supervision to ensure that high quality child protection advice and support is available to all Trust staff. Safeguarding children supervision is supplementary to clinical supervision in accordance with national guidance. All clinical staff working directly with children and young people should access supervision commensurate with their role.

4.4 **Annual appraisals** will include reference to safeguarding children training and supervision for all staff working with children and young people.

5.0 Procedure: What to do if you are worried a child is being abused

5.1 Safeguarding children advice and support flowcharts



Request for Support Form via: http://www.kscb.org.uk/procedures/child-in-need-chin
Upload form and submit: https://kentcc-self.achieveservice.com/service/Single_request_for_support

Please use Chrome not Internet Explorer

East Sussex Referrals to:
0-19.SPOA@eastsussex.gcsx.gov.uk

Tel: 01323 464222

Important numbers:

- **'Front Door'** (Children's Social Services): 03000 41 11 11
- **Safeguarding Team MTW**: 01622 224599
- **Named Nurse Safeguarding Children** (Alison Jupp): 01892 638178 / 07834 171831
- **Safeguarding Nurse** (Jane Waterhouse): 07725 641991
- **Safeguarding Nurse** (Gerry Finney): 07864 968047
- **Deputy Named Midwife Safeguarding Children** (Heather Lawrence): 07769 687751

Local Children Social Services contact numbers:

Maidstone	03000 413444
The Weald (inc. Tunbridge Wells & Tonbridge & Malling)	03000 422525
Sevenoaks & Swanley	03000 413200
East Sussex (Eastbourne)	01323 464222
West Sussex (County Hall)	01403 229900
Medway	01634 334466
Sittingbourne	03000 412890
Out of hours, weekends and Bank Holidays:	
Kent	03000 419191
West Sussex Children's Specialist Services	033 022 26664
East Sussex (includes Brighton & Hove)	01273 335906 | 01273 335905

Early Help Service

If your concern does not reach the threshold for Children's Social Care then consider a referral to the Early Help Service (who can also sign post to other agencies/professionals). Contact details below:

District	Telephone number	Email address
Ashford	03000 41 03 05	AshfordEarlyHelp@kent.gov.uk
Canterbury	03000 41 62 22	CanterburyEarlyHelp@kent.gov.uk
Dover	03000 42 29 98	DoverEarlyHelp@kent.gov.uk
Dartford	03000 42 15 42	DartfordEarlyHelp@kent.gov.uk
Folkestone & Hythe	03000 41 10 08	ShepwayEarlyHelp@kent.gov.uk
Gravesham	03000 42 14 37	GraveshamEarlyHelp@kent.gov.uk
Maidstone	03000 42 23 40	MaidstoneEarlyHelp@kent.gov.uk
Sevenoaks	03000 41 79 39 (Monday to Wednesday) 03000 41 42 39 (Wednesday to Friday)	SevenoaksEarlyHelp@kent.gov.uk
Swale	03000 42 11 62	SwaleEarlyHelp@kent.gov.uk
Thanet	03000 41 95 67	ThanetEarlyHelp@kent.gov.uk
Tonbridge & Malling	03000 42 15 76	EarlyHelpNotificationT&M@kent.gov.uk
Tunbridge Wells	03000 41 62 00	TunbridgeWellsEarlyHelp@kent.gov.uk

Request for support from the "Front Door" (Children's Social Care)

Does your concern reach level 3 or 4 on the Kent Support Level Guidance?
http://www.kscb.org.uk/procedures/kent-support-levels-guidance

YES

Upload form from **KSCB website** (use Chrome)
http://www.kscb.org.uk/procedures/child-in-need-chin

- Save document to your desktop/documents
- Complete electronically
- 'Agreement to engage' – no signature or consent required but discuss with parents/carers that requesting support from Children's Social Care **unless** this will place the child at further risk
- Discuss your concerns with the Safeguarding team or your immediate line manager if Safeguarding unavailable
- Sections 3, 4, 5 & 6 are self-explanatory
- Sections 7 & 8 – your main (and secondary) reason for support (drop down boxes)
- Section 9 – 'Request Details' – what are you worried about and why is support needed? Consider any factor that may complicate concerns. State clearly what needs to change
- Section 10 – any other agencies involved (e.g., GP, Midwife, Health Visitor etc.)

NO

Consider a referral to the **Kent Early Help Service** or another appropriate agency or professional

Early Help contact details –
Early Help will also advise on appropriate services professionals to refer family/child to:
http://www.kelsi.org.uk/special-education-needs/integrated-childrens-services/early-help-contacts

Ensure that a copy of the form is sent to:
Safeguardingchildrenteam.mtw@nhs.net

Midwifery concerns to –
heather.lawrence3@nhs.net

Upload form via the following link:
https://kentcc-self.achieveservice.com/service/Single_request_for_support

5.2 Staff should also refer to the following documents

- Working Together to Safeguarding Children (2018): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf
- When to Suspect Child Maltreatment: https://www.nice.org.uk/guidance/cg89
- What to do if you're worried a child is being abused (2015): https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2
- The NSPCC guide to spotting signs and symptoms of abuse: https://www.nspcc.org.uk/preventing-abuse/signs-symptoms-effects/
- Information sharing advice: https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

5.3 Advice should be sought from the Safeguarding Team – contact via the Trust Switchboard

5.4 Staff should make every effort to work openly and honestly with parents and carers, and where appropriate involve them in all discussions around concerns and decision making. Where involving the parents/carers may place the child at further risk then a decision will can be made to withhold discussions with parents/carers.

5.5 Staff should ensure that all parents/carers and children are informed that confidentiality may not be maintained if the withholding of information will prejudice the welfare of the child.

5.6 All observations and explanations involving concerns should be recorded contemporaneously in the healthcare records and should include the following :

- All children who are seen in the Emergency Department (ED)/A&E must have a safeguarding assessment completed before discharge
- Who has Parental Responsibility (PR) for the child
- Information on the child's appearance and behaviour
- Any views/comments/wishes and feelings expressed by the child
- Attitude of the parents and interaction with the child
- Details of any injury (use of a body map is mandatory)
- Details of all discussions held
- All records must be signed, dated and timed

5.7 Staff can contact Children's Specialist Services at any time for a consultation if they have concerns about a child; advice should be sought from the Safeguarding Team prior to any consultation if available

5.8 Consent from parents/carers must be sought to make an Early Help or Child in Need referral. Consent is not mandatory for a referral where 'significant harm' is suspected. If consent is declined then a referral can still be made but the referral must be explicit as to why consent has not been obtained.

5.9 All children who are subject to a Child Protection Plan, Child in Need Plan or discussed at/known to the Multi Agency Risk Assessment Conference (MARAC) or the Adolescent Risk Management (ARM) Panel will have an alert placed on their records; any unborn child will have an alert placed on the mother's healthcare records which will be transferred to the child's healthcare records once born.

6.0 Management of suspected abuse in the Emergency Department (ED) of hospital

- All children seen in the ED **must** have a safeguarding assessment completed and **must not** be discharged until this has been completed.
- Full demographic details of the child **must** be obtained including who has Parental Responsibility for the child, who accompanied the child to the ED and whether they have a Social Worker or an Early Help plan.

6.1 Assessment of suspected Non-Accidental Injury (NAI)

- When a child is referred with an injury following an allegation of abuse, or where this is suspected following initial assessment, the child should be urgently referred to the duty Paediatric Consultant for a formal child protection assessment including a physical examination. If the child is seen by the Middle Grade Doctor the on call Consultant Paediatrician must always be notified about the child. For physical examinations a chaperone should be present in addition to parent/carer. If appropriate (taking into account age, cognition and developmental stage) consent for examination should be obtained from the child. If the child refuses and is competent or is assessed to have capacity under the Mental Capacity Act 2005 then the examination cannot take place. If the child is not competent and/or parents refuse examination this should be discussed urgently with Children's Social Services.
- Detailed documentation of history and examination should be recorded together with use of body maps (see Appendix 6). Where concerns regarding significant harm/likelihood of significant harm are confirmed a child protection referral to Children's Social Services should be made promptly. Consent is not needed for this referral.
- If a child requires a skeletal survey for a suspected Non Accidental Injury (NAI) (please refer to the Skeletal Survey Guidance 2017 and the Royal College Paediatrics and Child Health Guidelines 2008)[10] then the child should not be discharged until the report from the expert radiologist has been received. If clinically fit, discharge to a place of safety should only take place with agreement from Children's Specialist Services and the Named Nurse for Safeguarding Children.
- All non-mobile children who present with a fracture, burn or bruise must be reviewed by the on call Consultant Paediatrician or Middle Grade Doctor. Any child under 3 years old with a long bone fracture must also be reviewed by the on-call Consultant Paediatrician.
- Children should only be admitted to hospital as a place of safety after discussions with Children's Specialist Services and the Named Nurse for Safeguarding Children.
- If a child is assessed to be in immediate danger and there is no cooperation from parents then advice should be sought immediately from both Children's Specialist Services and the police; an Emergency Protection Order may be arranged.

[10] http://www.rcpch.ac.uk/system/files/protected/news/StandardsforRadiologicalInvestigationsD[1].pdf

- In the event of parent / carers removing the child from the ED or hospital, Police and Social Services must be contacted immediately by the person in charge of the clinical area. The person in charge must inform all agencies involved in any incident of this type of the outcome of the incident and record that this has been done in the healthcare records; the manager for the appropriate clinical area must also be informed and this must be documented in the healthcare records.

6.2 Admission to hospital

- All children admitted to a Maidstone and Tunbridge Wells NHS Trust Paediatric bed will be under the responsibility of the duty Consultant Paediatrician.
- The named Social Worker must be informed of any admission for children subject to a Child Protection Plan or Child in Need Plan.
- Any child aged between 16 and their 18th birthday who is admitted to an adult ward will be afforded the same safeguarding protection as younger children on a Paediatric ward.
- All documentation to be completed on admission with details of the child's parents/carers and who has Parental responsibility for that child.
- Contact should be made with the Health Visitor or School Nurse team responsible for the child/family who may be able to provide staff with more information.

6.3 Discharges from hospital

- Where there are Safeguarding concerns a child may only be discharged with the agreement of the Consultant Paediatrician and the Named Nurse for Safeguarding Children
- Any follow up plan must be recorded in the healthcare records
- Inform the Social Worker, Health Visitor or School Nurse team that child has been discharged
- Particular attention is required in the discharge planning of babies from neonatal Intensive Care Units, since these babies are at high risk of re-admission to hospital. These children will need a coordinated programme of follow-up, with special attention to vision, hearing, developmental progress and immunisations.
- No child about whom there are concerns about deliberate harm should be discharged from hospital back into the community without an identified GP. The Consultant under whose care the child has been admitted is responsible for ensuring this happens. If unable to obtain a GP when the child is fit for discharge, the child must remain in hospital until one is obtained.
- **Transfer of care for children (including unborn children) about whom there are concerns -** If a child is transferred to another hospital or area of the country, professionals caring for that child must ensure that care is transferred appropriately. There should be verbal handover of care followed by written documentation of concerns to the receiving practitioner. The Named Nurse for Safeguarding Children must be contacted in order to hand over to relevant Designated/Named Nurses in that area.

6.4 Referrals for a Child Protection Medical (Not CSA medical)

- All Child Protection medicals required should be carried as quickly as possible by the on call Consultant Paediatrician
- The Child Protection medical should be carried out in the most appropriate setting

6.5 Child Sexual Abuse (CSA) Medicals

- CSA damages the child emotionally, even when physical signs are absent. The evidence for CSA depends, in the majority of cases, on the child's disclosure or on observations of the child's behaviour, and, rarely on the findings of the medical examination alone. Delay in responding to an allegation of CSA may lead to –
  - Silencing of the child
  - Loss of forensic or other evidence
  - Absconding of the alleged perpetrator
  - Loss of the child's trust and confidence in the adult and agency
  - Further harm to the child
- The primary focus is the welfare of the child and this may mean that any action taken and discussion with other agencies may take place without the knowledge or consent of the parents/carers
- Following any disclosure a referral must be made to Children's Specialist Services and a strategy meeting held in a timely manner

What to do if you have concerns?

Above advice should be sought initially from the Kent and Medway Sexual Assault Referral Centre (SARC). The SARC offers care and support to men, women and children who have experienced rape or sexual assault.

Contact details (24 hour call centre):

0330 223 1267 (under 13's), or

0330 223 1622 (Over 13's)

Following a consultation with the SARC, if advised or if the professional remains concerned then a referral should be made to Children's Specialist Services as per usual procedures.

The CSA pathway should be followed.[11]

6.6 Fabricated or Induced Illness (FII)

There are three main ways in which a parent or carer may fabricate or induce an illness in a child -

- Fabrication of signs and symptoms, which may include past medical history
- Falsification of hospital charts and records, letters and documents, specimens of body fluids
- Induction of illness by a variety of means

If there are any concerns in relation to fabricated or induced illness, it is imperative that these concerns are **not** discussed either with the parent/carer or the child themselves.

Advice should be sought immediately from the Safeguarding Team and/or the Paediatric Consultant on call. Further advice should be sought from Children's Social Services.

[11] http://www.kscb.org.uk/procedures/sexual-abuse2

It is vital that all information and concerns should be documented in the child's healthcare records in a contemporaneous manner, without the knowledge of the parent/carer.

Guidance is available which should be read in conjunction with the Working Together Guidelines (2015). [12]

6.7 Children who have self-harmed or taken a deliberate overdose

- All children who have self-harmed or taken a deliberate overdose attending the ED's at Maidstone and Tunbridge Wells NHS Trust **must** be referred to, and seen by, the on-call Psychiatric Liaison team prior to discharge. A care plan must be agreed which may involve a referral to the Child and Adolescent Mental Health Service (CAMHS).
- The Safeguarding Team must liaise with the relevant School Nurse Team to share any concerns about the child

6.8 Management of adults who present to the ED where domestic abuse, mental health or substance abuse is known or suspected

Research has shown that these issues (known as the 'Toxic Trio') can have a serious impact on the health, development and safety of a child (born or unborn). All staff have a responsibility to respond to any disclosures of domestic abuse and safety planning is always the priority.

- Any adult who presents in the ED with any of the above **must** be asked if they have any children they are responsible for – if they have then full demographic details of children should be obtained (name, DOB etc.) and it **must** be documented where the children are and who is looking after them
- Staff should complete a 'Safe Lives' (formerly a CAADA-DASH) assessment and consider a referral to MARAC if appropriate (see Appendix 5); seek advice from the Safeguarding Team[13]
- Staff should refer to the Maidstone and Tunbridge Wells NHS Trust Domestic abuse / violence policy and procedure and read in conjunction with the 2014 NICE Domestic Abuse Guidelines[14]
- Referral to services for domestic abuse can be made using the current referral pathways[15].
- Further information can be found at www.domesticabuseservices.org.uk/

6.9 Honour based abuse (HBA) and forced marriage

- Honour based abuse is a crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community and is a fundamental abuse of Human Rights (Home Office 2013, United Nations Convention on Human Rights 1951)
- HBA is a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and / or community by breaking their honour code.

[12] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf
[13] http://safelives.org.uk/sites/default/files/resources/Dash%20without%20guidance%20FINAL.pdf
[14] https://www.nice.org.uk/guidance/ph50
[15] http://www.domesticabuseservices.org.uk/professionals/promotional-material/

- Honour based abuse can be distinguished from other forms of violence, as it is often committed with some degree of approval and/or collusion from family and/or community members. Such crimes cut across all cultures, nationalities, faith groups and communities. They can transcend national and international boundaries.
- Staff should be aware that adults in forced marriages can experience psychological, physical, sexual and financial violence.
- Staff should be alert to signs and symptoms of adults in forced marriages which may include deliberate self-harm, depression, anxiety, and substance misuse; adults may seek professional advice for an unrelated issue but may mention some 'family problems'
- Staff should refer to the national guidelines for advice and contact the Safeguarding Team[16]
- When a disclosure of potential forced marriage is made staff should:
  - Take any disclosure seriously and not dismiss the need for immediate protection nor assume that someone else is dealing with situation
  - Not contact the family
  - Use careful questioning to establish the full facts
  - Offer advice and provide the person with information about specialist advice and information services.
  - Share information with the Children's Specialist Services and police as appropriate
  - If a child makes a disclosure the appropriate Safeguarding procedures will need to be followed; Safeguarding Adult procedures may need to be followed if an adult makes a disclosure
  - Advise the adult that a breach in confidentiality may be necessary in order to ensure their safety.
  - Maintain accurate records and record all information in the healthcare records

6.10 Female Genital Mutilation (FGM)

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons[17]. FGM is illegal in the UK (Female Genital Mutilation Act 2003) as is taking a child out of the UK to have FGM performed on them. New guidelines were published in 2016 which guide policy and practice[18]. Please also refer to the Trust Female Genital Mutilation Policy and Procedure.

From the 31st October 2015 **all** healthcare professionals have a mandatory duty to report all known or suspected cases of FGM in those aged under 18 to the police (via 101) and Children's Specialist Services. For all cases where a child is deemed at risk of FGM this also falls within the threshold of significant harm and a referral to Children's Specialist Services is mandatory.

16 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322307/HMG_MULTI_AGENCY_PRACTICE_GUIDELINES_v1_180614_FINAL.pdf

17 http://www.who.int/mediacentre/factsheets/fs241/en/

18 https://www.gov.uk/government/publications/multi-agency-statutory-guidance-on-female-genital-mutilation
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512906/Multi_Agency_Statutory_Guidance_on_FGM__-_FINAL.pdf

Any concerns **must** be raised with the Safeguarding Team. As an organisation the Trust reports quarterly to the Kent Safeguarding Children Board on FGM prevalence figures.

6.12 Prevent and the Channel process

Prevent is part of the governments counter-terrorism strategy, CONTEST. Its aim is to stop people becoming terrorists or supporting terrorism.

Within Kent there is a process for identifying at risk individuals and referring them to the Channel Panel. This is a multi-agency panel which assesses the risk that an individual may pose and develops a safety plan to protect the individual and the community. Guidance is available[19]. Any concerns should come through the Safeguarding Team and information will be shared with Operation Dovetail, the Home Office process used in Kent.

6.13 Missing children

Any child reported missing from Maidstone and Tunbridge Wells NHS Trust premises should be reported to the police and Children's Specialist Services. Please refer to the Maidstone and Tunbridge Wells NHS Trust Missing Children Policy and Procedure and the current Kent Safeguarding Children Board procedures (which follow national guidelines)[20].

6.14 Concern for the unborn child and pregnant woman

- All health professional involved in providing maternity care (including midwives, obstetricians, paediatricians and sonographers) should be aware of the support services offered by the local authority for children and families in need. These professionals also need to be aware of what action to take should they identify any children at risk of harm – including the unborn. Their duty is no different than that for a child as above. Advice must be sought from the Named Midwife or Deputy Named Midwife for Safeguarding; in their absence the Named Nurse for Safeguarding Children must be contacted.
- In such cases, a concern and vulnerability form (C&V) must be completed (see **Appendix 4**). A C&V form is simply an information sharing tool between professionals involved in the care of the pregnant woman and her unborn child. If a concern has been identified there must be a clear action plan with outcomes; this must be documented with professional responsibilities clearly identified.
- Staff must be aware that they have a duty to safeguard not only the unborn but also any siblings. The professional who identifies the risks, or needs, in a family has the responsibility to act on their concerns and complete a C&V form; it must be sent to the Community Liaison Office (at Tunbridge Wells Hospital); information must also be uploaded to the woman's electronic records (E3). Staff may wish to seek advice from the Deputy Named Midwife for Safeguarding or Named Nurse for Safeguarding Children. A copy of the form will be forwarded to the Safeguarding Team from the Community Liaison office.

19 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/425189/Channel_Duty_Guidance_April_2015.pdf

20 http://www.kscb.org.uk/procedures/missing-children

- One hard copy of the C&V form will be kept on the delivery suite. The C&V form must be updated regularly throughout the pregnancy; any information from Child Protection Conference's, Child in Need meetings, core groups or professionals meetings must be recorded in both the healthcare records and on E3; a precis must be added to the hand held healthcare record. Any pre-birth plans or discharge plans must be clearly documented and available for all staff to view.
- Should a vulnerable woman deliver at another unit outside of Maidstone and Tunbridge Wells NHS Trust, the hand held healthcare records should clearly state that a C&V form is held by Maidstone and Tunbridge Wells NHS Trust and contact details should be readily available.

7.0 Child death reporting

Please refer to the current Kent and Medway Safeguarding Procedures [21] and Kent Safeguarding Children Board procedures[22].

Every child death is a tragedy and all enquiries should balance the forensic and medical requirements and supporting the family. The Local Safeguarding Children Board is responsible for ensuring that a review of each death of a child in their area is undertaken by the Child Death Overview Panel (CDOP).

The Named Nurse for Safeguarding Children must be informed of all child deaths on the Trust premises -

- Contact number – ☎ 07834 171831

The Child Death service can be contacted on –

- kent.cdr@nhs.net
- ☎ 03000 424642 (main office)
- **Named Nurse Child Death –** ☎ 03000 424745

7.1 Roles and responsibilities when responding to an unexpected death of a child

- When a child dies unexpectedly, several investigative processes may be instigated, particularly when abuse or neglect is a factor. The following procedure aims to ensure that those professionals/organisation involved work together in a coordinated way in order to minimise duplication and ensure that the lessons learnt contribute to safeguarding and promoting the welfare of children in the future
- All professionals involved with a child who dies unexpectedly (before and/or after the death) must collaboratively respond to the child's death. The local Designated Paediatrician for Unexpected Deaths in Childhood (or the nominated substitute when she/he is unavailable) should coordinate the work of the team convened in response to a child's death.
- An immediate response form should be completed on the Kent Safeguarding Children Board website via the following link : https://www.qesonline.com/Kent/eCDOP/Live/Public/ImmediateResponseForm

[21] http://www.proceduresonline.com/kentandmedway/chapters/p_unexpect_death.html
[22] http://www.kscb.org.uk/__data/assets/pdf_file/0008/66581/2016.07.31-Kent-CDOP-Unexpected-Child-Death-Procedures-Final.pdf

- A Form A notification should then also be completed, available at - https://www.ges-online.com/Kent/eCDOP/Live/Public
- A joint home visit at an early stage by the Designated Doctor and Senior Investigating Officer (Police) is encouraged and can provide valuable information from family as well as offering sensitive support in a conducive

7.2 – Sections 10 and 11 of the current Kent Safeguarding Children Board Child Death Procedures give more specific advice on the roles and responsibilities for Hospital Staff and Paediatricians[23].

8.0 Request for support (previously known as a referral to Children's Social Care)

The safety and welfare of the child (and/or unborn child) is paramount and must be the first consideration of all staff. Staff must remember to keep the child in focus when working closely with parents and to avoid any undue risk to the child (or unborn child), in the form of collusion. Staff are expected to work in partnership with statutory and voluntary agencies to protect children and to make referrals to Children's Specialist Services. Staff are also expected to listen to the child and document their feelings and wishes.

The responsibility of safeguarding children investigations lies with the statutory agencies, i.e. Children's Specialist Services and Police. Health professionals must not investigate the incident but they have a duty to assist the local authority during any inquiry (Section 47 Children Act 1989).

8.1 What to do if you have concerns and how to contact Social Services

- Any member of staff must report immediately to the nurse or person in charge of the clinical area if there is any suspicion or concern in relation to a child's welfare.
- **However it is the responsibility of the practitioner who has the concern to act on that concern**. Under no circumstances should any member of staff assume that a concern has been acted on if there is no evidence to prove otherwise.
- A discussion should take place between all staff caring for the child and a subsequent management plan decided. This must also involve the person in charge of the relevant area and the safeguarding team and/or duty consultant paediatrician.
- The Named Doctor, Nurse or Midwife can be contacted via switchboard. Any advice given by the Safeguarding team will be emailed to the relevant practitioner and must be saved in the child's healthcare record. Staff should check on both the ED IT system and Allscripts for evidence of 'alerts' or 'flags' for that child.

[23] http://www.kscb.org.uk/__data/assets/pdf_file/0008/66581/2016.07.31-Kent-CDOP-Unexpected-Child-Death-Procedures-Final.pdf

- Practitioners can discuss safeguarding concerns with Children's Specialist Services before making a Request for Support; if a Request for Support is not appropriate Children's Specialist Services will discuss an appropriate plan with the practitioner. Prior to contacting Children's Social Care, staff should discuss the concerns with the Trust Safeguarding Children Team or on call Consultant Paediatrician. Consent is not required from parents to discuss concerns with Children's Specialist Services.
- Kent has a new process for referring a child to Children's Social Care. This is known as a Request for Support. Guidance on levels of support (previously known as thresholds) is available to aid practitioners to ensure that the correct level of support is provided at the right time. Advice must be sought from the Safeguarding team (if available) prior to submitting a Request for Support. The link to the form and upload platform can be found via the following link: http://www.kscb.org.uk/procedures/child-in-need-chin
- When it is assessed that the level for a Request for Support has been reached the practitioner **should** (if practicable) contact Children's Specialist Services via the Kent Central Duty Team –

  03000 411111 (office hours) or 03000 419191 (Out of Hours)
- A Request for Support is submitted via a dedicated on-line platform via the following link: https://kentcc-self.achieveservice.com/service/Single_request_for_support
- For children from the **Medway** (telephone: 01634 334466) area please use the following form –

  http://www.mscb.org.uk/pdf/ChildrensSocialCarereferralform.pdf
- For children from **East Sussex** (telephone: 01323 464222) please use the following form –

  http://www.eastsussexlscb.org.uk/professionals/referral-forms/
- A copy of the referral must be placed in the child's current healthcare record (and uploaded on to AllScripts) and sent to the Safeguarding Team at: safeguardingchildrenteam.mtw@nhs.net
- Parent/carers and if appropriate the child, should be consulted and informed about concerns. Consent should be sought from parents to make a referral and evidenced on the referral form. If consent not sought or obtained this must be evidenced again.
- Staff must keep legible contemporaneous healthcare records which are written, signed and dated, that demonstrate the events and all details, decision and actions taken. Full details of the concern or injury, action taken, other professionals involved and any relevant history should be documented.
- All doctors involved in the care of a child about whom there are concerns about possible deliberate harm, must provide Children's Social Services with a written statement of the nature and extent of their concerns. A Child Protection Medical should be completed at the earliest opportunity if appropriate. If a misunderstanding of medical diagnosis occurs, these must be corrected at the earliest opportunity, in writing. It is the responsibility of the doctor to ensure that his or her concerns are properly understood.

- The referring practitioner should follow up the outcome of the Request for Support within 48 hours (or deputise to another member of staff); all decisions should be documented.
- If for any reason there is a disagreement with the decisions made by Children's Specialist Services it is incumbent on all practitioners to challenge this. There are clear procedures for this which can be found in the current Kent and Medway Safeguarding Procedures via the following link –

  http://www.proceduresonline.com/kentandmedway/chapters/p_resolution.html

  Please liaise with the Safeguarding Team if you wish to challenge any decisions.

8.2 Flagging system for children with Child Protection Plans

The difficulties of information flows between social care and health were identified by Lord Laming in both the original and review enquiries into the death of Victoria Climbié (2003 and 2009).

Kent County Council Children's Specialist Services share information on a weekly basis about children subject to child protection plans with agreed contacts within each Health organisation. This information is added to the Trust hospitals IT systems on the children's records to inform staff. For unborn children the information is placed on the mother's records and transferred to the child's records at birth.

When a child (unborn or otherwise) is subject to a child protection plan or the mother of an unborn child presents, this information will be readily available to practitioners and will be used to inform the assessment of the child and/or mother. The ED's on both sites are live with the Child Protection information System (CP-IS). This provides practitioners with in-time data as to whether a child is subject to a Child Protection Plan or is a Child in Care. It also provides contact details of the child's Social Worker. It is only available in ED. Information that the child has attended and relevant information should be shared with the child's Social Worker. Out of working hours health professionals should refer to the Out of Hours Social Services team if the concerns are urgent and immediate (03000 419191). Information will also be shared with the relevant Health Visitor and School Nurse Teams.

8.3 Where a child is considered to be in immediate danger of harm

Trust staff should seek urgent medical attention and advice. The Consultant Paediatrician on call and the Named Nurse for Safeguarding Children should be contacted immediately; Children's Specialist Services (via the Central duty Team) should be contacted by phone.

In circumstances when parental/carer/child co-operation is lacking and as a consequence the child is placed at immediate risk, the police should be contacted in order to help manage the situation and to protect the child. Police Protection may be necessary and Children's Specialist Services will advise and work together with Health and the Police. Please contact the Trust Security Team for advice and support.

In the event of parent / carers removing the child from the department, Police and Social Services must be contacted immediately by the person in charge, who will also inform the manager for the appropriate clinical area, the on call Consultant Paediatrician and the Named Nurse Safeguarding Children.

The person in charge must inform all agencies involved in the incident of the outcome and record that this has been done. A DATIX e-report should be raised.

9.0 The Mental Capacity Act (MCA) 2005 and consent

Please refer to the current MCA Code of Practice –

https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

The Mental Capacity Act (MCA) 2005 applies to everyone involved in the care, treatment and support of people aged 16 and over living in England and Wales who are unable to make all or some decisions for them self. The MCA covers children aged 16 and 17 who also fall within the jurisdiction of the Children Act 1989.

The MCA does not generally apply to people under the age of 16 except where the Court of Protection is making a decision regarding a child's property and finance, or, where there has been an offence committed of ill treatment or wilful neglect; this will apply equally to a person under the age of 16.

Capacity - (or lack of capacity) refers specifically to a person's ability to make a particular decision or provide informed consent at the time it needs to be made.

Care or treatment for young people aged 16–17
People/staff carrying out acts in connection with the care or treatment of a child aged 16 to 17 who lacks capacity to consent will generally have protection from liability as long as the person carrying out the act -

- has taken reasonable steps to establish that the young person lacks capacity
- reasonably believes that the young person lacks capacity and,
- it is established that the act is in the young person's best interests, and follows the Act's principles.

When assessing what is in the young person's best interests, the person providing care or treatment must consult with those involved in the young person's care and anyone interested in their welfare – if it is practical and appropriate to do so. This may include the young person's parents. Care should be taken not to unlawfully breach the young person's right to confidentiality (see chapter 16 of the Code of Practice).

Legal proceedings involving young people aged 16 to 17
Sometimes there will be disagreements about the care, treatment or welfare of a young person aged 16 or 17 who lacks capacity to make relevant decisions. Depending on the circumstances, the case may be heard in the family courts or the Court of Protection. Any concerns around disagreements on care and treatment must be referred to the on call Consultant Paediatrician, Named Nurse Safeguarding Children and the Trust Legal Services.

10.0 Private fostering

Private fostering is an informal arrangement whereby a child is living with a family or adult who has no family ties to that child. A child may be privately fostered for a number of reasons including accessing education or their own family are living abroad.

A privately fostered child is defined as a -

- Child under the age of 16 (or 18 if disabled) who is cared for and accommodated by someone who does not have parental responsibility for them, or is not a close relative, for 28 days or more
- Close relatives include grandparents, siblings, aunts/uncles, or cousins

Any member of staff who suspects or has reason to believe that a child is being privately fostered must –

- Seek advice from the Safeguarding Team
- Ensure that the carer is aware of their statutory duty to refer the situation to Children's Specialist Services
- The staff member must inform Children's Specialist Services if they believe that a child is being privately fostered
- Guidance available via the following link – http://www.kent.gov.uk/education-and-children/adoption-and-fostering/private-fostering#

11.0 Child Protection Conference and Strategy Meeting

Following a Request for Support to Children's Specialist Services the Local Authority will reach a decision on the outcome of the referral. If the threshold for 'significant harm'[24] is reached the Local Authority is mandated to investigate and make enquiries regarding the child and their family and formalise a plan on the way forward.

A Strategy Meeting may be held to plan the investigation. All staff that submit a referral would be expected to take part in any initial Strategy Meeting alongside the Named Nurse Safeguarding Children (or their nominated deputy) usually via a conference call. Other staff involved with the child (including a Consultant Paediatrician and the Named Doctor for Safeguarding Children) would be expected to share information they hold on the child/family to inform the Strategy Meeting. Staff have a duty to cooperate with the investigation under Section 47 Children Act 1989. Support will be available at all times.

Minutes from all meetings will be held in the current healthcare record (either in paper form or on AllScripts) and with the Safeguarding Team.

Child Protection Conference – it is the responsibility of the local authority to decide whether to convene a Child Protection Conference. Where a decision is taken to not convene a Child Protection Conference this can be challenged by any professional involved with that child and the Named Nurse Safeguarding Children. Staff should contact the Named Nurse for Safeguarding Children for advice.

[24] Sections 31 and 47 Children Act 1989 (2004)

All staff attending a Child Protection Conference are expected to produce a report to share with and inform the conference members. Reports should be completed on the approved Kent Safeguarding Children Board proforma which can be found via the following link – http://www.kscb.org.uk/guidance/child-protection-conferences-and-plans/child-protection-conference

This form should be used for both initial and review Child Protection Conferences and should be submitted to the Child Protection Conference Chair at least 48 hours prior to the conference. A copy of the report must be placed in the healthcare record and sent to the Safeguarding Team. Support is available to all staff should they require it. It is expected that all reports will be shared with parents prior to the conference. If this is not possible the reason why must be documented.

Any staff member who is required to attend Child Protection Conferences, Strategy Meeting's or planning meetings will have the support of their line manager or the Named Nurse; midwives will have the support of the Named Midwife or Named Nurse. This should including debriefing and supervision if required. It is entirely appropriate to ask for professional support at the conference.

Each individual has a right to make their contribution and give their point of view. Any staff member who attends a Child Protection Conference has the right to have their opinion recorded by the conference chair; this will be reflected in the minutes. If any staff member disagrees with a decision of the conference this must be recorded at the time of the conference. Conference minutes and subsequent action plans should be checked carefully on receipt for any discrepancies and copies placed in the kept in the child's healthcare record. All minutes will be held by the Safeguarding Team. In cases where concerns have been raised during pregnancy, all information will be held in the mother's healthcare records. Following the birth of the baby all information will be transferred immediately into the baby's hospital healthcare record.

12.0 Information sharing and confidentiality

Please use the following link for up to date advice –

https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

12.1 Sharing information amongst professionals working with children and their families is essential for the purposes of safeguarding and promoting the welfare of children. It is often only when information from a range of sources is put together that a child can be seen to be in need or at risk of serious harm. Staff are mandated to cooperate with any enquiries by Children's Specialist Services under Section 47 Children Act 1989. GDPR is not a barrier to information sharing.

12.2 The duty of confidentiality owed to children is that same as that for adults. Any disclosure must be justifiable and staff must weigh up the child/young person's right to privacy and the degree of current or likely harm. It must always be made clear that confidentiality may not be maintained if the withholding of information will prejudice the welfare of a child.

12.3 Professionals work in partnership with parents and or carers and it is good practice to gain their consent (and that of the child) for sharing information. Where there are specific concerns that informing the parent/carer that information is to be shared may place the child (ren) at further risk then parents/carer(s) would not be informed.

Section **12.4** highlights some examples when parents should not be told about information sharing until there has been a formal strategy to review the concerns and risks to the child.

The law will not prevent a practitioner from sharing information with others if:

- Consent has been obtained
- The public interest in safeguarding a child's welfare overrides the need to maintain confidentiality
- Information is being shared to inform an assessment being undertaken by social services. The Children Act (2004) places an obligation on health professionals to share information when an assessment is being undertaken.
- Disclosure is required under a court order or other legal obligation. If you are required by a court order to provide a statement or report please contact your line manager and the legal team who will guide you through the process. The Safeguarding Team can also provide support.

12.4 Information should not be shared with parents in cases of FII[25] or if the sharing of information would be likely to contaminate evidence in further investigations such as in sexual abuse, female genital mutilation or forced marriage allegations.

Professionals must exercise caution when asked for information over the telephone. The caller's identity must always be verified and a work telephone number established. Do not share information via a mobile phone. Information may be shared by email via an nhs.net email account **only** to a secure local authority email account. Telephoning the parents back on their work number is recommended.

12.5 Sharing of records - There may be a request from other organisations (Children's Specialist Services, Police etc.) to share the contents of healthcare record or the records themselves. The Trust has clear policies for sharing confidential information. Do **not** photocopy and share any records with any outside agency without prior agreement. Please seek advice from your line manager and the Trust Legal Team; the Trusts Named Nurse for Safeguarding Children and the Caldicott Guardian can provide advice.

12.6 Any information shared must be documented accurately with the reason given for disclosure and to whom the disclosure is made. All staff must ensure that the records are signed and dated/timed contemporaneously.

25 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/277314/Safeguarding_Children_in_whom_illness_is_fabricated_or_induced.pdf

13.0 Learning and improvement

Professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others.

Good practice should be shared so that there is a growing understanding of what works well. Conversely when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

These processes should be transparent with findings of reviews shared publically and nationally. Everyone has an interest in understanding both what works well and also why things go wrong.

Safeguarding Children Boards have a duty to review cases regularly to ensure that lessons are learnt about how organisations work together to safeguard and promote the welfare of children. Cases which do not meet the criteria for a statutory review but may highlight good practice or valuable lessons around working together are pivotal in ensuring a clear understanding of what is or is not good practice.

The Trust has a duty to cooperate in these reviews to highlight any areas for improvement but also to ensure we as an organisation are working to the highest standards.

13.1 There are different types of reviews which may include a Serious Case Review (SCR) or a Child Death Review (see section 7.0). A SCR is commissioned when a child dies or suffers a serious injury where abuse or neglect is suspected and there are concerns about how professionals or organisations worked together to safeguard that child. The Kent Safeguarding Children Board will also audit the practice and procedures at the Trust to provide assurance that the Trust is fulfilling its statutory responsibilities.

Further information on SCRs can be found using the following link –

https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

14.0 Resolution of professional disagreement – the current Kent and Medway Safeguarding procedures provide the most up to date advice.

Please click on the following link –

http://www.proceduresonline.com/kentandmedway/chapters/p_resolution.html

14.1 Disagreements between health professionals

Differences of clinical opinion may occur between health professionals in relation to the management or diagnosis of a child about whom there are concerns. When this occurs in relation to the diagnosis of possible deliberate harm to a child, a recorded discussion must take place between the persons holding the different views. When the deliberate harm of a child has been raised as an alternative diagnosis to a purely medical one, the diagnosis of deliberate harm must not be rejected without full discussion. If this is still unresolved the Trust Named Doctor and/or Nurse must be informed to assist in working towards a resolution. If this is not possible, the local CCG Designated Doctor/Nurse for Safeguarding Children should be involved.

Accurate documentation of differences and subsequent resolutions is imperative.

It is expected that **all** professionals who are involved to date with the child, will have the opportunity to have their opinion and concerns heard by the individual providing a second opinion.

14.2 Disagreements with other agencies

If disagreements occur with the handling of concerns reported at the referral stage, with the outcome of a Section 47 enquiry, or arising from a child protection conference, then the Named Nurse/Doctor must be informed. The procedure to be followed is found in the current Kent and Medway Safeguarding procedures.[26]

15.0 How children can make a complaint when there are concerns/allegations against a member of staff.

The Trust is committed to listening to children especially when they are expressing concerns about either their own or another child's welfare. Parents and children are able to make complaints via the Trust PALS Service. Any disclosure of concerns over a child's welfare must be brought to the attention of the Safeguarding Team.

15.1 Allegations against staff

Allegations of abuse against any member of staff must be dealt with quickly and consistently in a way that provides effective protection for the child and supports the person who is the subject of the allegation.

Anyone receiving allegations about staff must report the concerns to their manager and not make an early decision about whether the allegation is true. If the allegation is made against a senior manager, it should be reported to an alternative senior manager.

An allegation may require consideration from any of the following three inter-related perspectives.

- Child protection enquires by Children's Social Services
- Criminal investigation by the police
- Staff disciplinary procedures

The Local Area Designated Officer (LADO) must be informed of any allegation of abuse against staff. The LADO can consult or refer to police and/or social services as appropriate.

Advice can be found via the following link:
http://www.kscb.org.uk/__data/assets/pdf_file/0008/72944/01.03.2017-Managing-Allegations-Against-Staff-Practice-Guidance-FINAL.pdf

It is recommended that Police and Social Services investigations are completed before any disciplinary process can be concluded. However these may run concurrently.

Consideration must be given to support mechanisms for staff during a period of exclusion e.g. occupational health. **Please see the policy** 'Supporting Staff involved in Traumatic and Stressful Incidents, Complaints or Claims Policy and Procedure.'

[26] http://www.proceduresonline.com/kentandmedway/chapters/p_complaints.html

If a member of staff has concerns about malpractice, illegal acts or omissions at work of colleagues relating to the care of a child, the Trust Speak Out Safely (SOS) Policy and Procedure (formerly Whistle Blowing) should be used in order to protect the child.

16.0 Responding to sexting (youth produced sexual imagery)

The Kent Safeguarding Children Board has produced guidance for agencies professionals working with children and young people that may need to respond to sexting incidents or youth produced sexual imagery- this can be found via the following link [27] -

http://www.kscb.org.uk/guidance/online-safety

[27] http://www.kscb.org.uk/__data/assets/pdf_file/0006/60909/Sexting-KSCB-version-5-final.pdf

APPENDIX 1

Process requirements

1.0 Implementation and awareness

- Once ratified the Policy Ratification Committee (PRC) Chair will email this policy/procedural document to the Corporate Governance Assistant (CGA) who will activate it on the Trust approved document management database on the intranet, under 'Policies & guidelines'.
- A monthly publications table is produced by the CGA which is published on the Trust intranet under 'Policies & guidelines'; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
- A global email to all staff will be sent out to ensure that all staff aware of the new policy

2.0 Monitoring compliance with this document

- In line with the Laming report, it is appropriate and essential that audit of compliance to this policy and procedure is carried out. The areas to be audited will be identified and reviewed by the Trust Safeguarding Children Committee
- The Trust Safeguarding Children Committee will review the Safeguarding Children Policy and Practice Guidance.
- An annual report will be submitted to the Quality Committee and to the Trust Board
- The policy will be reviewed every 3 years by the Trust Safeguarding Children Committee to ensure all information contained therein is evidence based and up to date with current local and national guidelines
- Evidence will be collated monthly on training compliance and referrals made to Children's Specialist Services
- The Named Nurse for Safeguarding Children will ensure that all Trust staff are informed of any procedural or statutory changes in a timely manner
- Quarterly data will be submitted to the Kent Safeguarding Children Board to provide assurance that the Trust is fulfilling its statutory obligations
- A Section 11 audit will be completed every 2 years and submitted to the Safeguarding Children Committee and the Kent Safeguarding Children Board

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every three years, following the procedure set out in the 'Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures' [RWF-OPPPCS-NC-CG25].

If, before the document reaches its review date, changes in legislation or practice occur which require extensive or potentially contentious amendments to be made, a full review, approval and ratification must be undertaken by the Trust Safeguarding Children committee.

If minor amendments are required to the policy and procedure between reviews these do not require consultation and further approval and ratification. Minor amendments include changes to job titles, contact details, ward names etc.; they are 'non-contentious'.

For a full explanation please see the 'Principles of Production, Approval and Implementation of Trust Wide Policies and Procedures' [RWF-OPPPCS-NC-CG25]. The amended document can be emailed to the CGA for activation on the Trust approved document management database on the intranet, under 'Policies & guidelines'. Similarly, amendments to the appendices between reviews do not need to undergo consultation, approval and ratification.

4.0 Archiving

The Trust approved document management database on the intranet, under 'Policies & guidelines', retains all superseded files in an archive directory in order to maintain document history.

APPENDIX 2

CONSULTATION ON: Safeguarding Children Policy and Procedure
Consultation process – Use this form to ensure your consultation has been adequate for the purpose.
Please return comments to: Alison Jupp Named Nurse for Safeguarding Children (alisonjupp@nhs.net)
By date: 28 April 2017

Job title:	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff MUST be included in ALL consultations:				
Corporate Governance Assistant	07/04/2017			
Chief Pharmacist and Formulary Pharmacist	07/04/2017	7.4.17	N	
Formulary Pharmacist	07/04/2017			
Staff-Side Chair	07/04/2017			
Emergency Planning team	07/04/2017			
Head of Staff Engagement and Equality	07/04/2017			
Health Records Manager	07/04/2017			
All individuals listed on the front page of this document				
All members of the approving committee: Safeguarding Children Committee	07/04/2017			
Other individuals the author believes should be consulted				
All Consultant Paediatricians including Paediatric Safeguarding Children Lead	07/04/2017			
Consultant Obstetricians	07/04/2017			
Paediatric Matron	07/04/2017	19.4.17	Y	Y
Head of Midwifery, Woman and Children and Sexual Health	07/04/2017			
Deputy Head of Midwifery	07/04/2017			
Inpatient and Outpatient Midwifery Matrons	07/04/2017			
A&E Matron	07/04/2017			
Midwife Safeguarding Lead and Deputy Named Midwife	07/04/2017			
Head of Legal Services	07/04/2017			
Chief Nurse	07/04/2017			
Matron Safeguarding Adults	07/04/2017			
The following staff have given consent for their personal names to be included in this policy and its appendices: Alison Jupp				

APPENDIX 3

Equality impact assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development and approval process. **Please note that completion is mandatory for all policy and procedure development exercises.**

Title of policy or practice	**Safeguarding Children Policy and Practice Guidance**
What are the aims of the policy or practice?	• To ensure that the safety and welfare of all children is paramount • To ensure the processes for management of safeguarding children are robust and consistent • To comply with organisational, local and national guidelines
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	No
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Gender identity	No
People of different ages	Only applies to anyone who has not reached their 18th birthday
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	No
People who have a physical or mental disability or care for people with disabilities	No
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	Policy only applies to anyone who has not reached their 18th birthday
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures and leaflets'.

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet, under 'Policies & guidelines':

No.	Title	Unique ID	**Title and unique id of policy that the appendix is primarily linked to**
4	Concern & vulnerability form	RWF-OPF-CS-C-NUR8	This policy
5	MARAC referral form	RWF-OPF-CS-NC-NUR8	Domestic abuse / violence policy and procedure [RWF-OPPPCS-NC-NUR7]
6	Body map	RWF-OPF-CS-C-NUR3	This policy

Safeguarding Children Supervision Policy and Procedure

Target audience: All clinical staff who come into contact with children and their families.

Author: Named Nurse Safeguarding Children, Deputy Named Midwife and Safeguarding Children Nurse
Contact details: 01892 638178

Other contributors: Paediatric Directorate
Named Midwife

Executive lead: Chief Nurse

Directorate: Women's, Paediatrics & Sexual Health

Specialty: Midwifery / Safeguarding Children

Supersedes: Safeguarding Children Supervision Policy and Procedure (Version 1.0: August 2013)

Approved by: Safeguarding Children Committee, 25th May 2018

Ratified by: Policy Ratification Committee, 14th September 2018

Review date: September 2022

Document history

Requirement for document:	• To comply with the Intercollegiate Document on Safeguarding Competencies (Royal College Paediatrics and Child Health [RCPCH] 2014) • To enable staff to access good quality safeguarding children supervision • Promote and develop services which reduce the likelihood of harm or further harm to children • To provide a supportive, reflective environment for practitioners and map practice to evidence with suggested action plans • To provide a process in which individual practitioners can be challenged pertaining to their safeguarding children practice
Cross references (external):	27. Working Together to Safeguard Children (HM Government 2015) https://www.gov.uk/government/publications/working-together-to-safeguard-children--2 28. What to do if you're worried a child is being abused: advice for practitioners (HM Government 2015) https://www.gov.uk/government/publications/what-to-do-if-youre-worried-a-child-is-being-abused--2 29. Kent & Medway Safeguarding Children Procedures (Kent Safeguarding Children Board 2017) http://www.proceduresonline.com/kentandmedway/ 30. The Victoria Climbie Enquiry Lord Laming Report (2003) https://www.gov.uk/government/publications/the-victoria-climbie-inquiry-report-of-an-inquiry-by-lord-laming ; 31. The Protection of Children in England a Progress Report Lord Laming https://www.gov.uk/government/publications/the-protection-of-children-in-england-a-progress-report 32. Intercollegiate Document on Safeguarding Competencies (Royal College Paediatrics and Child Health [RCPCH] 2014) https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competences-healthcare-staff 33. Children Act 1989 http://www.legislation.gov.uk/ukpga/1989/41/contents 34. Children Act 2004 http://www.legislation.gov.uk/ukpga/2004/31/contents 35. Safeguarding Practitioners Information Sharing Guidance (HM Government 2015) https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice 36. Kent Safeguarding Children Board Threshold Guidance – https://www.kscb.org.uk/procedures/kent-support-levels-guidance 37. NICE Guideline: When to Suspect Child Maltreatment – https://www.nice.org.uk/guidance/cg89 38. NICE Guideline: Domestic Abuse and Violence: multi-agency working - https://www.nice.org.uk/guidance/ph50 39. Lord Laming's inquiry into the death of Baby P; executive summary (2009) http://www.haringeylscb.org/sites/haringeylscb/files/executive_summa

	ry_peter_final.pdf 40. Francis Report (2014) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf
Associated documents (internal):	• Safeguarding Children Policy and Procedure [RWF-OPPPCS-C-NUR6]

Keywords:	Safeguarding	Supervision	Policy
	Children		

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	New policy / procedure	August 2013
2.0	Reviewed and updated – changes made to staff requiring 1:1 supervision after consultation.	September 2018

Summary for

Safeguarding Children Supervision Policy

The Trust places the highest priority on safeguarding all children who come into contact with the Trust. The Trust expects all staff to meet their statutory responsibilities and comply with best practice guidance. The child's welfare is paramount and staff will ensure that the child's safety and welfare is their first concern (including those not yet born).

Effective and accessible supervision is essential to help practitioners cope with the emotional demands of work with children and their families and to help to put in practice the critical thinking required to understand cases holistically, complete analytical assessments, and provide an intervention.

The national requirement for staff supervision where children are considered to be at risk of significant harm is well documented and has been a recommendation in recent Safeguarding Review Practice (formally known as Serious Case Review).

Regular safeguarding supervision will promote monitoring of quality and lead to improved outcomes for children, their families and vulnerable adults,

The needs of the child are paramount. The process of supervision is underpinned by the principle that every member of staff remains accountable for their own practice. The supervisor is accountable for the advice they give and action they take.

Contents

1.0 Introduction, purpose and scope

Introduction

1.1 Lord Laming's inquiries into the death of Victoria Climbié (2003)[4] and Baby P (2009)[12] together with public enquiries and safeguarding review Practice (formally known as Serious Case Review) recommend that practitioners should receive supervision specific to safeguarding children.

1.2 Working to ensure children are protected from harm requires sound professional judgments to be made; it is demanding work that can be distressing and stressful. All of those involved should have access to advice and support.

1.3 For many practitioners involved in day-to-day work with children and families, effective supervision is important to promote good standards of practice and to support individual staff members. Supervision should help to ensure that practice is soundly based and consistent with organisational, local and national policies and guidelines.

1.4 Effective professional supervision can play a critical role in ensuring a clear focus on a child's welfare. Supervision should support professionals to reflect critically on the impact of their decisions on the child and their family.

1.5 Under Section 11 of the Children Act 2004[6] all healthcare organisations have a duty to make arrangements to safeguard and promote the welfare of children and young people, and to cooperate with other agencies to protect individual children and young people from harm. This duty means that healthcare organisations must ensure that they discharge their functions with regard to the need to safeguard and promote the welfare of children and young people.

The Trust must ensure that there are clear lines of accountability for the provision of services designed to safeguard and promote the welfare of children. This is achieved by:

- Ensuring that there is appropriate supervision and training for staff (including Safeguarding Training) in accordance with the current Intercollegiate Document (2014)[5]; all staff must have mandatory safeguarding children training at induction
- Promoting and developing services which reduce the likelihood of harm or further harm to children
- Providing a supportive, reflective environment for practitioners and map practice to evidence with suggested action plans
- Providing a process in which individual practitioners can be challenged pertaining to their safeguarding children practice
- Promoting a culture of listening to children, taking into account their wishes and feelings both in individual decisions and in the development of services
- Ensuring that there are clear Speak Out Safely procedures and a culture that enables safeguarding and promoting the welfare of children to be addressed (Francis Report 2014)[13]
- Having clear information sharing procedures with other professionals and with Kent Safeguarding Children Board and East Sussex Safeguarding Children Board
- Ensuring that there are safe recruitment practices for all staff who have contact with both children and parents/carers, including procedures for obtaining a Disclosure and Barring Service (DBS) check where appropriate

- Ensuring all staff feel competent to carry out their responsibilities and duties and the Trust will create an environment where staff feel able to raise concerns and feel supported in their safeguarding responsibilities
- Ensuring that there are a Named Doctor, Named Nurse and Named Midwife in accordance with the Intercollegiate Document (2014); Named staff will have sufficient time, funding and supervision to fulfil their safeguarding responsibilities effectively
- The key message is that **safeguarding is everyone's responsibility.**

Scope

1.6 This is a Trust wide policy/procedure that applies to all clinical staff who come into contact with children and their families.

2.0 Definitions/glossary

Term	Definition
Child	Anyone who has not yet reached their 18th birthday
Safeguarding	The action taken to promote the welfare of children and protect them from harm; it is everyone's responsibility and everyone has a duty to cooperate (HM Government 2015).
Safeguarding supervision	A process whereby an appropriately qualified, experienced and nominated supervisor meets with a member of staff or volunteer to allow that person to reflect upon their safeguarding practice and to review their practice relating to children and young people and raise any concerns about which they may require resolution.
Supervisor	The appropriately qualified, experienced and nominated staff member who provides the supervision. They are accountable for the advice they give and the actions that are taken.
Supervisee	The member of staff or volunteer who receives the supervision. Members of staff are individual practitioners who remain accountable for their own professional practice.
Young person/people	A child aged 16 and 17

Please also refer to the current Trust Safeguarding Children Policy and Procedure for a comprehensive glossary.

3.0 Duties

Person/Group	Duties
Chief Executive	Responsible for ensuring that all staff are able to meet the duties set out in section 1.5
Chief Nurse	Responsible for: • Safeguarding children practice, and will take responsibility as the strategic lead on all aspects of the Trust's contribution to safeguarding children • Representing the Trust on the Health Safeguarding Group a sub-committee of the Kent Safeguarding Children Board; • Ensuring that all appropriate safeguarding processes are in place, including compliance with all legal and statutory requirements
Safeguarding Children Committee	• The Safeguarding Children Committee forms an integral part of the Governance system in the Trust and is chaired by the Chief Nurse. • The Committee provides strategic direction for all safeguarding children activities across the Trust, to ensure engagement of all agencies and to gain assurance that the Trust is compliant with all local and statutory requirements.
Named professionals (Named Doctor, Named Nurse and Named Midwife)	The named professionals have expertise in child health and development, the types of child maltreatment and the local arrangements for Safeguarding and promoting the welfare of children. The posts of Named Doctor, Named Nurse and Named Midwife are statutory requirements under the Working Together (2015)[1] document and are the Designated Professionals. They have joint responsibility for: • Promoting good professional practice, providing advice and expertise to fellow professionals • Taking a lead in the provision of safeguarding training and supervision, working closely with the Trust Safeguarding Lead, Designated Professionals and the Local Safeguarding Children Board
Clinical Directors	Responsible for ensuring through their Governance leads that: • All relevant staff - existing and new – are aware of the procedural arrangements for Safeguarding Children and Safeguarding Children supervision and that mandatory training is up to date • All appropriate staff access Safeguarding Supervision as per the current policy
Deputy Named Midwife, Named Nurse Safeguarding Children and Safeguarding Children Nurse	In addition to their duties under 'Named professionals', they are responsible for updating the policy as necessary, to reflect changes in practice or legislation and ensuring there are clear procedures for disseminating updated information to all staff in a timely manner
All Trust	Must:

Person/Group	Duties
employees who come into contact with children and their families	• Familiarise themselves with the Safeguarding Children Supervision Policy • Ensure that safeguarding children forms an integral part of all aspects of the care they provide and to use a child centred approach when working with children and their families • Understand their responsibilities in relation to safeguarding children; • Identify their development and training needs in relation to safeguarding children • Maintain records in accordance with Trust policy and professional body guidelines Staff working in adult areas must be aware of the potential link between domestic abuse, mental health and substance misuse (the 'Toxic Trio') in parents/carers and potential child protection issues.

4.0 Training / competency requirements

4.1 **Competency** – all staff require a level of competency to enable them to carry out their statutory responsibilities to safeguard children. The Trust expects that training will be in accordance with the Intercollegiate Document (2014). This document sets out the level of skills, knowledge and competencies for staff depending on their role and degree of contact with children, young people and families, the nature of their work, and their level of their responsibility.

4.2 **Compliance** for training is reported through the Learning and Development Department and monitoring is in place via the Trust Safeguarding Children Committee.

4.3 **Supervision** - The Trust Safeguarding Children Team provides Safeguarding Children Supervision to ensure that high quality child protection advice and support is available to all Trust staff. Safeguarding children supervision is supplementary to clinical supervision in accordance with national guidance. All clinical staff working directly with children and young people should access supervision appropriate to their role.

4.4 **Annual appraisals** will include reference to safeguarding children training and supervision for all staff working with children and young people. Further advice and guidance is available from the Safeguarding Children Team; contact telephone number Ext. 24599 email safeguardingchildrenteam.mtw@nhs.net

5.0 Purpose

5.1 Safeguarding Children Supervision is an indispensable tool for:

- Ensuring services are delivered competently and effectively to children and families.
- Effective, evidence based programmes of care (that are responsive to the individual needs of children and families).
- Improved decision making in Child in Need/Safeguarding/Child Protection work.
- Clarity for worker on role and responsibilities.
- Effective inter-agency work based on establishing clear channels of communication and the development of collaborative working within own agency and between other agencies.
- Ensuring staff are supported, developed and challenged where appropriate.
- Enhanced professional development.
- Assuring service users and their carers that the organisation is accountable for local core practice standards and nationally set standards.
- To ensure financial governance and probity.

6.0 Supervision

Supervision is undertaken by the Safeguarding Children Team and other appropriately qualified staff. This is mandatory for specific staff groups (Appendix 11).

6.1 Forms of supervision

- Immediate advice and support regarding individual cases and current concerns to any member of staff within the organisation.
- One to one supervision to specific staff groups
- Group supervision to specific staff groups
- 'Ad hoc' supervision to any staff member requiring advice or support

6.2 Frequency of supervision

- Ad hoc supervision will be offered to any member of staff during working hours by the safeguarding team.
- Individual (one-to-one) supervision will be offered to specified staff every 13 weeks (see Appendix 11)
- Group supervision will be offered to specified staff every 13 weeks (see Appendix 11)
- New staff in specific roles will receive individual supervision every 2 months for their first year of employment

These are the minimum requirements; supervision can take place more frequently if felt to be required by the supervisee or supervisor.

6.3 Supervision contract

A supervision contract (Appendix 4) will be agreed and signed on a yearly basis. The purpose of the contract is to agree:

- Clarity of expectations between supervisor and supervisee
- Roles and responsibilities
- Relevant practical issues
- An agreed action plan

6.4 Issues which can be brought to supervision

Staff are able to bring any concern to Safeguarding supervision and should not limit the discussion to children who are already known to Children's Specialist Services or subject to a Child Protection Plan or a Child in Need plan.

Staff may wish to prioritise the following -

- Children considered to be at risk of immediate harm – staff should not delay a discussion with Children's Specialist Services prior to any supervision session
- Complex or challenging cases where there is a history of Children's Specialist Services involvement or where there are multiple professionals involved due to on-going health needs
- Children (including unborn children) subject to a Child Protection Plan
- Children (including unborn children) subject to a Child in Need plan
- Children in Care (formerly known as a Looked After Child)
- If the Practitioner requires clarification on potential safeguarding concerns
- Children/families who present with other vulnerability factors which may include -
    - Parental mental health issues
    - Domestic abuse
    - Parental substance/alcohol misuse
    - Children who are not bought to appointments
    - Children or parents with learning difficulties/disabilities
    - Faltering growth of unknown cause
    - Communication difficulties
    - Lack of engagement
    - Disguised compliance
    - High risk Child Sexual Exploitation or other exploitative risks such as Modern Slavery or Human Trafficking
    - Radicalisation
    - Children who have refugee status or classified as Unaccompanied Asylum Seeking Children (UASC)

(Please note: this is not an exhaustive list.)

6.5 Recording supervision

Individual (1:1) supervision

- Specified staff are to have a minimum of 4 sessions in 12 months (or 6 if staff are newly qualified or new to the role)
- Each session will be time limited to 1.5 hours; extra time or a further session can be mutually agreed
- All supervision sessions will be recorded using the approved documentation (Appendix 6, 7, 8 or 9 as appropriate)
- It is the responsibility of the supervisee to complete the documentation prior to the supervision taking place; **if documentation is not completed the supervision session will not go ahead**
- Any action plan will be mutually agreed during the discussion.

- Both the supervisor and supervisee will have a copy of the documentation which will be stored safely; the Safeguarding team will store records both electronically and in paper form
- Any action plan agreed will be instigated; if the agreed actions cannot be completed it is the responsibility of the staff member to provide evidence of why an action has not been completed
- An attendance record will be kept for all individual sessions and a copy forwarded to the line manager for their records (Appendix 10)

Group supervision

- Staff who require group supervision (see Appendix 11) will attend 4 sessions per year, limited to 2 hours per session
- All supervision sessions will be recorded using the approved documentation (Appendix 6 or 7 as appropriate)
- An attendance record will be kept for all group sessions and a copy forwarded to the line manager for their records (Appendix 10)
- Staff can discuss individual children/families or general Safeguarding themes
- Both the supervisor and supervisee will have a copy of the documentation which will be stored safely; the Safeguarding team will store records both electronically and in paper form

Ad hoc supervision

- This is open to any staff member who requires it either as a one off session or as part of on-going support
- All supervision sessions will be recorded using the approved documentation (Appendix 5)
- Both the supervisor and supervisee will have a copy of the documentation which will be stored safely; the Safeguarding team will store records both electronically and in paper form.
- Any action plan agreed will be instigated; if the agreed actions cannot be completed it is the responsibility of the staff member to provide evidence of why an action has not been completed.

APPENDIX 1

Process requirements

1.0 Implementation and awareness

- Once ratified, the Chair of the Policy Ratification Committee (PRC) will email this policy/procedural document to the Corporate Governance Assistant (CGA) who will upload it to the Trust Policy database on the intranet, under "Policies & guidelines".
- A monthly publications table is produced by the CGA which is published on the Trust intranet under "Policies & guidelines". Notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
- On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.

2.0 Monitoring compliance with this document

- It is important to monitor and assess the extent to which Safeguarding Children Supervision achieves its objectives in maintaining and developing high standards of care in Safeguarding Children practice. The responsibility for this lies with the Named Nurse for Safeguarding Children.
- The Named Nurse Safeguarding Children will monitor and audit staff attendance, any training needs identified and recurrent practice concerns.
- Managers will be informed of all staff who do not attend booked sessions.

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every 4 years.

4.0 Archiving

The Trust approved document management database on the intranet, under '"Policies & guidelines", retains all superseded files in an archive directory in order to maintain document history.

APPENDIX 2

CONSULTATION ON: Safeguarding Children Supervision Policy and Procedure
Please return comments to: Alison.jupp@nhs.net
By date: 28.03.18

Job title:	**Date sent**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff must be included in all consultations:				
Corporate Governance Assistant	13.03.18	15.03.18	Yes	Yes
Chief Pharmacist and Formulary Pharmacist	n/a			
Formulary Pharmacist	n/a			
Staff-Side Chair	13.03.18			
Complaints & PALS Manager	n/a			
Emergency Planning Team	13.03.18			
Head of Staff Engagement and Equality	13.03.18			
Health Records Manager	13.03.18			
All individuals listed on the front page of this document	13.03.18			
All members of the approving committee (Safeguarding Children Committee)	25.05.18			
Other individuals the author believes should be consulted:				
Paediatric Safeguarding Children Lead	13.03.18	15.03.18	Yes	Yes
Paediatric Matron	13.03.18			
Head of Midwifery, Woman and Children and Sexual Health	13.03.18			
Deputy Head of Midwifery	13.03.18			
Inpatient and Outpatient Midwifery Matrons	13.03.18			
ED Matron	13.03.18			
Midwife Safeguarding Lead and Deputy Named Midwife	13.03.18	14.03.18	Yes	Yes
Chief Nurse	13.03.18			
Deputy Chief Nurse	13.03.18			
Safeguarding Adults Matron	13.03.18			
All midwives	13.03.18	14.03.18	Yes	Yes
All paediatric nurses	13.03.18			
The following staff have given consent for their personal names to be included in this policy and its appendices: Alison Jupp				

APPENDIX 3

Equality Impact Assessment

This policy includes everyone protected by the Equality Act 2010. People who share protected characteristics will not receive less favourable treatment on the grounds of their age, disability, gender, gender identity, marital or civil partnership status, maternity or pregnancy status, race, religion or sexual orientation. The completion of the following table is therefore mandatory and should be undertaken as part of the policy development, approval and ratification process.

Title of document	Safeguarding Children Supervision Policy and Procedure.
What are the aims of the policy or practice?	Ensure safeguarding children supervision is carried out effectively.
Is there any evidence that some groups are affected differently and what is/are the evidence sources?	See supporting documentation under Cross references (external).
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Gender identity	No
People of different ages	Only applies to anyone who has not reached their 18th birthday
People of different ethnic groups	No
People of different religions and beliefs	No
People who do not speak English as a first language (but excluding Trust staff)	No
People who have a physical or mental disability or care for people with disabilities	No
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	No
Marriage and civil partnership	No
Gender reassignment	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	This policy specifically relates to requirements as set out by intercollegiate document pertaining to practitioners' practice relating to children and their families.
When will you monitor and review your EqIA?	Alongside this document when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this document

FURTHER APPENDICES

The following appendices are published as related links to the main policy/procedure on the Trust approved document management database on the intranet, under 'Policies & guidelines':

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Safeguarding children supervision contract	RWF-OPF-CS-NC-NUR3	This policy
5	Safeguarding supervision professional discussion	RWF-OPF-CS-NC-NUR4	This policy
6	Safeguarding children record of supervision	RWF-OPF-CS-NC-NUR5	This policy
7	Update form – paediatric cases	RWF-MAT-FOR-5	This policy
8	Safeguarding children record of supervision for midwives	RWF-MAT-FOR-6	This policy
9	Update form – midwifery cases	RWF-MAT-FOR-7	This policy
10	Supervision register of attendance	RWF-OPF-CS-NC-NUR7	This policy
11	Staff who require safeguarding children 1:1 or group supervision	RWF-MAT-APP-2	This policy

[Disciplinary Policy and Procedure]

Standards of conduct at work

Introduction

1. This document is intended to set standards in relation to the more common questions of conduct and to make clear that failure to meet these standards will normally lead to action being taken. In addition, the document sets out the circumstances in which dismissal will normally take place without previous warnings.

2. Breaches of discipline will be dealt with in accordance with the Trust's Disciplinary Policy and Procedure [RWF-OPPPCS-NC-WF10].

General standards of conduct at work

3. A high standard of general conduct is expected from staff at all times. All staff are expected to combine prompt and efficient service with concern and respect for the feelings of other people.

4. All staff should follow the reasonable instructions of their supervisors and managers and carry out their assigned duties.

Attendance for duty

5. Staff are expected to attend for duty at the correct time and work their contracted hours. Unauthorised absence will be dealt with as a disciplinary issue.

6. Leave should be arranged in accordance with local procedures. Absence including sickness absence should be reported, authorised, recorded and managed according to local procedures and Trust policy.

Attendance for mandatory appointments/training sessions

7. It is the responsibility of the member of staff to undertake mandatory training e.g. staff induction, fire lectures, moving and handling training. All staff are also required to attend Occupational Health appointments at the Trust's request.

Smoking on duty

8. No smoking is permitted in non-designated areas of Trust premises.

Use of equipment or resources

9. Staff should ensure they take appropriate care and treat with respect Trust equipment and resources and according to any local rules and procedures on their safe and appropriate use.

Private business

10. Conducting private business arrangements for personal financial gain in paid time is forbidden unless agreed other wise as part of normal contractual arrangements or with the permission of the Executive Director responsible for the department.

Security

11. Staff should comply with the Trust security management policy at all times.

Confidentiality

12. The nature of all health service work, especially information about patients and staff, is highly confidential. Information should not normally be given to any unauthorised person or agency without prior permission. If staff are ever in doubt they should seek advice from their manager.

Information Technology (IT) / Information Governance (IG) policies and procedures

13. Staff should ensure they familiarise themselves and comply with the Trust IT and IG policies and procedures.

Health and safety and infection control

14. All staff should comply with infection control measures and the health and safety of patients, the public, staff or contractors working on Trust premises. Staff are expected to familiarise themselves with and observe any reasonable instructions issued by the Trust or Health and Safety Executive on the safe performance of their work.

Discrimination, bullying and harassment

15. All members of staff should treat other staff, visitors and patients with dignity and respect at times. Action will be taken against staff whose behaviour is discriminatory, abusive, bullying or which constitutes racial, sexual, or any other form of harassment.

Relationship with colleagues

16. Staff should endeavour to maintain a harmonious working relationship with other staff at all times.

Professional registration

17. Staff requiring professional registration in order to carry out their job should ensure their registration is maintained and up to date at all times.

Compliance with other Trust policies and procedures

18. Staff are expected to familiarise themselves and comply with Trust policies and procedures.

Offences which could constitute gross misconduct

19. A serious breach of any Trust policy or professional requirement could constitute gross misconduct.

20. The following offences (detailed in points 21-37 below) are amongst those regarded as very serious and may lead to dismissal after following the disciplinary procedure. Where the conduct amounts to gross misconduct this may be summary dismissal, which means dismissal without notice and without pay in lieu of notice.

General standards

21. Any breach of the general standards of conduct which is so serious that it justifies dismissal without warning.

Serious breaches of infection control and health and safety measures

22. Serious breaches of infection control and health and safety requirements where staff, patients or visitors are put at significant risk.

Theft and unauthorised removal or use of property

23. Any instance of theft or unauthorised removal or use of property from the Trust, or from patients, visitors, or other members of staff on Health Service premises.

24. Health Service property must not be removed from Health Service premises for personal use, or used for private purposes within the premises without prior written approval of the appropriate manager.

Fraud

25. Any deliberate attempt to defraud the Trust, members of the public, another member of staff or a patient in the course of official duties. This includes the misrepresentation of entitlement to expenses, allowances, or payment from the Trust or falsification, or misrepresentation of attendance, absence, pay or expenses claims.

Corruption

26. The receipt of money, goods, favours, or excessive hospitality in respect of services rendered e.g. from contractors in anticipation, or recognition of receiving orders for goods, or services. This does not include trivial articles clearly intended for advertising (e.g. note pads, diaries) nor small personal gifts from patients etc.,

but in any case of doubt, the advice of the line manager should be sought. See the Trust's 'Gifts, Hospitality, Sponsorship and Interests Policy and Procedure'. Any cash given by a patient must be paid into the appropriate office as quickly as possible in accordance with the Trust's Standing Financial Instructions.

Failure to disclose a personal financial interest

27. Failure to declare any personal financial interest in outside companies, firms or other agencies with which the Trust deals in accordance with Trust policy.

Assault and fighting

28. Any assault upon a patient, a member of the public or another member of staff that is associated in any way with Trust business.

Malicious damage or complaints

29. Malicious damage to Health Service property, the property of patients, visitors, or staff or malicious and unfounded complaints about patients, visitors or staff.

Being unfit for duty

30. Incapacity at work through the use of drink, drugs, or substances (see the Trust's 'Alcohol and Substance Misuse Policy and Procedure').

Misrepresentation

31. Making a false or deliberately misleading statement in a job application, health declaration or other employment context.

Deliberate falsification of records

32. Deliberately falsifying or entering misleading information on Trust reporting, recording or information systems.

Serious breaches of IT policies and procedures

33. Serious breaches of IT policies and procedures include:

i. copying, acquiring or using illegal software on Trust's computer system

ii. using another individuals password or sharing own

iii. Accessing data or software that is not necessary for completion of duties.

iv. Deliberately accessing internet sites containing pornographic, offensive or obscene material

v. Serious abuse of internet privileges.

vi. Serious misuse of email.

Serious breach of Trust IG policy and procedure

34. Staff should adhere to the Trust IG policies and procedures; serious breaches could result in dismissal with or without notice.

Current or spent convictions

35. Staff should not withhold information about current or spent criminal convictions or cautions on appointment to post or arising during the course of employment.

Offences committed whilst off duty

36. A member of staff who commits an offence outside of work which results in them being arrested, charged or convicted may be subject to disciplinary proceedings at work in relation to the offence.

Legal right to work in the UK

37. Staff with immigration restrictions in place should ensure that their legal right to work in the UK is maintained at all times. Failure to do so will result in dismissal for the reason of Statutory Duty/Restriction as it would break to law if the Trust continued employment.

This document is not intended to provide an exhaustive list of conduct issues that could be considered by a disciplinary panel and possible dismissal from the Trust.

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure

Requested/ Required by: Chief Nurse

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Speciality: Corporate Nursing Team

Supersedes: Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure 2013 (Version 3.0: November 2013)

Approved by: Safeguarding Adults Committee, 3rd June 2015 (Version 4.0)

Ratified by: Policy Ratification Committee, 8th June 2015 (Version 4.0)

Review date: June 2018

Document history

Requirement for document:	A legal requirement with the advent of the Mental Capacity Act 2005 for all staff to be working within this legislation, when someone lacks the Mental Capacity to make their own decision at the required time.
Cross references:	• Mental Capacity Act 2005
Associated documents:	• Maidstone and Tunbridge Wells NHS Trust. *Safeguarding Adults: Protection and Support of Vulnerable Adults Policy and Procedure* [RWF-OPPPCS-C-NUR5] • Maidstone and Tunbridge Wells NHS Trust. *Consent to Examination or Treatment, Policy and Procedure for* [RWF-OPPPES-C-SM5] • Maidstone and Tunbridge Wells NHS Trust. *Resuscitation Policy / Not For Attempted Cardiopulmonary Resuscitation Policy and Procedure* [RWF-OPPPPS-C-TIO3] • Maidstone and Tunbridge Wells NHS Trust. *Care of the Dying Policy and Procedure* [RWF-OPPPCSS-C-CAN2] • Maidstone and Tunbridge Wells NHS Trust. *Discharge Policy and Procedure, Operational* [RWF-OPPPES-C-AEM6] • Maidstone and Tunbridge Wells NHS Trust. *Restraint Policy and Procedure* [RWF-OPPPCS-C-NUR4]

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	Mental Capacity and Consent, Guidance for Staff	Jan 2007

Version control:		
Issue:	**Description of changes:**	**Date:**
2.0	Reformatted and reviewed / Inserted simple flow chart and guidance regarding assessment of Mental Capacity as Appendix 7 / Amendment to wording in section 4.7 – replace '*receive'* with '*have access to' /* Trust solicitors amendments accepted and added to document	March 2010
2.1	Appendix 11 is under review	Oct 2010
3.0	• Strengthened that a patient has to retain the information for long enough to make the decision, which means that a patient can make a decision one day and may need to be reminded of the decision they made when next seen. • Given more information about what needs to happen in the case of a dispute about the persons Mental Capacity or if the decision made is challenged • Confirmed when cases have to go to the Court of Protection • Given further guidance about capacity assessments and day to day decision making and how to document this pragmatically for patients with a profound lack of Mental Capacity • Combined the Trust formats for assessing mental capacity and best interest making from two documents into one. • Informed Medical staff they may be required to be 'Certificate Provider' if an inpatient is wishing to make out a Lasting Power of Attorney • Inclusion of the MCA Risk/Benefits Table format • Instructed staff to copy Matron for Safeguarding Adults into referrals for IMCA Service so that this can be logged onto the Safeguarding Database and use of this service monitored. • Inclusion of the IMCA Referral Form • Instructed staff to copy Matron for Safeguarding Adults into DOLS Applications made • Addition of the Deprivation of Liberty Safeguards Forms 1 & 4 as appendices • Guiding staff about having sight and taking copies of any declared Lasting Powers of Attorney. • Referring staff to the guidance document on how to gain specialist or legal advice • Strengthened advice for staff about documenting refusals of care/treatment and considering different approaches • Inclusion of definition of Serious Medical Treatment (SMT) • Strengthened course of action when someone lacks Mental Capacity and Serious Medical Treatment (SMT) decision is being made • Identifying which parts of the Act Applies to 16 – 17 year olds and children	April 2013 – Undertaken Oct 2013
4.0	• Updated Policy and Procedure in light of the Supreme Court Judgement and the introduction of the 'Acid Test' in relation to a Deprivation of Liberty Safeguard (DOLS). • Clarified who in the Trust can be a signatory for the DOLS Application Forms • Strengthened information about how the DOLS will be kept under review by managers within the Directorates • Inclusion of the DOLS Flowchart • Review of training requirements • Clarification about assessing a patients mental capacity to make the decision to be admitted to hospital for care and treatment or to remain in hospital if they present as being confused • Inclusion of the fact that if a patient dies whilst a DOLS is in place the Coroner must be notified and it is for the Coroner to decide upon next steps • Update of DOLS Office Contact details • Added Appendix identifying further what is a Mental Disorder under the Code	June 2015

Version control:		
Issue:	**Description of changes:**	**Date:**
	of Practice: Mental Health Act 1983	
4.1	• Archived old DOLS form 1 and updated DOLS form 4.	August 2015

Policy statement for

Mental Capacity Act and Deprivation of Liberty Safeguards Policy

This policy and procedure acknowledges the importance that the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) have in ensuring that patients should be empowered, as far as is possible, to make their own decisions.

The Act has been developed to ensure a person-centred process occurs when staff are faced with assessing and enabling a patient to make their own decisions or are having to make Best Interest Decisions on their behalf.

All people who care for someone who has any level of mental incapacity, are required to work within the meaning of the Act. However, professionals who care for people with mental incapacity have a formal duty to have regard to the Act and the Code of Practice.

Maidstone and Tunbridge Wells NHS Trust staff will be required to follow this policy and procedure to ensure that they are working within the meaning of the

Mental Capacity Act and Deprivation of Liberty Safeguards Procedure

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Appendices

Procedure for Assessing Mental Capacity, Best Interest Decision Making Processes and Assessing Whether a Deprivation of Liberty Safeguard is Required

1.0 Introduction and scope

1.1. This document is intended to ensure that staff are working effectively with patients who have impaired mental capacity and within the Mental Capacity Act 2005, and associated Code of Practice. It gives guidance on how to help people to make decisions, assess for mental capacity and if they are unable to make a particular decision, what principles staff should follow to act in another person's best interests.

1.2. The Mental Capacity Act (The Act) received Royal Assent in April 2005, and has been fully implemented, since October 2007. This document reflects the principles enshrined within The Act and the guidance in the Code of Practice.

2.0 Definitions

2.1. Mental capacity: is broadly speaking, the ability of an individual to make informed decisions regarding specific elements of their life. It is also sometimes referred to as 'competence'.

2.1.1. Capacity is not an absolute concept. Different degrees of capacity are required for different decisions, with the level of competence required increasing with the complexity of the decision.

2.2. Lack of capacity: For the purposes of this Act, a person lacks capacity in relation to a matter if at the relevant time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of the mind or brain.

This means that a person lacks capacity if:

- They have an impairment of or disturbance that affects the way their mind or brain works (for example, a disability, temporary/permanent confusion, condition or trauma) **and**
- The impairment or disturbance means that they are unable to make a *specific decision* at the *relevant time* it needs to be made.

2.3. Assessment of capacity: should be decision specific and time relevant use of Appendix 8: Assessment of Capacity and Recording Best Interest Decisions for Serious Medical Treatment should be used when Serious Medical Treatment (SMT) or investigations are being considered.

2.4. Best Interest Decisions: Any decisions made, or anything done for a person who lacks capacity to make specific decisions, must be in the person's best interests. There are standard minimum steps to follow when working out what is in someone's best interests. These are included in the Trust Format for documenting Best Interest Decisions. (Appendix 8: Assessment of Capacity and Recording Best Interest Decisions for Serious Medical Treatment)

2.5. Consent is the voluntary and continuing permission of the person to the intervention in question. It should be based upon an adequate knowledge of the purpose, nature, likely effects and risks of that intervention, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent (Refer to the Trust's Policy and Procedure for Consent to Examination or Treatment).

2.5.1 In English law prior to The Act, if a person lacked the mental capacity to consent, no one could give consent to medical treatment on his or her behalf.

2.6. Personal welfare lasting powers of attorney can now be set up to enable appointed attorneys to make a number of decisions about a person's life, when they have lost the capacity to make those decisions. This may include the power to give or refuse consent to medical examination and/or treatment. If no registered **Personal Welfare Lasting Power of Attorney (LPA)** exists, then The Act gives the power to the Decision Maker to make Best Interest Decisions on behalf of the person who lacks capacity. All people, who become decision makers, including Attorneys, will have to show that they are making decisions in the person's Best Interests.

2.7 The Decision Maker is the person who will be carrying out the medical procedure, examination or treatment if there is no Health and Welfare LPA in place and registered.

2.7.1 Reference to the 'Best interests decision making legal checklist' will need to be made and documented by the Decision Maker. (Appendix 13)

2.8 Deprivation of Liberty: The European Court of Human Rights (ECtHR) has said that a Deprivation of Liberty depends upon the specific circumstances in each individual case. As a result there is no single definition or standard checklist that can be used to identify where people are being deprived of their liberty. However, a number of cases concerning deprivation of liberty have come before the ECtHR and UK Courts where judgements have ensued with regards to what could be considered as a deprivation of liberty. There has also been a UK Supreme Court Judgement which has sought to clarify the conditions that are required for a Deprivation of Liberty to be occurring – see 2.13 below. (Appendix 11: Deprivation of Liberty checklist).

2.9 Deprivation of Liberty Safeguard (DOLS): – People are entitled to be cared for in the least restrictive way possible and care planning should always consider whether there are other, less restrictive options available to avoid unnecessary deprivation of liberty. However, if all alternatives have been explored and the hospital or care home believes that it is necessary to deprive someone of their liberty to deliver the care or treatment they need, then there is a standard process they must follow to ensure that the deprivation of liberty is lawful and that the person is protected with the appropriate safeguards in place.

2.10 The Acid Test for DOLS:
Following on from the P v Cheshire West and P&Q v Surrey County Council Supreme Court judgements (March 19th 2014) the following now applies:

For a patient who has a mental disorder (refer to Appendix 18) and lacks the mental capacity to make the decision to be admitted to hospital for care and treatment, the two questions, practitioners should consider are as follows:

1) Is the person subject to **continuous supervision** and **control**?

AND

2) Is the person free to leave? (The person may not be trying to leave or saying that they want to leave, however if the practitioner would stop them from leaving *if* they were able to leave, or attempted to leave, then this would mean that the person is not free to leave).
   Therefore if someone lacks Mental Capacity to decide to stay in hospital and is under **continuous supervision and control** and they are **not free to leave** this would amount to a deprivation of liberty and the safeguards need to be applied.

2.11 **Managing authority:** The Hospital or Care Home where the person will need to be detained to receive the proposed care or treatment.

2.12 **Supervisory body:** The Local Authority will be responsible for receiving applications to authorise DOLS. They will also be responsible for arranging and ensuring the six required assessments are completed by a Best Interest Assessor and a Section 12 Doctor.

2.13 **Best interest assessor:** One of the official assessors that the Supervisory Body (Local Authority) appoints to carry out some of the statutory assessments with regards to the Deprivation of Liberty Safeguards.

2.14 **Section 12 Doctor:** One of the official assessors that the Supervisory Body (Local Authority) who is an Approved Mental Health Practitioner, usually a Psychiatric doctor to carry out the remaining statutory assessments in relation to the DOLS applied for.

2.15 **Un-friended / un-befriended:** A patient who lacks mental capacity and has no family or friends to advocate on their behalf.

3.0 Duties

3.1 All staff must adhere to the Five Statutory Principles of the Mental Capacity Act 2005. The Five Statutory Principles are as follows:-

Principle 1: A PRESUMPTION of capacity

Every adult has the right to make his or her own decisions and must be presumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability or due to their appearance.

Principle 2: Individuals being SUPPORTED to make their own decisions

A person must be given all practicable help before anyone treats them as not being able to make their own decisions. This means you should make every effort to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.

Principle 3: UNWISE decisions

People have the right to make what others might regard as an unwise or eccentric decision. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. You cannot treat them as lacking capacity for that reason.

Principle 4: BEST INTERESTS

If a person has been assessed as lacking capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests.

Principle 5: LESS RESTRICTIVE option

Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all. In essence, any intervention should be proportionate to the particular circumstances of the case.

http://www.scie.org.uk/publications/mca/principles.asp (web link to source used)

Please also see Appendix 7.

3.2 Medical Director - The Medical Director must ensure that all medical staff are conversant with the Mental Capacity Act and are complying with the statutory principles of the Act.

3.3 Chief Nurse - The Chief Nurse must ensure that all Nurses are conversant with the Mental Capacity Act and are complying with the Statutory Principles of the Act.

3.4. Head of Therapies - It is the duty of the Head of Allied Health to ensure that all Allied Health Professionals working in the Acute Trust are conversant with the Mental Capacity Act and are complying with the Statutory Principles of the Act.

3.5. Matron Safeguarding Adults and Trust Safeguarding Medical Leads - It is the duty of the Matron and Trust Safeguarding Medical Leads to advise in the most complex cases with regard to Mental Capacity Assessments and Best Interest Decision Making processes. It will also be their duty to ensure that there is a training programme for MCA to reach all appropriate clinical staff. It is the duty of the Matron for Safeguarding Adults to ensure that CQC notifications for outcomes of DOLS applications are completed and sent on behalf of the Chief Nurse.

3.6. Associate Directors of Nursing Services (ADNS) - It is the duty of the ADNS to identify and release key staff with the correct grade and skills to undertake the MCA and DOLS training that is offered to equip staff with the requisite skills and knowledge.

4.0 Training / competency requirements

4.1 All staff who potentially have direct patient contact will require a basic understanding of the Mental Capacity Act 2005, delivered through Trust E-Learning Induction, Clinical Induction and a range of training opportunities.

4.2 All staff who are likely to be assessing mental capacity for patients with regard to simple decisions will require Level 1 MCA Basic Awareness or completed the Trust E-learning Level 2 for Safeguarding Adults or undertaken training with the Matron for Safeguarding Adults (Matron SA).

4.3 All staff who will be assessing for more complex decisions will need to undertake Mental Capacity Act Training from Clinical Trust Induction, or Level 2 Safeguarding Adults Clinical Update, or Level 2 Safeguarding Adults Clinical E-Learning, or Bespoke MCA Training from the Matron for SA or its equivalent i.e. from the Trust Solicitors, or Safeguarding Adult Medical Leads for the Trust or DOLS Kent County Council Training.

4.4 All staff who will be likely to be assessing and requesting a DOLS will require the training above from within the Trust and in addition DOLS training from Matron for SA or DOLS, within the Level 3 Safeguarding Adults training or Kent County Council Training.

4.5 DOLS training is available from Kent County Council and this enables practitioners to explore complex issues with their peers from other agencies. This can be accessed through the Kent County Council Adult Services Website and is free of charge.

4.6 Trust Safeguarding Medical Leads will ensure that all medical staff have access to the appropriate level of training commensurate with their roles and responsibilities.

4.7 Matron SA offers bespoke MCA Training and visits clinical areas to deliver requested bespoke training.

5.0 Procedure - Assessment of capacity

5.1 The Act sets out a two stage test for Mental Capacity. If there is a concern that someone may lack the Mental Capacity to make a particular decision at the relevant time then the staff member needs to consider whether the person has:

STAGE 1

- an impairment or disturbance (for example, a disability, confusion, temporary/permanent, condition or trauma) that affects the way their mind or brain works and whether …

STAGE 2

- the impairment or disturbance is severe enough to mean that they are unable to make a specific decision at the time it needs to be made.

Use of the Trust Format for Assessment of Capacity and Recording Best Interest Decisions for Serious Medical Treatment will guide you through this assessment.

See also **Appendix 7 'Simple guidance and flow chart'**

5.2 The impairment or disturbance can be permanent or temporary, for example a person may have fluctuating capacity.

5.3 No one should be labelled 'incapable' as a result of a particular medical condition or diagnosis.

5.4 A lack of capacity cannot be established merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour which might lead others to make unjustified assumptions about capacity.

5.5 The Act goes on to set out the four abilities that a person requires to be judged as being able to make the decision. He or she must be able to do **all** of the following:

1. to **UNDERSTAND** the information relevant to the decision, **and**
2. to **RETAIN** that information, **and**
3. to **USE OR WEIGH UP** that information as part of the process of making the decision, **and**
4. to **COMMUNICATE** the decision (whether by talking, using sign language or by any other means)

5.6 For some people with impaired cognitive functions, their ability to meet all of these criteria will fluctuate over time.

5.7 Some people, for example those in the early stages of dementia, are able to retain information for a limited period only. The fact that a person is able to retain the information relevant to a decision for a short period only does not mean they are unable to make the decision. They need only to retain the information for as long as is required to make that particular decision at the relevant time. The patient must be able to retain the information for the time that it takes to make the decision. Most decisions will therefore require the information to be retained for a brief period only e.g. cup of tea or cup of coffee?

Significant or difficult decisions might require the patient to retain the information over a number of days or weeks before a decision is acted upon e.g. invasive procedures, surgery, change of medication etc. Practitioners may need to think creatively about how the patient can be reminded that they have made this particular decision in the case of a patient whose mental capacity fluctuates.

5.8 An individual may be competent to make certain decisions, but at the same time not have the capacity to make other, more complex decisions.

5.9 When assessing capacity to make a particular decision, the assessment should be made at the same time as the decision needs to be made. Where it involves more than one decision, each decision must be considered in turn, as a person may have capacity to make one decision but lack capacity to make another. Those making the assessment should ensure that:

- the person has all the information, or sufficient information in order to make that specific decision,
- the information is explained or presented in a way that is easiest for the person to understand (taking into account the particular needs of the individual),
- arrangements are made to take account of whether there are particular times of the day when the person's understanding is better, or there are locations where they feel more at ease, or to postpone the decision to another occasion if that would be better for the person, (if the decision can be delayed)
- where the person can be helped or supported to make choices or express a view by someone else, such as a relative or an independent advocate, that arrangements are put in place to provide that support.

5.10 A person should not be treated as unable to make a decision because he or she makes an unwise decision, or one which appears irrational. The crucial test is defined in paragraph 5.1 and 5.5 above to determine the individual's level of understanding and decision-making capacity.

5.11 In cases where capacity has been assessed but there is concern, or doubt, or challenge about the patient's mental capacity to consent to medical treatment, that doubt should be resolved as soon as possible either by gaining a second opinion from within the Trust, by seeking a second opinion from outside the Trust from a practitioner with the necessary knowledge and expertise to assess capacity in relation to the complexity of the decision to be made.
In the meantime, whilst the question of capacity is being resolved the patient must be cared for in accordance with the clinical judgement of the Doctors in relation to what is considered to be in the patient's best interests. You must keep the person and their family or friends informed of what is happening. **If the disagreement persists this situation should not be allowed to simply drift.** If all appropriate steps to seek independent assistance to resolve this matter have failed then the Trust should not hesitate to make an application to the Court of Protection or seek advice from the Official Solicitor. (Appendix 10: Seeking legal or specialist advice: complex cases pathway)

5.12 In some cases where capacity is being questioned the professionals assessing capacity can consider using the **Assertion of capacity form** which requires the patient to sign that they agree that they have the Mental Capacity to make the required decision at the relevant time and understand any risks attached to the making of that decision. (Appendix 12: Assertion of capacity form).

6.0 Support to enable the person to make a decision

6.1. In line with The Act it requires that assessments of Mental Capacity are completed for each and every decision, when the practitioner is concerned that the patient can not make their own decision. This can mean for someone who is profoundly incapacitated that a number of capacity assessments are required each day. A pragmatic approach is advocated for routine, day to day decisions and staff are required to document these in the day to day contemporaneous notes.

A formal Mental Capacity Assessment should be completed for significant, complex or controversial decisions, applying for a DOLS and decisions that would involve placing the incapacitated patient at risk or where the mental capacity of the patient is disputed. Use the Trust Format for Assessment of Mental Capacity and Recording Best Interest Decisions in these cases. (Appendix 8).

6.2. Staff have a duty to support patients/service users to make decisions and the Act states that all ***practicable*** steps should be taken to help someone make their own decisions before they can be regarded as unable to make a decision. Therefore, it will be useful for staff to document the steps they have taken to support and enable the patient to make the particular decision. This might be that you have:-

- Used simple language
- Changed the environment to suit their needs
- Used easy read leaflets
- Drawn diagrams, pictures etc
- Desensitised them to a new environment
- Used a language interpreter or a sign language interpreter

6.3 All information relevant to the decision must be explained to the person ensuring that it is delivered in a way that the individual can most easily understand. It should be recognised that even where people have capacity to make decisions, their level of capacity may vary and therefore the way information is delivered will be determined by individual circumstances. In this respect it may be necessary for the person giving information to make a judgment, as a balance may need to be struck between giving a person insufficient information upon which to make a decision and giving too much information or too much detail which could be confusing to the individual concerned.

6.4 Care and thought about the most effective method of communication will help the person to understand the nature of the decision and the choices available.

- Simple language should be used, avoiding jargon. Use of pictures or objects could be helpful
- Family, carers and others who know the person well, can advise on the most effective methods of communication with the person
- The presence of relatives, friends or other people who know the person, can assist communication
- Communication aides may be necessary
- It might be necessary to gain the assistance of the Speech and Language Therapist.
- It might be necessary to gain the assistance of an interpreter or Sign Language interpreter.
- Consider giving a lengthier appointment.

6.5 Most people find it easier to make decisions when they are in an environment where they feel more at ease.

- Consider the most appropriate location for the person. A familiar place is often the most suitable, if practicable.
- Consider the timing of the decision, as some people's functioning may vary between different times of the day, or may be affected by particular medication.
- Consider – can the decision wait? Does the decision need to be made now?

6.6 The person may benefit from having the support of another person, to provide support in their decision-making.

7.0 Who can assess mental capacity?

7.1 Every professional working in health and social care will almost certainly at some time in their working life need to assess for capacity.

7.2 The decision as to who is the best person to assess for capacity is dependent on the decision which needs to be made. For most day-to-day decisions, such as when to get up or what clothes to wear, the carer most directly involved with the person needing the care will be best placed to assess the person's capacity to make the decision at the time it needs to be made.

7.3 For more complex assessments, professionals with specific training and experience in assessing capacity may be involved. The following factors may indicate the need for involvement of a more experienced professional:

- The gravity of the decision or its consequences
- Where the person concerned disputes a finding of incapacity or capacity
- Where there is disagreement between family members, carers and/or professionals as to the person's capacity
- Where the person concerned is expressing different views to different people, perhaps through trying to please each or tell them what s/he thinks they want to hear
- Where the person's capacity to make a particular decision may be subject to challenge, either at the time the decision is made or in the future
- Where there may be legal consequences of a finding of capacity/incapacity
- The person concerned is repeatedly making decisions that put him/her at risk or that result in preventable suffering or damage

7.4 In circumstances involving legal matters, such as making a Lasting Power of Attorney (LPA), the solicitor involved will need to decide whether or not the person has sufficient capacity to make the decision to donate this power. They may ask for an assessment from a psychiatrist or medical practitioner if there is any doubt, where a second opinion is required or there is a conflict of interest in signing the certificate of capacity. If a patient has been in our care for some time Trust practitioners may be asked to be the 'Certificate Provider' to assert that the patient does have Mental Capacity to make out this LPA. This duty will sit with the most senior doctor available in the care team caring for the particular patient.

7.5. When consent for medical treatment or examination is required, the doctor *proposing and carrying out the treatment* should decide whether the patient has the capacity to consent or refuse the treatment. It is not necessary, except in more complex or disputed cases, for a referral to be made to another Consultant in that speciality or in some circumstances a psychiatrist for an assessment of mental capacity.

7.6. For care planning issues, such as decisions on whether or not to move a person into residential care, or accept a care package; assessments can be made by social workers/case managers who have specific experience of working with people who may lack capacity and will be assisting with commissioning those services on behalf of the incapacitated patient. Medical and nursing practitioners will be asked for their input into this assessment of mental capacity as we are likely to have come to know the patient well along with their associated level of need.

8.0 Documentation

8.1 It will not usually be necessary to document the assessment of a person's capacity to consent to routine and low-risk interventions, such as providing personal care, insertion of a catheter, or taking a blood sample.

8.2 When assessing capacity to make choices regarding significant actions, it is essential for health and social care professionals to document clearly the process of assessment. It is recommended that you set out the process of reasoning with reference to the Act, as set out in 5.1 and 5.5 of this procedure. If departing from the Code it is essential that you document your justification for non-adherence to The Act.

8.3 Under the Act and Code of Practice there are specific rules in connection with, Lasting Powers of Attorney (Medical Proxies) and Advance Decisions (Living Wills or Advance Directives). It is important that you find out from the patient or their relatives whether such documents exist that might influence whether or not you make decisions on their behalf in the event that they lack capacity. You may need to take advice on the validity and applicability of the documents. Lasting Powers of Attorney (LPA) will need to have been registered by the Office of Public Guardian (OPG) if they are to be effective. If they are registered by the OPG each page will have an OPG Holographic sticker on it to show it has been validated. Note that Health and Welfare LPAs can only be used when the donor has lost capacity whereas Property and Affairs LPAs may be used (unless indicated otherwise) both before and after loss of capacity.

8.4 If a relative or friend indicates that they have a relevant LPA you must ask to see it so that you can be assured that it is registered and relevant to the decision being made at the time. It is good practice to take a copy of the LPA sign and date each page of the copy and place the validated copy in the patient's notes for reference.

8.5 It will be good practice to document decisions made on behalf of the incapacitated patient using a 'best interest decision' discussion or formal meeting. Use the Trust Format for Assessment of Mental Capacity and Recording Best Interest Decisions. Formal minutes of this meeting can be documented on the Trust Format for a Best Interest Decision Making Meeting (Appendix 14).

9.0 Decision making processes - Best Interest Decisions

9.1 The Act lays out a clear framework for actions taken for or on behalf of someone who lacks capacity to make decisions. This framework is set out below.

9.2 Any act done, or decision made, for or on behalf of a person who lacks capacity must be done, or made, in their best interests. This incorporates the requirement to always act to maximise the person's autonomy, dignity and self-respect.

9.3 Before an act is done, or the decision is made, consideration must always be given as to whether there is an alternative way of achieving the desired outcome, which is less restrictive of the person's rights and freedom of action.

9.4 In determining what is in a person's best interests, The Act sets out a statutory checklist of factors which must *always* be taken into account when a decision is being made or an action done for a person lacking capacity. (Appendix 13: Best interest decision making legal checklist).

9.5. A determination of best interests must not be made solely on the basis of a person's age, appearance, behaviour or any other aspect of a person's condition which may lead to unjustified assumptions about what might be in a person's best interests.

9.6 They must consider all the relevant circumstances of which they are aware, and which would be reasonable to regard as relevant.

9.7 They must consider whether it is likely that the person will at some time regain capacity in relation to the matter in question, and if it appears likely that they will, assess when that is likely to be.

9.8 They must, as far as possible, permit and encourage the person to participate, or to improve their ability to participate, as fully as possible in any act done for them and any decision affecting them.

9.9 They must also consider, as far as possible:

- The person's past and present wishes and feelings,
- Any previously held instructions (such as advance decisions)
- The beliefs and values that would be likely to influence their decision if they had capacity, and
- Any other factors that they would be likely to consider if they were able to do so.

9.10 They must take into account, if it is practicable and appropriate to consult them, the views of:

- Anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
- Anyone engaged in caring for the person or interested in their welfare, as to what would be in the person's best interests.
- Any Attorney appointed under a general or specific Lasting Power of Attorney

9.11 In complex cases it will be useful to hold a Best Interest Decision Making Meeting following the Trust format. All key stakeholders will need to be invited, so that all viewpoints can be considered by the Decision Maker. It might be useful to use the 'MCA risk benefits table' at Appendix 9 to document how the decision has been reached and the alternative courses of action considered within the decision making process.

9.12 It is acknowledged that occasionally time constraints will mean that the appropriate stakeholders will not be able to attend a meeting at short notice therefore Best Interest Discussions can and will be recorded stringently, in place of holding a Best Interest meeting.

9.13 Clinical decisions are for the clinician to make however, for someone who has capacity, discuss the decision to be made with the patient and patient's family, if the patient allows. (Cross reference the Consent to Examination or Treatment, Policy and Procedure for).

If a patient lacks the mental capacity to be informed/involved with the decision about serious medical treatment you must involve and consult with:

- Family and friends
- If un-befriended an Independent Mental Capacity Advocate (IMCA)
- ***Refer to section 10.0 for Lasting Power of Attorney, Section 11.0 for Advance Decisions and Section 12.0 for IMCA and SMT.***

10.0 Lasting Powers of Attorney

10.1 There are two types of Lasting Powers of Attorney (LPA) -

- A property and affairs LPA
- A personal welfare LPA

10.2 If a person has a registered Lasting Power of Attorney, (LPA), in relation to personal welfare decisions and the person has lost capacity, staff will need to adhere to this LPA's decisions, as if they were the relevant person i.e. the patient. The LPA granted may give the Attorney full power or place conditions/restrictions on how the power is to be exercised. It may give guidance for the decision-maker. Staff will need to scrutinise the document to appraise themselves of the position. The appointed Attorney will need to adhere to the Mental Capacity Act's Five Statutory Principles and the Best Interest Decision Making processes.

11.0 Advance decisions

11.1 An Advance Decision enables someone over the age of 18 years, to refuse to give consent to a specified medical treatment for a time in the future when they may lack capacity to consent to or refuse that treatment.

11.2 An Advance Decision must be valid and applicable to the current circumstances. If it is valid, it has the same effect as a decision that is made by a person with capacity: Healthcare professionals must follow the Advance decision.

11.3 Healthcare professionals will be protected from liability if they:

- Stop or withhold treatment because they reasonably believe that an advance decision exists, and that it is valid and applicable.
- Treat a person because, having taken all practicable and appropriate steps to find if the person has made an advance decision to refuse treatment, they do not know that an advance decision exists or are satisfied that a valid and applicable advance decision does not exist.

11.4 People can only make an Advance Decision under The Act if they are aged 18 or over and have the capacity to make that decision. They must say what treatment they want to refuse and they can cancel their decision – or part of it – at any time, whilst they still have the capacity to do so.

11.5. If the Advance Decision refuses life-sustaining treatment it must:

- Be in writing (it can be written down by someone else or recorded in healthcare notes).
- Be signed by the patient, if the patient is able, if unable then the witnesses will sign that the patient is unable.
- Be witnessed by someone not involved in this care or related to the patient
- Be dated.
- State clearly that the decision applies even if life is at risk.

12.0 Independent Mental Capacity Advocate eligibility and referral processes

12.1 If the person lacks capacity to make a particular decision at the relevant time AND has no family or friends other than paid carers to represent them (or no one who it is appropriate to consult) **AND** when decisions are being made about serious medical treatment or significant changes of residence e.g.:

- stay in hospital longer than 28 days, or
- stay in care home for more than 8 weeks
- change of accommodation
- Deprivation of Liberty Safeguard being applied for

then a referral to the Independent Advocacy Service (IMCA) **must** be made. **(Appendix 15 - IMCA referral form and contact details).**

12.2 Serious Medical Treatment "is treatment which involves providing, withdrawing or withholding treatment in circumstances where

a) In a case where a single treatment is being proposed, there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail for him,

b) In a case where there is a choice of treatments, a decision as to which one to use is finely balanced, or

c) What is proposed would be likely to involve serious consequences for the patient."

"'Serious consequences are those which could have a serious impact upon the patient, either from the effects of the treatment itself or its wider implications. This may include treatments which:-

- cause serious prolonged pain, distress or side-effects
- have potentially major consequences for the patient (for example, stopping life sustaining treatment or major surgery), or
- have a serious impact on the patient's future life choices (for example, interventions for ovarian cancer)."'

(Ref: Jones, R, Mental Capacity Act Manual, 4th Edition, 2010, pg 141)

12.3 If an IMCA is instructed then they will need to have access to all the relevant information and documentation that relates to the decision that is required to be made**.**

12.4 An IMCA will be invited to be involved in the Best Interest Decision Making discussions or meeting and will seek to advocate on behalf of the person about whom the decision is being made.

12.5 It is the IMCA's duty to prepare a report for the Decision Maker to consider.

12.6 The IMCA can also challenge the Decision Maker if necessary.

12.7 The IMCA does **not** become the Decision maker

12.8 If staff make a referral to the IMCA Service this referral **must** be copied to the Matron for Safeguarding Adults to be added to a central database of IMCA referrals.

12.9 The IMCA referral form for West Kent can be found on the Kent County Council Website and is also attached as Appendix 15.

13.0 Acts in connection with care or treatment

13.1 The Act lays out a system of protection against legal liability, where a person is providing care or treatment for someone who lacks capacity.

13.2 The key to safeguarding the relevant person (patient) and the staff member will be properly documenting the assessment of mental capacity and best interest decision making processes.

13.3 This will cover actions that would otherwise result in a civil wrong or crime if someone has to interfere with the person's body or property in the ordinary course of caring. For example, acts of physical assistance with personal care or hygiene, help with eating and drinking, shopping or buying goods with the person's money. A longer, but not exhaustive list of acts is contained in the Code of Practice (CoP) to The Act.

13.4 Restraint is the use of force - or threat to use force – to make someone do something that they are resisting, or where you are restricting a person's freedom of movement, whether they are resisting or not (CoP 6.40)

13.5 Physical restraint is only lawful if the following requirements are met:-

- Restraint must be **necessary** to prevent harm to the person lacking capacity.
- Restraint must be **proportionate** to likelihood and seriousness of harm.
- It must not extend to a deprivation of liberty.

13.6 Restraint is only permitted if the person using it *reasonably* believes it is **necessary** to prevent harm to the incapacitated person and if the restraint used is **proportionate** to the **likelihood and seriousness** of the harm. **(Refer to the Trust's Restraint Policy and Procedure for more information).**

14.0 Deprivation of Liberty Safeguards Procedures (DOLS)

14.1 The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DOLS) were introduced to prevent further breaches of the Convention on Human Rights following the 'Bournewood' judgement in the European Court of Human Rights.

14.2 If a patient is detained in hospital without protection of the Mental Health Act 1983 and that detention is deemed to amount to a Deprivation of Liberty (as opposed to a ***restriction*** of liberty) , that detention will breach Article 5 of the Human Rights Act. Therefore to safeguard the individual patient and Hospital Trust, a Deprivation of Liberty Safeguards (DOLS) authorisation application will need to be made if it is considered that a Deprivation of Liberty is likely to occur or is urgently needed. (Use of the Deprivation of Liberty Safeguards Checklist Appendix 11 will help you decide whether or not the restrictions in place are amounting to a Deprivation of Liberty).

14.3 The Deprivation of Liberty Safeguards can only apply to a patient aged 18 years and over.

14.4 The Deprivation of Liberty Safeguards Code of Practice highlights the importance of following the principles of the Mental Capacity Act in relation to capacity and best interest processes **before** making a request for an assessment of whether a person should have the Deprivation of Liberty Safeguards applied. At a minimum you should assess the patient's mental capacity to make the decision to remain in hospital for care and treatment or to leave. Care Planning and Risk Assessments will play a pivotal part in justifying that you have worked within the meaning of The Act to seek the least restrictive way to safeguard a person in your care.

14.5 A Supreme Court Judgement in March 2014 (P vs Cheshire West and P&Q vs Surrey County Council) clarified the position in relation to whether or not a Deprivation of Liberty is occurring and this judgement talks of 'The Acid Test'. The Acid Test is as follows:

If the patient lacks mental capacity to make the decision to be in hospital for care and treatment and there is a mental disorder (refer to Appendix 18), there are two key questions to ask to apply the 'acid test':

(1) Is the person subject to continuous supervision and control?
(2) Is the person free to leave?

All of these factors are necessary. You should seek legal advice if intensive levels of support are being provided to any person as part of a package of care or treatment.

The focus is not on the person's ability to express a desire to leave or to attempt to leave, but on what those with control over their care arrangements would do if they sought to leave.

NB: for a person to be deprived of their liberty, they must be subject both to continuous supervision and control **and** not be free to leave.

In all cases, the following are not relevant to the application of the test:

(1) the person's compliance or lack of objection;
(2) the relative normality of the placement (whatever the comparison made); and
(3) the reason or purpose behind a particular placement.

These factors do remain relevant in relation to assessing whether or not the care arrangements are in the patient's best interests or not.

The judgement leaves Managing Authorities i.e. The Trust, in a position whereby everyone in hospital with dementia or learning disability who lack the mental capacity to decide to remain in hospital, that we have effective control over and we would stop from leaving, if they attempted to do so, should have an authorised DOLS in place.

Patient's who purely have lost consciousness and have no mental disorder will not have an authorised DOLS. However if they have lost consciousness due to a brain injury or brain trauma and have not been able to consent to being in hospital a DOLS will need to be considered.

Where there is an opportunity for gaining consent from patient's prior to admission to ICU, for example as part of the consenting process for surgical procedures, that they agree to staff having complete control and continuous supervision over them and that they would be stopped from leaving should they try, this might be an effective way of

avoiding the need to apply for a DOLS for these patients, if it is included in the consenting process.

However, in the case of the patient who has had a brain trauma through an RTA, CVA, and is kept under sedation (for all the right clinical reasons) we will have to apply for an Urgent and Standard DOLS for all of these patients, if they are unable to consent to being in hospital for this care and treatment.

14.6 Requests for authorisation to deprive someone of their liberty are divided into **standard** authorisations and **urgent** authorisations.

- Using the DOLS Form 1 (Appendix 17) a Standard Authorisation application will need to be made to the Supervisory Body (contact details below) if the Managing Authority considers that the way in which someone will need to be treated may amount to a Deprivation of Liberty. It is then for the Supervisory Body to commence the assessment process. The Supervisory Body will appoint at least two assessors to complete the six required assessments. The Supervisory Body will have 21 calendar days to arrange and complete the required six assessments. **(Refer to the DOLS Code of Practice Chapter 4).**
- Using the DOLS Form 1 (Appendix 17) an Urgent Authorisation is to be granted by the Managing Authority to itself for up to 14 calendar days, where an emergency situation arises and depriving someone of their liberty is in the Best Interests of the patient. At the same time as authorising an Urgent Deprivation of Liberty Safeguard the Managing Authority **MUST** apply for a Standard Authorisation from the Supervisory Body. In this case the Supervisory Body will have 14 calendar days to arrange and complete the six required assessments. (The normal valid period for an Urgent Authorisation is usually 7 calendar days. As a result of the Supreme Court Judgment (March 2014) the Kent Mental Capacity Act Local Implementation Network have agreed to extend this to 14 days, as these are 'extraordinary circumstances').
- **As a result of the Supreme Court Judgement the Supervisory Body request that all Urgent Authorisations are given in the first instance for 14 days, unless there is good reason to believe that it will definitely be required for less days. This is due to the exceptional circumstances that have arisen as a result of the Supreme Court Judgement.**

14.7 The Deprivation of Liberty Safeguard if authorised gives the Managing Authority leave to detain the person in that particular Hospital. These authorisations are not transferable between different hospitals. However, if an authorisation for Deprivation of Liberty Safeguard is still required and the patient is transferred between wards, within the same hospital, the authorisation can be transferred with the patient.

14.8 The Deprivation of Liberty Safeguard authorisation is not authorisation for the care and treatment to be carried out and so the proposed care or treatment must still be decided and agreed upon using the Mental Capacity Act five Statutory Principles and Best Interest Decision Making processes.

14.9 The implications of the Code of Practice for Deprivation of Liberty Safeguards (DOLS) will extend to residential and nursing homes where care is provided for mentally incapacitated residents (e.g. people with dementia or a learning disability), and where the care plan involves preventing the person from leaving the home.

14.10 DOLS provides legal protection for vulnerable people who may need to be deprived of their liberty in their best interests in a hospital or care home. They put in place rules about when a person may lawfully be deprived of their liberty and what rights they have if they are deprived of their liberty.

14.11 Deprivation of Liberty is different from **restraint and/or a restriction of liberty**, although the difference is often one of degree and/or intensity. Certain restraints/restrictions could move up the scale and become deprivations of liberty. The courts recognise that restraint may be appropriate when it is used to prevent harm to the person who lacks capacity and it is a proportionate response to the likelihood and seriousness of harm. **(Refer back to 13.5).**

14.12 If a patient dies whilst a Deprivation of Liberty Safeguard is in place a referral to the Coroner MUST be made – this will be treated as a 'death in custody'. It will be for the Coroner to decide if any further investigations are required and the level of inquest to be held. This is the case for both expected deaths and unexpected deaths.

14.13 Please ensure that the patient's consultant knows that the patient has an Urgent DOLS Authorisation in place and that a Standard DOLS has been applied for at the earliest opportunity.

15.0 When can someone be deprived of their liberty?

15.1 The MCA /DOLS set out clear guidelines on when someone can be deprived of their liberty

- **the person MUST lack capacity**
- the DOLS must be for keeping the patient in a certain place for the purpose of providing a specific treatment or care that is in the person's best interests.
- Doctors or care professionals must be satisfied that there is no suitable alternative care plan that would not deprive the person of their liberty.
- The Managing Authority (the hospital or care home where the person is staying) must apply to its supervisory body for authorisation to begin the care plan to deprive the patient of their liberty.

15.2 When a DOLS is required the Supervisory Body must arrange and carry out six assessments to confirm that the deprivation of liberty is lawful and appropriate:

1. **age assessment:** to check whether the person is aged 18 or over
2. **no refusals assessment**: to ensure that the proposed treatment does not conflict with a valid decision already made by an attorney or deputy on the person's behalf, or with a decision made in advance by the relevant person themselves
3. **mental capacity assessment**: to confirm whether the person being deprived of liberty lacks capacity to consent to the arrangements made for their care and treatment
4. **mental health assessment**: to check whether the person being deprived of liberty is suffering from a mental disorder within the meaning of the Mental Health Act 1983. That means any disorder or disability of mind, apart from dependence on alcohol or drugs. It includes all learning disabilities. This is not an assessment to determine whether the person requires mental health treatment.
5. **eligibility assessment:** to confirm whether the person is eligible to be deprived of their liberty under the MCA DOLS
6. **best interests assessment:** firstly to establish whether the proposed care plan would deprive the person of their liberty, and secondly to confirm whether it is:

i. in the best interests of the person to be subject to the authorisation
ii. necessary in order to prevent them from coming to harm
iii. a proportionate response to the likelihood of them suffering harm and the seriousness of that harm.

15.3 If the answer is yes to all six assessments, then an authorisation will be granted to deprive the person of their liberty in order that the Care Plan can be carried out.

(Refer to DOLS Code of Practice Chapter 4)

15.4 Due to the fact that Urgent Authorisations can be granted from within the Managing Authority i.e. Hospital or Care Home the forms authorising an Urgent Authorisation of a DOLS must be signed by a designated signatory from within the Managing Authority.

15.5 The designated signatory will need to have a reasonable belief that the six assessments required to be arranged and carried out by the Supervisory Body will be met and that there is not a least restrictive way of keeping the person in the hospital for their care or treatment available to be used. At all times the Five Statutory Principles of the Mental Capacity Act 2005 must be adhered to.

15.6 Officers of the Trust who are nominated as designated signatories will need to have a good grasp of the application of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards in order to authorise an Urgent DOLS request when called upon. Advice can be sought from the Matron for Safeguarding Adults within office hours and from Clinical Site Managers and on-call managers out of office hours.

15.7 The Consultant or Senior Doctor in charge of the treatment of the person **and** either the Directorate Matron or Ward Manager (in Hours) or Clinical Site Manager (out of hours) will need to assess and confirm whether a Deprivation of Liberty is likely to occur or is occurring, and what type of request should be made to the supervisory body. When the forms requesting an Urgent DOLS and Standard DOLS are completed and sent to the Supervisory Body, the Supervisory Body will then arrange for the six assessments to be carried out. The completed forms **must** be copied into the Matron for Safeguarding Adults.

15.8 The following will be nominated as designated signatories in the Trust given that we provide a 24/7 service.

Within working hours the range of people who are nominated as signatories:
Band 7 and above who work clinically
Consultant in charge of case
Doctors
Directorate Matron
Matron Safeguarding Adults
Clinical Site Managers (out of hours)
Associate Director of Nursing
Deputy Chief Nurse

Outside of office working hours the nominated signatories are:
On call manager
Clinical Site Manager
Band 7 and above who work clinically
Doctors
Consultant on call for the specialty

15.9 All documentation with regards to the Mental Capacity Assessment, Best Interest Decision Making processes and meetings, Care Plan and Risk Assessments should be assessed by two of the above professionals to ensure that the proposed DOLS authorisation and application for assessment is the best course of action to take.

15.10 It is not for the Supervisory Body to advise whether or not an application for a DOLS should be made however they are able to give guidance and information. If the patient is a resident of Kent, once the form is completed and signed it must be sent via secure email to the

Supervisory Body at the DOLS Office,
Third Floor Brenchley House
123 – 125 Week Street
Maidstone, ME14 1RF

Telephone: 03000 415777

Secure Email for the DOLS Office to receive Urgent Authorisations and applications for Standard Authorisations DOLS.office@nhs.net

Email to receive general enquiries DOLS@kent.gov.uk

If the patient lives in East Sussex the email address is:

DOLS@eastsussex.gov.uk

Copy Matron for Safeguarding Adults into all the completed DOLS Forms for review

mtw-tr.saar-dols@nhs.net

If the patient lives elsewhere, contact Matron for SA for advice as to where to send the forms on to.

15.11 It is the Managing Authority's responsibility to keep the DOLS authorisation and conditions under review within a time schedule appropriate to the individual case. Consultants, Ward Mangers and Directorate Matrons will need to keep those patients that a DOLS has been completed for, under review. If their condition or situation changes then the DOLS office and the Matron for Safeguarding Adults must be informed.

15.12 It is the responsibility of the Ward Manager to inform the Matron for Safeguarding Adults of all DOLS applications **and** authorisations, so that this information can be collated and reviewed, to enable completion of the required notification to CQC the outcome of each DOLS application.

15.13 It is the Ward Managers responsibility to inform the relatives or friends of the patient who is deprived of their liberty that this is the case, The Ward Manager will need to give them a printed copy of the DOLS Application

15.13.1 The relatives or friends need to be informed that the Supervisory Body i.e. the Local Authority, will contact them to find out who is best placed to be the Relevant Persons Representative, so as to advocate on the patient's behalf. This conversation is also a good opportunity to inform those contacted that should their relative/friend pass away whilst under a DOLS that the Coroner will need to be informed as their death would be treated as a 'death in custody' and that an inquest would follow.

16.0 High Court / Court of Protection

16.1 If the outcome of the Mental Capacity Assessment or the Best Interest Decision Making process is disputed and this dispute can not be resolved, but action is necessary, the Court of Protection as final arbiter may have to be involved. This is especially the case where serious medical intervention (including withholding of treatment) is required and for decisions relating to change of accommodation. The Court of Protection will wish to see evidence of the attempts at resolution and so assessments, Best Interest meetings and conversations with interested parties will need to have been documented effectively. Witness statements will be required. Expert Witness Testimony/Report may be sought by the Court.

16.2 There are some decisions that are so serious that they have to be brought before the Court of Protection to ensure that the proposed action is lawful before the action is taken. Cases involving any of the following decisions should be brought before a court::

- Decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS).
- Cases involving organ or bone marrow donation by a person who lacks capacity to consent.
- Cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes) and
- All other cases where there is a doubt or dispute about whether a particular treatment will be in the person's best interests.

(MCA 2005 Code of Practice, page 143)

16.2 The Court of Protection will be accessed via the Trust Legal Services. That department holds the list of the Trust's solicitors who can be contacted for advice in these circumstances. Out of Hours legal advice can also be accessed via the executive on call.

17.0 When someone lacks capacity and objects to intervention

17.1 When a person lacks capacity to consent to a particular intervention, the provisions of the Mental Capacity Act 2005 apply. See particularly s5 of that Act.

17.2 Objections to particular actions can take many different forms, from physical resistance to verbal objections, passive resistance and other non-verbal responses. It is not possible, nor would it be appropriate to be prescriptive regarding how to respond to objections, and how to attempt to overcome them, the carer should apply the principles of The Act in making any decision or taking action and record their reasons in the patient's notes.

17.3 It is not unusual for people to refuse a particular form of care due to lack of insight into the need for the intervention. Examples may be:

- A person with dementia sends away a home care worker who is tasked to do regular cleaning or to prepare a meal, saying that they have already cleaned the living room or had dinner.
- A person who is incontinent is reluctant to wear pads
- A person with diabetes refuses their insulin injection.
- A person refuses to be turned to prevent pressure ulcers

- A person with a psychotic illness refuses medical treatment for a physical condition because they have a delusional belief that they can cure themselves.

17.4 In these circumstances, skilled and sensitive responses from the member of staff will frequently (but not always) enable the task to be completed. Clear and ongoing communication with the patient is likely to help enable cooperation. Document all attempts to deliver the care or treatment **and** document the refusals. Consider approaching the patient at different times or asking another clinician to deliver this care. **(Refer to the Trust's Restraint Policy and Procedure for more information).**

17.5 The effect of the failure to provide the particular intervention will vary with the nature of the care or treatment. In some circumstances, the effect will be gradual and/or restricted to reducing the service user's quality of life. Cleaning or washing could be examples. Other examples will have a faster and more drastic effect, such as declining to eat, or to accept insulin, or have positional changes.

17.6 Consideration must always be given to the likely effect of the failure to provide the planned care or treatment, to the person, their environment and to those around them. This will help determine the urgency of the decision-making needed regarding implementation of the care plan.

17.7 It is imperative that in circumstances where an incapacitated patient is refusing or resisting care or treatment, discussions are held with senior staff in the Trust to consider how to ensure the appropriate care is delivered. If necessary, these discussions should include the wider care team, family members or involve gaining advice from the Trusts solicitors.

18.0 Consent and human rights

18.1 The concept of best interests gives rise to human rights considerations. It is important not to treat patients in circumstances that might be considered degrading and in breach of Article 3 of the European Convention on Human Rights.

18.2 The use of force to treat an incapacitated patient might be regarded as degrading in some circumstances. However, not to treat may be considered negligence. Careful consideration is therefore needed in such circumstances, including advice from within the multi-disciplinary team and from senior staff. An application to the Court of Protection may be required to determine the matter.

19.0 Children and young people

Children under 16 years of age – this Act does not generally apply to people under the age of 16 years. However, there are two exceptions

1) The Court of Protection can make decisions about a child's property or finances, or appoint a deputy if the child lacks capacity to make these decisions and is likely to still lack capacity to make these decisions when they reach 18 years.
2) Offences of ill-treatment or wilful neglect of a person who lacks capacity can also apply to victims younger than 16 years.

Young people aged 16 – 17 years - Most of the Act applies to young people aged 16 – 17 years, who may lack mental capacity to make specific decisions for themselves. There are four exceptions:

1) Only people aged 18 years and over can make a Lasting Power of Attorney (LPA)
2) Only people aged over 18 years can make and Advance Decision to refuse medical treatment
3) A person under the age of 18 years can not be deprived of their liberty. Other guidance or safeguards will need to be put into place if the patient needs to be kept in hospital against their will and advice sought from the Paediatric Team or Children's Safeguarding team.
4) The Court of Protection may only make a statutory will for a person aged 18 years and over.

20.0 Care and treatment for people with a mental disorder

20.1 Special rules exist for treatments for people suffering from mental disorder and liable to be detained under the Mental Health Act 1983. These rules are enshrined in Part IV of that Act.

20.2 These rules apply only to treatments specifically designed to treat mental disorders (e.g. psychotropic medication, E.C.T, etc.) For all other forms of intervention, the limitations described in the sections above apply equally to those people detained under the Mental Health Act as to those people in the community.

21.0 Effect of the Act and Code

21.1 Clinical staff need to become acquainted with the principles and guidance in the Act and Codes of Practice and to refer to those principles in your note keeping. It is important that if you consider it necessary to depart from those principles, you set out your reasons clearly in your notes to protect you in the event of any subsequent complaint or claim by the patient or relatives.

22.0 Monitoring and audit

In order to ensure that this policy is embedded and followed the following will be monitored and reviewed at the Safeguarding Adults Committee**:**

- An annual audit of consent form 4 to ascertain that the appropriate consent process is taking place; that mental capacity assessments have been conducted and that patients who require advocates have had referrals/assistance put in place. This will be carried out in conjunction with the Trust Consent audit. Findings of the audit will be presented to the Safeguarding Adults Committee with any appropriate action plans.
- Bimonthly training updates will be presented to the Safeguarding Adults Committee by the Matron for Safeguarding Vulnerable Adults. This should identify areas of compliance and areas/groups of health care professionals where improvements need to be made.
- A bi-monthly report regarding DOLS Applications and IMCA referrals with their outcomes will be presented to the Safeguarding Adults Committee by the Matron for Safeguarding Adults.

APPENDIX ONE

Process Requirements

1.0 Implementation and awareness

Communication plan

- Once approved the document lead or author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust approved document management database on the intranet, under 'Trust polices, procedures and leaflets'.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Trust intranet under "Policies"; notification of the posting is included on the intranet "News Feed" and in the Chief Executive's newsletter.
  - On reading of the news feed notification all managers should ensure that their staff members are aware of the new publications.
  - Global letter and emails to be sent to all staff identifying new Mental Capacity Act policy and procedure.
  - Flyer to be attached to all staffs' payslips
  - Launch of new policy and procedure to be included in the Chief Executives weekly update

All Trust clinical staff require a basic understanding of the policy and procedure and so are required to know that the policy and procedural document has been published

2.0 Review

Policy and procedure to be reviewed every 3 years in line with Trust policy or to be reviewed sooner and updated should case law or changes in national trends and guidelines dictate.

3.0 Archiving

Q-Pulse (Trust Intranet) retains all superseded files in an archive directory in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure

Consultation process – use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Matron Safeguarding Adults:

By date: 07.04.2015

Name –	Date sent	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Local Counter Fraud Specialist	09.03.2015			
Executive Directors	09.03.2015			
Medical Director	09.03.2015			
AHP Therapy Manager	09.03.2015			
Chief Nurse	09.03.2015			
Deputy Chief Nurse	09.03.2015			
Clinical Directors	09.03.2015			
Attendees of the Quality & Safety Committee	09.03.2015			
Attendees of the Trust Safeguarding Adults Committee	Feb 2015	Feb 2015	Y	Y
All Managers on call	09.03.2015			
Directorate Managers	09.03.2015			
Risk Manager	09.03.2015			
Clinical Site Managers TWH and Maidstone	09.03.2015			
All ADNS'	09.03.2015			
Directorate Matrons	09.03.2015			
Medical and Surgical Consultants	09.03.2015	10.03.2015	Y	Y
Associate Director of Governance, Quality & Patient Safety	09.03.2015			
Trust Solicitor	09.03.2015	16.04.2015	Y	Y
Quality and Patient Safety Manager	09.03.2015			
Head of Information Governance	09.03.2015	10.03.2015	Y	Y
Policy Ratification committee				
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of Policy or Practice	Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure
What are the aims of the policy or practice?	To ensure all staff adhere to the principles of the Mental Capacity Act 2005 and that patient's benefit from the Safeguards enshrined in the MCA 2005.
Identify the data and research used to assist the analysis and assessment	
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Males or Females	No
People of different ages	Parts of the Act apply to 16 yrs and above. All of the Act appropriate to people 18 yrs +
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak english as a first language	No
People who have a physical disability	No
People who have a learning disability	No
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	N/A
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust polices, procedures and leaflets'.

Maidstone and Tunbridge Wells NHS
NHS Trust

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust Intranet:

No.	Title	Unique ID
4	Flow chart - assessing mental capacity	RWF-OPPM-CORP175
5	Flow chart – when someone lacks capacity	RWF-OPPM-CORP176
6	Flow chart – best interest decision process	RWF-OPPM-CORP177
7	Mental Capacity Act: simple guidance and flowchart	RWF-OWP-APP64
8	Assessment of capacity and recording best interest decisions for serious medical treatment	RWF-OWP-APP65
9	MCA - risks and benefits table for best interest decision making	RWF-OPF-CS-C-NUR10
10	Seeking legal or specialist advice: complex cases pathway	RWF-OPPM-CORP156
11	Deprivation of Liberty safeguards: deprivation checklist for managing authority	RWF-OWP-APP728
12	Assertion of capacity form	RWF-OPF-CS-C-NUR11
13	Best interest decision making legal checklist	RWF-OWP-APP729
14	Best interest decision making meeting agenda template	RWF-OWP-APP67
15	Independent Mental Capacity Advocacy (IMCA) referral form	RWF-OWP-APP68
16	Kent & Medway Deprivation of Liberty Safeguards Office / Deprivation of Liberty checklist for managing authority	RWF-OPF-CS-C-NUR12
17	DOLS form 1 - standard and urgent authorisation request	RWF-OPF-CS-C-NUR14
18	List of mental disorders (not exhaustive)	RWF-OWP-APP833

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Core Statutory and Mandatory Training Policy and Procedure

Requested/ Required by: Workforce Committee

Main author: Learning and Development Manager

Other contributors:	Staff-side Representative
Document lead:	Learning and Development Manager **Contact details:** 01622 224875
Directorate:	Workforce
Specialty:	Learning and Development
Supersedes:	Core Statutory and Mandatory Training Policy and Procedure (Version 2.0: April 2009) (Version 2.1: December 2009) (Version 2.2: January 2010) (Version 2.3: December 2010) (Version 2.4: October 2011)
Approved by:	Senior HR Meeting, 3rd June 2014
Ratified by:	Workforce Committee, 17th June 2014
Review date:	To be formally reviewed in June 2019 or at times of legislative or significant change

Document history

Requirement for document:	• NHSLA Risk Management Standards • Health & Safety Executive • Care Quality Commission • Clinical Commissioning Groups • Improving Working Lives • The Trust recognises its legal and ethical responsibilities to create and maintain a working environment that will ensure the health, safety and welfare of all persons on Trust Statutory and Mandatory training is an integral component of our high quality service provision and the Trust is committed to ensuring that all staff undertake the training identified as statutory or mandatory
Cross references:	• NHSLA Risk Management Standards • Health & Safety Executive • Care Quality Commission • Boorman, Dr S. (2009). *NHS Health and Well-Being Review – Final Report* • Boorman, Dr S. (2009). *NHS Health and Well-Being Review – Interim Report* • Department of Health (2000) *An Organisation with a Memory. Report of an Expert: Group on Learning from Adverse Events in the NHS* • Elaine Sauvé Associates for the Department of Health. (2005). *An Education and training Framework for Staff providing Healthcare in Prisons* (Available at: www.dh.gov.uk) • Health Professions Council. (2009). *Your duties as an education provider: Standards of education and training* • NHS Employers. (2010). 'Health and safety essential guide' *NHS Employers website pages* • NHS Executive. (1997). *Code of Practice in the Appointment and Employment of HCHS Locum Doctors* • Department of Health. (2004). *Introduction to Today's NHS: NHS Corporate Induction Programme* • NHS Employers. (2008). *Staff Induction Packs* (Available at on request from www.nhsemployers.org) • NHS Employers and Department of Health (2004) *Guidelines for NHS Employers: Induction Programmes for Consultants and GPs Recruited From Abroad* • Department of Health. (2006). *Safer Recruitment – a guide for NHS employers.* London: Department of Health. • *Health and Safety at Work etc., Act 1974*. London: The Stationery Office. • Management of Health and Safety at Work Regulations 1999. • Regulatory Reform (Fire Safety) Order 2005. • Health Professions Council. (2004). *Standards of Education & Training.* London: Health Professions Council. Available at: www.hpc-uk.org
Associated documents:	The Trust's strategies, policies and guidance are held on the QPulse database and can be accessed by all staff through the Trust's intranet site. Paper copies are held in libraries on all sites. • Maidstone and Tunbridge Wells NHS Trust. *Risk Management Policy and Strategy* [RWF-OPPPCS-NC-CG13] • Maidstone and Tunbridge Wells NHS Trust. *Management of Violence and Aggression Policy and Procedure* [RWF-OPPPCS-NC-FH8]

	• Maidstone and Tunbridge Wells NHS Trust. *Control of Contractors Policy and Procedure* [RWF-OPPPCS-NC-EST5] • Maidstone and Tunbridge Wells NHS Trust. *Induction Policy and Procedure* [RWF-OPPPCS-NC-WF19] • Maidstone and Tunbridge Wells NHS Trust. *Moving and Handling of Patients and Loads Policy and Procedure* [RWF-OPPPCS-NC-FH11] • Maidstone and Tunbridge Wells NHS Trust. *Fire Safety Policy and Procedure* [RWF-OPPPCS-NC-CG4] • Maidstone and Tunbridge Wells NHS Trust. *Infection Control Policy and Procedure* [RWF-OPPPCSS-C-PATH15] • Maidstone and Tunbridge Wells NHS Trust. *Recruitment, Selection and Employment Checks Policy and Procedure* [RWF-OPPPCS-NC-WF47] • Maidstone and Tunbridge Wells NHS Trust. *Bullying and Harassment Policy and Procedure* [RWF-OPPPCS-NC-WF24] • Maidstone and Tunbridge Wells NHS Trust. *Health Records Policy and Procedure* [RWF-OPPCS-NC-TM31] • Maidstone and Tunbridge Wells NHS Trust. *Resuscitation Policy / Not For Attempted Cardiopulmonary Resuscitation Policy and Procedure* [RWF-OPPPPS-C-TIO3] • Maidstone and Tunbridge Wells NHS Trust. *Safeguarding Children Policy and Procedure* [RWF-OPPPCS-C-NUR6] • Maidstone and Tunbridge Wells NHS Trust. *Safeguarding Adults: Protection and Support of Vulnerable Adults Policy and Procedure* [RWF-OPPPCS-C-NUR5] • Maidstone and Tunbridge Wells NHS Trust. *Blood Transfusion Policy and Procedure* [RWF-OPPPCSS-C-PATH1] • Maidstone and Tunbridge Wells NHS Trust. *Venous Thromboembolism Prevention Policy and Procedure* [RWF-OPPPCSS-C-CAN4] • Maidstone and Tunbridge Wells NHS Trust. Severe Sepsis, Early Management of [RWF-OPPPPS-C-TIO10] • Maidstone and Tunbridge Wells NHS Trust. *Medical Devices Policy and Procedure* [RWF-OPPPCS-NC-EST2] • Maidstone and Tunbridge Wells NHS Trust. *Medicines Policy and Procedure* [RWF-OPPPCSS-C-PHAR1] • Maidstone and Tunbridge Wells NHS Trust. *Policy and procedure for the control of contractors* [RWF-OPPPCS-NC-EST5] • Maidstone and Tunbridge Wells NHS Trust. *Disciplinary Policy and Procedure* [RWF-OPPPCS-NC-WF10]

Version Control: *Details of approved versions*

Issue:	**Description of changes:**	**Date:**
1.0	Initial document	August 2007
2.0	April 2009 review of procedures	April 2009
2.1	Amendments to Appendix Four	December 2009
2.2	Amendments to Appendix Four	January 2010
2.3	Review of policy and procedures	December 2010
2.4	Appendix 4 amended / Appendix 6 added	October 2011
3.0	Complete re-write due to changes in governance structure, learning management system and appraisal processes	June 2014

Policy statement for

Core Statutory and Mandatory Training Policy and Procedure

Maidstone and Tunbridge Wells recognises that Staff Training is of vital importance in providing an efficient service and safe environment for our patients, staff, and the general public.

Statutory and Mandatory training is an integral component of our high quality service provision and the Trust is committed to ensuring that all staff undertake the training identified as statutory or mandatory. This will include all staff (including bank staff) who have contracts with the Trust. It is the responsibility of individuals and their managers to ensure that they are booked onto training within the identified time scales, some courses are also available by e-learning to enable flexibility of provision and 24 hour access to information. Failure to do so may mean that staff are unable to work until their statutory and mandatory training is up to date.

Trust staff will be released to attend Statutory and Mandatory Training and the granting of permission for other training will be dependent on staff having attended their required Statutory or Mandatory training for the year. All staff including bank staff will be paid their normal rate of pay for attending the programme. For permanent staff working part time hours, managers will be expected to ensure that any excess hours are paid or granted as time-off in lieu.

Statutory and Mandatory training programmes will be agreed and reviewed by Learning and Development and the subject leads and facilitators and ratified by the relevant Committee.

The provision of Statutory and Mandatory training is essential in managing risk and maintaining high standards within the clinical governance framework. The Statutory and Mandatory training outlined in this document is the minimum core requirement for the Trust. Line Managers should identify any other training requirements specific to the role as part of the appraisal process.

The cost of Statutory and Mandatory training is funded in full by the Trust for all employees.

The Trust Board must be assured that this programme of training is being adhered to. This will be achieved through regular Board level reporting via the Workforce Committee and Health and Safety Committee.

Core Statutory and Mandatory Training Procedure

Contents **Page**

7.0 Introduction and scope

These procedures set out the statutory and mandatory training processes for all staff.

8.0 Definitions

Statutory: Statutory Training is information, instruction and training that Employers are required to provide by Statute Law as described in Section 2 of the Health and Safety at Work Act (1974). All staff must participate in this training, a statutory requirement is a MUST DO by Law.

Mandatory: Mandatory Training is that training which is deemed to be most suitable for our organisation to meet its statutory requirements of competency. All staff must participate in this training as identified for their role. A mandatory requirement is a MUST DO for the organisation.

***Staff*:** For the purposes of this policy, the word staff will cover all whole-time, part-time, bank staff, students and volunteers. Contracted staff will be monitored under the *MTW Control of Contractors Policy and Procedure*.

9.0 Duties

3.1 Maidstone and Tunbridge Wells NHS Trust

The Trust has a duty to its staff, visitors and patients to ensure that:

- appropriate statutory and mandatory training is provided for all staff, whether employed whole, part-time or on the bank to meet the needs of their role;
- managers are aware of statutory and mandatory training requirements for their staff;
- all staff attend statutory and mandatory training sessions at the required time intervals;
- accurate records are kept of all statutory and mandatory training undertaken;
- procedures are in place to follow up those who fail to attend statutory and mandatory training;
- procedures are in place to follow up staff that are overdue their statutory and mandatory training;

3.2 Director of Strategy and Workforce

The Director of Strategy and Workforce on behalf of the Trust Board has Executive responsibility for ensuring that all staff receive appropriate and timely Statutory and Mandatory training.

3.3 Managers

It is the responsibility of all line managers to ensure that their staff remain up to date with relevant Statutory and Mandatory training and any additional training specific to the needs of the role. Managers must ensure staff are given protected learning time to complete Statutory and Mandatory training. Managers must follow up non-attendance at any Statutory and Mandatory training session by investigating why it occurred and ensure another date is

arranged. As part of the Trust appraisal process, line managers are responsible for supporting individuals to identify their Statutory and Mandatory training needs upon induction and during annual reviews or upon any changes to the working environment or role. They are then responsible for helping to source the appropriate learning activity to meet those needs before any other developmental training is authorised.

3.4 Staff

All staff have a joint responsibility with their line manager to identify their Statutory and Mandatory training requirements and attend within the specified timescales. They are also responsible for keeping their own record of attendance to demonstrate compliance as part of the appraisal process. Staff who fail to attend Statutory and Mandatory training for any reason must report this to their line manager and re-book.

Statutory and Mandatory training is a critical component of everyone's role and failure to comply with minimum standards will be considered a breach of terms and conditions of employment and may be dealt with under the *Trust Disciplinary Policy and Procedure*.

3.5 Learning and Development Department

The Learning and Development Department is responsible for the booking, monitoring and reporting of attendance at Statutory and Mandatory Training.

Learning and Development will work with training providers, facilitators, subject leads and key stakeholders to define, maintain and change statutory and mandatory training provision to ensure that provision is made in the most effective and efficient way. Activities, updates and changes will be reported to the Workforce and/or Health and Safety Committees where ratification is required.

The Learning and Development Department carries out evaluation of the statutory and mandatory training programme. This is on a random basis and the information is shared with course facilitators for training development.

The Learning and Development Department maintain training records on the Learning Management System which is updated on a daily basis.

The Learning and Development Department generate the compliance reports required for information to the Board, Health and Safety Committee and other Committees who oversee Statutory and Mandatory training compliance as required.

3.6 Trust Board, Workforce Committee and Health and Safety Committee

The Trust Board, Workforce Committee and Health and Safety Committee will be responsible for receiving the monthly Statutory and Mandatory training reports and reviewing compliance against this policy and agreeing recommendations for changes required for effective and cost efficient compliance.

3.7 Trust Training Facilitators and Subject leads

Trust training facilitators and subject leads are responsible for ensuring that they provide up to date robust training sessions which are fit for purpose and comply with current law and practice. They are also responsible for ensuring that maintain the appropriate levels of competence to deliver their training sessions. Facilitators will ensure that attendance at training is recorded accurately so that compliance against this policy can be measured and forward records immediately to the Learning and Development Administration team for recording.

Facilitators are also responsible for reporting on compliance against the specific policy their training is designed to support. The Learning and Development Department will provide facilitators with access to compliance reports through the Learning Management System to assist in the production of action plans to address compliance.

10.0 Training / competency requirements

It is the responsibility of a document lead to ensure that any policy or procedure they are preparing for the Trust includes consideration for the provision of training or guidance for managers and staff and that Learning and Development are included in the consultation process. Leads must ensure that sufficient training places/resources can be made available to meet the demand created by the policy or procedure they produce.

11.0 Procedure

5.1 Training needs analysis

Learning and Development produced a core statutory and mandatory training needs analysis to identify the risk management training requirements for all staff documented in the *Training Matrix* (**APPENDIX FOUR**) and the *Statutory and Mandatory Training Matrix for Medical Staff* (**APPENDIX FIVE**). Both documents indicate the training requirement and frequency for each staff group. The *Guide to Statutory and Mandatory Training Provision* (**APPENDIX SIX**) gives information on how staff can access the core training requirements.

The initial training needs analysis for each document was produced by collating legislative training requirements (statutory training) and external assurance frameworks that inform Trust policy documents (mandatory training). Further changes will be proposed on the basis of legislative, Trust, Subject lead and stakeholder recommendations. Proposed changes to the training needs analysis will be submitted to the Health and Safety Committee on the basis of internal and external developments and if ratified will be reissued on a trust-wide basis as necessary.

The matrix identifies core Trust Statutory and Mandatory requirements, however it is not exhaustive and role specific needs will be discussed with the line manager at Local Induction and specific role training and compliance can be viewed online using the Trust's learning management system.

5.2 Delivery of statutory and mandatory training

Training is delivered via a rolling programme of multi-topic training days for clinical and non-clinical staff covering core statutory and mandatory training subjects, e-learning, handbooks and toolbox talks to ensure there is a wide variety of accessible training available and out of hours provision. A prospectus and dates are published on the Learning Management system which can be viewed by all staff.

The Matrix identifies core Trust Statutory and Mandatory requirements, however it is not exhaustive and role specific needs will be discussed with the line manager at local induction.

Managers and staff will agree individuals' mandatory training requirements in accordance with the Core Statutory & Mandatory Training Policy and record and monitor these as part of the annual appraisal process.

Independent contractors will be treated in line with the *Control of Contractors Policy and Procedure* section 8.

5.3 Procedure for attendance

The line manager and employee will agree the date for training and the Learning and Development Administration team will book the employee onto the relevant training programme. The employee attends the training course and the trainer will collect the attendance sheets and forward these to the Learning and Development Department who record that the employee is up to date with their statutory and mandatory training.

The Trainer may also decide for those staff who have not completed the full course whether the level of attendance can be considered sufficient. This may result in staff needing to repeat book a course/session.

Compliance will be monitored in line with Section 5.5 of this policy.

5.4 Non-attendance

The Learning and Development department will notify line managers if their staff fail to attend booked training so that this can be followed up and re-booked. Failure to attend the re-scheduled date should be documented in the individual's personnel file. Staff who fail to undertake training and become non-compliant will be dealt with in line with section 5.6 of this policy.

It is recognised that on occasions domestic and operational requirements can impede attendance at a training session. It is important that if staff are unable to attend a training session or are unable to complete a training course, they or their manager inform the Learning and Development Administration team as soon as possible with a valid reason for non-attendance of the course/session.

If a cancellation occurs on the day the course is due to commence, it will be recorded as a Did Not Attend (DNA) and will be reported to the line manager.

Staff should note that failure to attend without informing their line manager is potentially a disciplinary offence.

5.5 Monitoring arrangements

The Trust Learning Management System is a database which will manage the administrative requirements of training events, qualifications and professional development courses within the Trust. It stores all information related to Trust delivered training courses such as bookings, time and place of delivery, learning objectives and tracks outstanding and completed training. The system will be used to analyse and produce reports such as course completion and outstanding training for all statutory and mandatory training and for Trust Board and other committee assurance.

The database will be administered by the Learning and Development Department and will provide the following functionality:

- Managers and staff will be able to access their training records through the system online enabling them to plan their schedule of training and keep track of what training has been completed.
- Managers will be able to run compliance reports to check which staff require updating;
- Facilitators/subject leads will be able to access compliance reports to assist with their training action plans;

In addition the Learning and Development team will use the system to monitor compliance as follows:

1. Email reminders for compliance update will be sent to staff and managers for action
2. Reminders will be sent for each subject on a monthly basis
3. Reminders will be audited every quarter
4. Managers and staff who have received three reminders and still remain non-compliant will be escalated to the directorate lead for investigation
5. If the directorate lead is unable to attain compliance upon investigation, this will be reported to the Chief Operating Officer and the Directorate HR Business Partner for formal investigation

The Trust aims for 85% compliance, however areas with less than 75% compliance will be asked to provide an action plan to the Health and Safety Committee and/or Workforce Committee to recover their position.

5.6 Non-compliance

In the first instance, line managers must address non-compliance with their staff member and continued non-compliance should initiate disciplinary action. If the continued non-compliance is escalated to the directorate lead for investigation it may be necessary to suspend staff with high risk non-compliance.

In addition as part of the annual appraisal process, staff will be prohibited from receiving the annual pay progression under Agenda for Change if they are not able to demonstrate compliance. Staff will also be denied funding for other training until their mandatory training obligations have been met.

5.7 Course content

Trust training facilitators and subject leads are responsible for ensuring that they provide up to date robust training sessions which are fit for purpose and comply with current law and best practice to maintain the health and safety of staff and patients. Learning and Development will discuss any feedback arising from evaluations and audits with the relevant lead.

5.8 Process for the development of action plans

Action plans will be created by Directorate leads and/or Subject leads/Facilitators and/or Learning and Development dependant on the required outcome as directed by the Workforce and/or Health and Safety Committee. These will be reviewed and monitored on a regular basis for compliance by the Health and Safety and/or Workforce Committee.

5.9 Process for the development of a training prospectus

The Learning and Development team will collate information from facilitators to update course content on the Learning Management System. The system automatically generates flyers and a prospectus for viewing online or for printing. The prospectus is a live document and will update information and dates as the system is updated.

12.0 Monitoring and audit

The Director of Strategy and Workforce as Chairman of the Workforce Committee, supported by the Learning and Development Manager, will be responsible for monitoring the compliance with this Policy / Procedure on behalf of the Trust. Information on Directorate compliance will be provided to the Trust Board on a monthly basis.

What needs monitoring?	Who will lead on this aspect of monitoring?	What tool will be used to monitor/check that everything is working according to this element of the policy?	How often will we need to monitor/ frequency?	To who or what committee will the results be reported (for information and action)?	Who will undertake the action planning for deficiencies and recommendations?	How will changes be implemented and lessons shared?
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Action Lead(s)**	**Change in practice and lessons to be shared**
Training Needs Analysis (TNA)	Learning and Development Manager	AT-Learning (AT-L)	Ongoing by Learning and Development, Facilitators/Subject leads and key Stakeholders	Workforce Committee, Health and Safety Committee	Learning and Development, Facilitators/Subject leads and Key Stakeholders	Reports to relevant Committee e.g. changes to Infection Prevention are reported to IPC Committee, Trustwide communications
Training Prospectus	Learning and Development Manager	AT-L	Ongoing live document through AT-L	Workforce Committee	Learning and Development Manager	Through feedback from Staff and Facilitators/Subject leads to Learning and Development Team and Trustwide communications

What needs monitoring?	Who will lead on this aspect of monitoring?	What tool will be used to monitor/check that everything is working according to this element of the policy?	How often will we need to monitor/ frequency?	To who or what committee will the results be reported (for information and action)?	Who will undertake the action planning for deficiencies and recommendations?	How will changes be implemented and lessons shared?
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangements**	**Action Lead(s)**	**Change in practice and lessons to be shared**
Action Plans to deliver training identified in TNA	Learning and Development, Facilitators/ Subject leads and Senior Directorate Managers	AT-L	Monthly reports to Board, bi-monthly reports to Health & Safety Committee	Workforce Committee Health and Safety Committee Standards Committee Other relevant Committees	Learning and Development, Facilitators/Subject leads and Senior Directorate Managers	Ratification and reporting through relevant Committee
Check permanent staff have completed relevant training	Learning and Development	AT-L	Monthly	Workforce Committee Health and Safety Committee Standards Committee Other relevant Committees	Learning and Development, Facilitators/Subject leads and Senior Directorate Managers	Through the Workforce Committee
Follow up on non compliance	Learning and Development,	AT-L	Monthly	Workforce Committee Health and Safety Committee	Learning and Development, Facilitators/Subject leads and Senior Directorate Managers	Through the Workforce Committee and/or Health and Safety Committee
Co-ordination of Training Records	Learning and Development Manager	AT-L	Ongoing	Workforce Committee	Learning and Development Manager	Through Learning and Development

APPENDIX ONE

Process requirements

1.0 Implementation and awareness

This policy and procedure should be implemented with immediate effect.

- This policy will be bought to the attention of all key staff detailed in Appendix Two via the email system of dissemination. It will also be presented to members of the Health & Safety Committee and Standards Committee for comment.
- The policy will be approved by the Senior HR Meeting Committee and ratified by the Workforce Committee.
- Once approved the document lead or author will submit this policy/procedural document to the Clinical Governance Assistant who will activate it on the Trust approved document management database on the intranet, under 'Trust polices, procedures and leaflets'.
- A monthly publications table is produced by the Clinical Governance Assistant which is published on the Bulletin Board (Trust intranet) under "Trust Publications"; notification of the posting is included on a bi-weekly Bulletin Board round-up email, circulated Trust wide by the Communications team.
- On receipt of the Trust wide Bulletin Board notification all managers should ensure that their staff members are aware of the new publications.

2.0 Review

This policy / procedure will be reviewed once every five years with the next review due in June 2019 (subject to any change in legislative requirements).

3.0 Archiving

The Trust intranet (Q-Pulse) retains all superseded files in an archive directory in order to maintain document history.

APPENDIX TWO

CONSULTATION ON: Core Statutory and Mandatory Training Compliance

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Learning and Development Manager

By date: 15th October 2013

Job title: *List staff to be included in the consultation. See Section 5.5 of the "Production, Approval and Implementation of Policies and Procedures" policy and procedure for guidance.*	**Date sent dd/mm/yy**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff MUST be included in ALL consultations:				
Clinical Governance Assistant	16.09.13	26.09.13	Y	Y
Chief Pharmacist (if pharmacy/prescribing issues are included in the document)				
Please list key staff whose reply is compulsory before approval can be granted:				
Chief Operations Officer	30.09.13			
Director of Nursing	30.09.13			
Risk Manager	30.09.13			
Head of Infection Prevention and Control	30.09.13			
Quality and Patient Safety Manager	30.09.13			
Associate Director of Workforce	30.09.13			
HR Business Partner	30.09.13			
Staff Side Chair	30.09.13			
Please list other staff to be included in the consultation but whose reply is not compulsory:				
Members of the Board	30.09.13	02.10.13	N	
Members of the H&S Committee	30.09.13	04.10.13	Y	Y
Senior Nurse - Practice Development	30.09.13	17.10.13	Y	Y
Matrons	30.09.13			
Clinical Directors	30.09.13	30.09.13	Y	Y
General Managers	30.09.13	01.10.13	N	
The role of those staff being consulted upon as above is to ensure that they have shared the policy for comments with all staff within their sphere of responsibility who would be able to contribute to the development of the policy.				

APPENDIX THREE

Equality Impact Assessment

In line with race, disability and gender equalities legislation, public bodies like MTW are required to assess and consult on how their policies and practices affect different groups, and to monitor any possible negative impact on equality.

The completion of the following Equality Impact Assessment grid is therefore mandatory and should be undertaken as part of the policy development and approval process. Please consult the Equality and Human Rights Policy on the Trust intranet, for details on how to complete the grid.

Please note that completion is mandatory for all policy development exercises. A copy of each Equality Impact Assessment must also be placed on the Trust's intranet.

Title of policy or practice	Core Statutory and Mandatory Training Policy and Procedure
What are the aims of the policy or practice?	To ensure that all staff receive at least the minimum training required according to Risk Management Standards
Identify the data and research used to assist the analysis and assessment	Analysis and assessment will be based on reported training compliance.
Analyse and assess the likely impact on equality or potential discrimination with each of the following groups.	**Is there an adverse impact or potential discrimination (yes/no). If yes give details.**
Males or Females	No
People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	No
People who do not speak English as a first language	No
People who have a physical disability	No
People who have a mental disability	
Women who are pregnant or on maternity leave	No
Single parent families	No
People with different sexual orientations	No
People with different work patterns (part time, full time, job share, short term contractors, employed, unemployed)	No
People in deprived areas and people from different socio-economic groups	No
Asylum seekers and refugees	No
Prisoners and people confined to closed institutions, community offenders	No
Carers	No
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	
When will you monitor and review your EqIA?	Alongside this policy/procedure when it is reviewed.
Where do you plan to publish the results of your Equality Impact Assessment?	As Appendix 3 of this policy/procedure on the Trust approved document management database on the intranet, under 'Trust policies, procedures

	and leaflets'.

FURTHER APPENDICES

The following appendices are published as related links to the main policy /procedure on the Trust approved document management database on the intranet (Trust policies, procedures and leaflets):

No.	Title	Unique ID
4	Core statutory & mandatory risk management training matrix	RWF-OWP-APP526
5	Medical staff statutory and mandatory training matrix	RWF-OWP-APP528
6	Guide to statutory and mandatory training provision	RWF-OWP-APP712