Maidstone and Tunbridge Wells NHS Trust

Ref: FOI/GS/ID 6942

Please reply to:
FOI Administrator
Trust Management
Maidstone Hospital
Hermitage Lane
Maidstone, Kent
ME16 9QQ
Email: mtw-tr.foiadmin@nhs.net
www.mtw.nhs.uk

04 October 2021

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 Protocols and policies regarding the care of transgender people.

You asked:
1) Any equality and/or diversity policies you have in place for patients.
2) Any equality and/or diversity policies you have in place for staff.
3) Any guidelines, protocols, policies, or similar relating to care provision for transgender adults.
4) Any guidelines, protocols, policies, or similar relating to care provision for transgender children and adolescents.
5) Any guidelines, etc. relating to mental capacity and/or informed consent.
6) Any guidelines, etc. relating to shared care agreements and/or working with private services to facilitate treatment, particularly with regards to transgender healthcare.

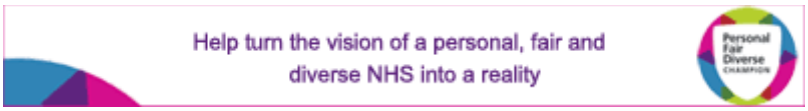
Trust response:

Please find embedded within this response the documentation requested.

The Trust embed this information in order for it to show once the response has been added anonymously to our website.

Equality and diversity policy and procedure (incorporating Single Equality Scheme (SES))

Requested/ Required by:	Workforce Committee
Author:	HR Business Partner **Contact Details:** [redacted]
Other contributors:	Staff Side Representative
Owner:	Director of Workforce
Directorate:	Corporate
Specialty:	Workforce
Supersedes:	Single Equality Scheme (Version 1.0, April 2011) Single Equality Scheme (Version 2.0, September 2013)
Approved by:	HR Senior Meeting, 20 August 2013
Ratified by:	Workforce Committee, 9 September 2013
Review date:	September 2018 [**Extension to June 2021** approved by the Chair of the Joint Consultative Forum on 4th December 2020, following the arrangements for extension as set out in the 'Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for policies') - RWF-OPPPCS-NC-CG25]



This policy has been written for implementation during periods of standard functioning within the Trust. Outside of those periods (such as major incidents or national emergencies) other 'emergency' policies may be written to supersede or run alongside this policy.

Document history

Requirement for document:	We have a responsibility to ensure that we do not discriminate either in the recruitment and retention of staff or in the services we provide. Some of the legislation which supports our work with equalities and diversity includes: • The Disability Discrimination Act 1995 (DDA) • The Race Relations Act 1976 (as amended) • The Sex Discrimination Acts 1975 & 1986 (SDA) • The Gender Recognition Act 2004 • The Carers (Equal Opportunities) Act 2004 • The Equality Act 2006 • The Civil Partnership Act 2004 • The Human Rights Act 1998 (HRA) • The Equal Pay Act 1970 (EPA) • The Employment Equality (Religion & Belief) Regulations 2003 • The Employment Equality (Sexual Orientation) Regulations 2003 • The Employment Equality (Age) Regulations 2006 • The Equality Act (Sexual Orientation) Regulations 2007 • The Racial and Religious Hatred Act 2006 This legislation places specific obligations on public sector organisations, which we cannot ignore. These are mandatory requirements, known as general and specific duties. The aim of the duty is to make equality central to the way public authorities work, and to put it at the heart of policymaking, service delivery and employment practice. The duty has three key aspects: 1. To eliminate unlawful or unfair discrimination or harassment 2. To promote equality of opportunity for all 3. To promote good relations between people from different minority groups. In meeting the duty, MTW has elected to produce a Single Equality Scheme (SES) which encompasses all six areas of legislation.
Cross references (external):	• Department of Health. (2009). Single Equality Scheme 2009-2012
Associated documents (internal):	• Equality and Human Rights Policy [RWF-OPPPCS-NC-WF11] • Equality and Human Rights Procedure [RWF-OPPPCS-NC-WF49] • Equality Impact Assessment Toolkit [RWF-OWP-APP575]

Version control:		
Issue:	**Description of changes:**	**Date:**

1.0	First version of this policy (Single equality scheme [RWF-OPPPCS-NC-WF14])	April 2011
2.0	Reviewed and updated; Single equality scheme incorporated into this policy and procedure	September 2013
2.1	**Extension to June 2021** approved by the Chair of the Joint Consultative Forum on 4th December 2020	December 2020

Policy statement for

Equality and diversity policy

Maidstone and Tunbridge Wells NHS Trust is proud to serve a diverse population and to employ a diverse workforce. It is fully committed to promoting equality of opportunity, access, dignity and respect in the services it provides and in its workforce strategy and employment practices.

We know that discrimination and poor access can have a detrimental impact upon the health of communities and that the needs of those communities and how they experience the NHS differ. Therefore our Single Equality Scheme (SES) (see **Appendix 4**) sets out plans to address any potential for discrimination. It also sets out our action plans (see **Appendix 5**) for equality and diversity in terms of race (ethnicity), disability, age, gender, sexual orientation, religion and belief.

The Single Equality Scheme outlines the Trust's objectives and actions over the next 3 years and includes its duties in respect of the specific strands of equality legislation.

The Single Equality Scheme will provide internal strategic direction, challenge attitudes and assumptions, encourage strategic partnerships, widen ownership and demonstrate commitment, particularly from the Trust's leadership. The scheme has taken on board the contributions of staff and community stakeholders in its development to reflect the priorities and concerns of diverse communities.

By adopting this Single Equality Scheme, the Trust Board has clearly acknowledged its support and commitment for the Scheme and the delivery of the action plans.

Equality and diversity procedure

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5	Singe Equality Scheme action plans
6	Equality Impact Assessments Toolkit

1.0 Introduction and scope

Maidstone and Tunbridge Wells NHS Trust is committed to delivering the very highest standards of access and care to patients from a diversity of cultures, different age groups and with a wide range of abilities and needs. We want to lead in the field of equality, diversity and human rights within the local healthcare economy and the community that we serve to become the healthcare provider of choice.

We are equally committed to being the employer of choice for existing employees and those wishing to work for us, enabling every individual working within the Trust to maximise their potential and contribution to the organisation.

The Single Equality Scheme (see **Appendix 4**) underpins the Trust's Equality & Diversity Policy and Procedure and ensures that clear objectives and action plans (see **Appendix 5**) are in place to support our commitment to ensure that we proactively develop a culture which is diverse; where individual differences are valued and respected; and to develop our services and workforce to reflect the communities that we serve.

We will take all reasonable steps to ensure there is no unlawful or unfair discrimination towards patients, communities and staff in relation to the nine characteristics protected by the Equality Act 2010:

- Age
- Disability including physical and mental impairment
- Gender re-assignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race including nationality and ethnicity
- Religion or belief
- Sex
- Sexual orientation

2.0 Definitions

2.1 People who are protected from discrimination on the basis of any of the nine characteristics listed above are described in this document as belonging to one or other "protected group".

3.0 Duties

3.1 **Members of staff** are expected to observe this policy, regardless of their role or employment status, and to behave appropriately towards other staff members and members of the public, in particular they are expected to:

- Support and implement the principles of equity and fairness
- Report any incident or behaviour which contravenes this policy and not indirectly support unfair treatment by ignoring what is happening around you
- Treat all staff, managers, patients, visitors and members of the public with dignity and respect

3.2 **Managers** have a responsibility for ensuring that this policy is fairly and consistently applied by them and they should ensure that:

- They are aware of the contents and importance of observing the principles of equality and diversity
- They eliminate any unfair practices of which they are aware, whether or not a complaint has been made
- Any allegations of discriminatory behaviour or practices are properly investigated, all relevant documentation retained and, disciplinary action taken (where appropriate) in a non-discriminatory manner.
- They are good role models of best practice for their staff.

3.3 **Human Resources staff** are responsible for providing advice and guidance to staff and managers on the application and effective implementation of this policy. They are also responsible for ensuring that the duty to promote is observed and actioned where necessary and the general duties of the equality legislation are observed.

3.4 **Legal liability**
Individual members of staff can be held personally liable for acts of unlawful discrimination.

3.5 The Trust, as an employer, may be liable for any act of unlawful discrimination committed by you during the course of your employment, unless it can be proved that all reasonable and practicable steps had been taken to prevent such an act from occurring. This also extends to a social setting, where staff are together because of their connection to work, for example, a leaving function.

3.6 The Trust has a primary legal and moral responsibility for ensuring that discrimination does not occur.

4.0 Training / competency requirements

4.1 All staff employed by the Trust are required to undertake Equality & Diversity training, this can be completed via e-learning or attending a

face to face training session delivered by Human Resources staff. All existing staff are required to undertake this training every three years and it also forms part of the Trust Induction programme for new staff.

5.0 Procedure

5.1 It is recognised that in serving diverse communities, the Trust needs to recruit and retain the right people with the right skills to deliver high quality care. This can be best achieved through a workforce that reflects the community that we serve. The Trust's values are centred on developing a personal, fair and diverse culture:

- We always put the patient first
- We respect and value our patients, visitors and staff
- We take every opportunity to improve services
- We aim to deliver high standards of quality and efficiency in everything we do
- We take every opportunity to enhance our reputation

5.2 Our aim is to engender an organisational culture that is good for all people, treating everybody with respect and dignity, promoting fairness, ensuring that our core standards of behaviour are reflected in all of our dealings with those who come into contact with the Trust.

5.3 We are committed to the principles of the Equality and Human Rights Commission (EHRC).

5.4 We believe that staff can achieve their full potential in an environment where all staff, regardless of their role, are valued and treated with dignity and respect. This is embedded in the Trust's values as detailed above. All staff working within the NHS are also expected to abide by the Nolan Committees Standards on Public Life: selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

5.5 Staff diversity will be viewed positively and in recognising that everyone is different, The Trust will value equally the contribution that individuals from different backgrounds can make. We will seek to engage with and support staff more widely through the development of local networks and also engagement and representation at Regional Networks, such as the SEC BME Network.

5.6 We are committed to equal opportunities for all. Our aim is to ensure that no patient, carer or visitor to the Trust, job applicant or member of staff, is discriminated against on the grounds of:

- Gender, sexual orientation or gender reassignment
- Part-time working
- Marital status
- Pregnancy, maternity or paternity
- Race, colour, nationality, national or ethnic origin
- Disability
- Religion or belief
- Age

- Membership/non-membership of a Trade Union

5.7 Selection for employment, training and promotion will be based solely on objective and job related criteria.

5.8 If you have a disability or develop a disability during your time working with the Trust, we will make reasonable adjustments to prevent you from being placed at a substantial disadvantage in all aspects of employment.

5.9 We are keen to resolve concerns raised by staff at an early stage. If you believe that you have been discriminated against, victimised or harassed, by staff or patients, on any of the grounds identified above then you should speak to your line manager in the first instance. The HR Directorate, Occupational Health and your staff or Trade Union representative will also be able to support you and help you to understand the options available to you through the appropriate Trust policies.

5.10 Equality and Diversity is implicit within all of the Trust's employment policies and these are all Equality Impact Assessed and regularly reviewed to ensure there is no element of bias or discrimination. The process for Equality Impact Assessments can be found in **Appendix 6** (Equality Impact Assessments Toolkit).

6.0 Monitoring and audit

6.1 This policy and procedure will be monitored on an on-going basis by the HR Department via:

- Analysis of equality and diversity data captured in relation to both staff and patients
- Feedback from staff, managers and HR staff who have used the policy
- Feedback from Diversity Steering Group(s)
- Monitoring of equality impact assessments

APPENDIX ONE

Process requirements

1.0 Implementation and awareness

- 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.

- This policy will be included on the Trust's intranet with other employment policies. It will also be publicised in updates on policies and form an integral component at Staff Induction and orientation.
- All staff briefed by their respective managers on the main aspects of this policy.
- Further promotion via trust communication methods e.g. team brief, trust news and trust e-mail bulletin

2.0 Review

To be reviewed five years after approval/ratification or sooner if monitoring highlights the need and/or changes in legislation.

3.0 Archiving

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

APPENDIX TWO

CONSULTATION ON: Equality & Diversity Policy and Procedure

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: HR Business Partner (DL)

By date: 18th July 2013

Name:	**Date sent**	**Date reply received**	**Modification suggested? Y/N**	**Modification made? Y/N**
The following staff MUST be included in ALL consultations:				
Local Counter Fraud Specialist	27/06/2013			
Clinical Governance Assistant	27/06/2013	03/07/2013	Y	Y
Staff-side Chair (AK)	23/05/2013	29/05/2013	Y	Y
Medical Staff-side Chair (MB)	27/06/2013			
Director of Strategy & Workforce	27/06/2013			
Associate Director of Workforce	23/05/2013			
Head of Employee Services	27/06/2013			
HRBP Team	23/05/2013			
ADO's/Heads of Nursing	27/06/2013			
GM's/Matrons/Heads of Service	27/06/2013			
JCF Members	27/06/2013			
JMNC Members	27/06/2013			
Head of Communications	27/06/2013			
Head of Quality & Governance	27/06/2013			
Director of Nursing	27/06/2013			
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

The duty to undertake Equality Impact Assessments is a legal requirement under the Equality Act and covers nine protected characteristics on the grounds upon which discrimination is unlawful

The completion of the following Stage One - 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 Diversity Policy on the Trust intranet, for details on how to complete the grid and to determine whether a Stage Two assessment is required.

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, service, function, project or proposal	Equality and Diversity Policy and Procedure
Department	Human Resources
Lead officer for assessment	HR Business Partner (DL)
What is the main purpose of the policy/service/function/project/proposal?	This policy sets out the Trust's commitment to delivering the very highest standards of access and care to patients from a diversity of cultures, different age groups and with a wide range of abilities and needs. It also demonstrates our commitment to recruiting and retaining a diverse workforce and becoming an employer of choice.
List the main activities of the policy or service redesign (e.g. Manual Handling would relate to health and safety of patients; health and safety of staff; compliance with NHS and Government legislation or standards etc).	As above and to ensure that the Trust meets its duties in respect of the specific strands of equality legislation for public sector organisations
Is the policy or service relevant to: - **Promoting Good Relations between different people?** **Eliminating discrimination?** **Promoting Equality of Opportunity?**	 Yes Yes Yes
Which groups of the population do you think may be affected by this policy/proposal etc?	**Is there an adverse impact or potential discrimination (yes/no).** **If yes give details.**
Women and men	No
People of different ages	No
Minority ethnic people	No
People in different religious/faith groups	No
People who do not speak English as a first language	Yes as they may have difficulty reading the policy but an interpreter can be sourced / provided.
People who have a physical disability	Yes, this document can be produced in Braille should this be required for the sight impaired.
People who have a mental disability	Yes as they may have difficulty understanding the policy but assistance can be sourced to aid understanding if necessary.
Women who are pregnant or on maternity leave	No

Single parent families	No
Lesbian, gay, bisexual and transgender people	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
Do you have any information that tells you of the current use of this policy/ service?	Yes/No (if yes please detail) Yes impact of Equality & Diversity policy is assessed through our Trust KPI's relating to Equality
Is it broken down by the protected characteristics, i.e. ethnicity, gender, disability etc?	Yes/No (please detail) Yes our Equality KPI's are broken down into the nine protected characteristic groups and monitored for any adverse impact
Does this information reflect the proportions from the 2001 Census? If there is no information available or if this is patchy, specify the arrangements that will make this available.	Yes/No (if no, can you explain why) Trust Equality KPI's will be assessed against Census data annually to determine whether there is any potential discrimination against minority groups
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	The potential discrimination identified above is minimal and justifiable and therefore a Stage 2 assessment is not required.
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 (QPulse).

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	Single Equality Scheme	RWF-OPPPCS-NC-WF14
5	Single Equality Scheme action plans	RWF-OPPM-CORP143
6	Equality Impact Assessment Toolkit	RWF-OWP-APP575

Single Equality Scheme (SES)

2012-2015

Help turn the vision of a personal, fair and diverse NHS into a reality

Chairman: David Highton Chief Executive: Miles Scott
Trust Headquarters: Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ
Telephone: 01622 729000 / 01892 823535

FOREWORD

We are pleased to introduce the Maidstone & Tunbridge Wells NHS Trust's Single Equality Scheme (SES). This is an updated version of the first Single Equality Scheme produced by the Trust in 2011, and focuses on embedding a culture of equal opportunity for all and sets out how we will meet our obligations under equality legislation over the next three years.

Ensuring that equality is at the heart of our organisation is essential if we are to successfully fulfil our responsibilities and duties as both an employer and health care provider of choice.

We are committed to a full review of our SES every 3 years and progress against our equality objectives and action plans will be incorporated into our workforce key performance indicators. The SES Action Plan [RWF-OPPM-CORP143] will link into our operational plans and progress will be monitored through an Equality & Diversity Steering Group, as well as changes in legislation and any significant workforce or service changes that may impact on our action plans.

It is the responsibility of all staff to proactively promote the Trust's approach to the implementation of the Single Equality Scheme.

1.0 INTRODUCTION

1.1 Maidstone & Tunbridge Wells NHS Trust is an acute Trust providing high quality health care for the community that we serve. We provide services from two major sites across Kent: Maidstone Hospital and Tunbridge Wells Hospital at Pembury.

1.2 The Trust employees a workforce of some 5000 staff and provides care for more than 660,000 people every year from Maidstone, Tunbridge Wells and surrounding areas. The resident population is 51% female and 49% male and the Black and Ethnic Minority population for the catchment area is around 3%. The population is projected to increase by more than 50,000 by 2022. In general rates of deprivation are relatively low.

1.3 The Trust has two main hospital sites:

- Maidstone Hospital in Maidstone
- Tunbridge Wells Hospital in Pembury

The Trust provides a full range of general hospital services to a population of approximately 500,000 people living in the south of west Kent and parts of north east Sussex. Many of the people we serve live in the Maidstone and Tunbridge Wells areas. In addition, the Trust

provides specialist cancer services, through its flagship cancer centre at Maidstone and unit at Kent & Canterbury Hospital, for the whole of Kent, Hastings and Rother, about 1.8 million people.

1.4 MTW is at the forefront of developments in minimally invasive laparoscopic surgery in the NHS and is increasing the range of other highly specialised services available locally to patients, including centres of expertise in trauma (emergency surgery), maternity, paediatrics (children's inpatient care) orthopaedics and planned complex surgery.

1.5 We employ a team of approximately 4,750 whole time equivalent staff and our Accident & Emergency Departments at both hospital sites have approximately 119,000 attendances per year, and the Trust treats approximately 84,000 inpatients per year and 387,500 outpatients.

1.6 The immediate geographical area that the Trust serves is characterised by the diversity of its population and by stark contrasts in health. Tunbridge Wells is amongst the most affluent. International migration of people with widely different backgrounds significantly impacts on health and social care services increasing the challenge to addressing health inequalities. The background of immigrants covers a broad spectrum however in Maidstone there is a greater emphasis on the number of poorer economic migrants, refugee and asylum seekers and the homeless. This is an additional challenge to achieving equal access to health and social care services.

1.7 The 2007 Index of Deprivation shows that those poorest areas are becoming relatively more deprived over time. To meet these challenges, the Trust works in partnership with other NHS organisations in the local health economy area. The Trust recognises the need to reach residents across the whole catchment area to support awareness and equality of access to the full range of our services.

1.8 The Trust's vision is simple, we aim to deliver high quality care for all and be the health care provider of choice. We will achieve this by ensuring patient safety is at the forefront of everything we do; that the rates of avoidable healthcare associated infections are reduced; that we listen to and actively engage with our service users and stakeholders; develop wider user involvement to influence care delivery and improve clinical effectiveness facilitated by using national benchmarks. This vision is supported by our Trust Values "PRIDE":

- We always put the patient first
- We respect and value our patients, visitors and staff

- We take every opportunity to improve services
- We aim to deliver high standards of quality and efficiency in everything we do
- We take every opportunity to enhance our reputation

1.9 To deliver this, it is important that we ensure that the needs of patients, users and staff are met when designing and delivering our services. Our workforce strategy clearly outlines the Trust's commitment to developing a culture which is diverse, where individual differences are valued and respected, and to further develop a workforce at all levels in the Trust including the Trust Board which reflects the community we serve.

2.0 PURPOSE

2.1 The Trust has a number of statutory public duties to promote equality. These duties consist of general duties and specific duties. The purpose of the specific duties is to help the Trust to meet our obligations under the general duties.

2.2. The purpose of the Single Equality Scheme (SES) is to set out the way in which the Trust will meet these duties and the requirements of the Equality Act which came into force on 1st October 2010.

2.3 The Equality Act brings together over 116 separate pieces of legislation into one single Act. Combined, they make up a new Act that provides a legal framework to protect the rights of individuals and advance equality of opportunity for all. The Act simplifies, strengthens and harmonises the current legislation to provide Britain with anew discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society.

2.4 The nine main pieces of legislation that have merged are:

- The Equal Pay Act 1970
- The Sex Discrimination Act 1975
- The Race Relations Act 1976
- The Disability Discrimination Act 1995
- The Employment Equality (Religion or Belief) Regulations 2003
- The Employment Equality (Sexual Orientation) Regulations 2003
- The Employment Equality (Age) Regulations 2006
- The Equality Act 2006, Part 2
- The Equality Act (Sexual Orientation) Regulations 2007

2.5 The aim is to develop measures and actions that ensure discrimination does not occur and to positive promote equality. An action plan to deliver the Single Equality Scheme can be found on Q-Pulse [RWF-

OPPM-CORP143], published as an appendix to the *Equality and diversity policy and procedure (incorporating Single Equality Scheme (SES))*.

3.0 WHAT IS A SINGLE EQUALITY SCHEME?

3.1 A Single Equality Scheme is a plan that outlines the action we will take over a period of time, aiming to address aspects of the general duty as outlined in the equalities legislation. The general duty is a positive duty that builds equality into the beginning of the process of policy making rather than making adjustments at the end of the process. It represents a change from a legal framework where the onus is on the individual to bring a complaint of discrimination to one where the onus is on us as an organisation to seek out actual or potential discrimination and address it.

4.0 EQUALITY LEGISLATION AND THE GENERAL STATUTORY DUTIES

4.1 There are three general duties that underpin the Single Equality Scheme. There are also specific duties required under the general duties, which we will adhere to. The general duties are:

4.2 <u>The Race Relations Amendment Act 2000: Race Equality Duty</u>

4.2.1 The Trust has a statutory duty to promote race equality with due regard to the need to:

- Eliminate unlawful discrimination
- Promote equality of opportunity
- Promote good relations between people of different racial groups

4.2.2 This general duty also applies to the Trust in our work with partner organisations (whether they are public, private or voluntary).

4.2.3 The Trust must also meet the following specific duties:

- Prepare and publish a Race Equality Scheme or Policy which states how it will meet the general duty in the areas of policy and service delivery; and
- Monitor specific employment procedures by racial group

4.3 <u>The Disability Discrimination Act 2005: Disability Equality Duty</u>

4.3.1 Section 49a of the Disability Discrimination Act has a General Duty which requires the Trust to have due regard to the need to:

- Promote equality of opportunity between disabled people and other people

- Eliminate discrimination that is unlawful under the Disability Discrimination Act
- Eliminate harassment of disabled people that is related to their disability
- Promote positive attitudes towards disabled people
- Encourage participation by disabled people in public life; and
- Take steps to meet disabled people's needs, even if this requires treatment that is more favourable

4.3.2 The Trust must also meet its specific duties which include:

- Prepare and publish a Disability Equality Scheme or policy which states how it will meet the general duty in the areas of policy and service delivery
- Involve disabled people

4.3.3 The Disability Equality Duty requires the Trust to formally involve disabled people in the development of the Single Equality Scheme. We will achieve this through engagement of disabled stakeholders.

4.3.4 The law provides protection form discrimination for people of all ages who have mobility and sensory impairments; learning disabilities; mental health conditions and progressive conditions. It can also cover those with heart disease, diabetes, severe disfigurement, depression, schizophrenia, dyslexia, epilepsy and Down's Syndrome.

4.4 **The Sex Discrimination Act 1975 as amended by the Gender Equality Act 2006**

4.4.1 The Trust has a statutory general duty to promote gender equality with due regard to the need to:

- Eliminate unlawful sex discrimination and harassment that is unlawful under the Sex Discrimination Act 1975 (SDA) and in relation to employment and vocational training (including further and higher education), eliminate discrimination and harassment against transsexual individuals
- Eliminate discrimination that is unlawful under the Equal Pay Act 1970 and 1983
- To promote equality of opportunity between women and men
- Prepare and publish a Gender Equality Scheme or policy, which states how it aims to meet the general duty in the areas of policy and service delivery

4.4.2 The requirements to eliminate unlawful sex discrimination and harassment include discrimination and harassment on the basis of gender reassignment.

4.4.3 These duties apply to services, employment, policy development, procurement, performance management, organisational design and delivery and any corporate activity not explicitly exempt from the Acts.

4.5 The Trust will also progress action on age, religion or belief and sexual orientation to address any form of discrimination. Within the Single Equality Scheme action plans we will seek to:

- Eliminate discrimination on the grounds of age, religion or belief and sexual orientation
- Promote equality of opportunity

4.6 The statutory duties, as outlined above, are intended to assist public authorities to promote equality and thereby adhere to the terms of the equality legislation. The core requirements of this statutory duty are:

- The preparation of an equality scheme(s)
- Implementation of the equality scheme (via an action plan)
- Annual reporting on progress

4.7 The scheme aims to help the Trust to achieve a number of objectives. These are:

- Meet the requirements of the Equality legislation stated above and set out our plans to improve minority groups' access to employment and services
- Make sure that the needs and views of minority groups are taken into account when we design or deliver services, make access improvements or develop policies through our Equality Impact Assessments (see Appendix 6 of the *Equality and diversity policy and procedure (incorporating Single Equality Scheme (SES))*)
- Continually monitor and improve the ways we deliver services to minority groups and provide access to employment
- Meet the principles of the Social Model of Disability (see below).

4.8 <u>Social Model of Disability</u>

4.8.1 The Social Model of Disability has been developed by disabled people in response to the medical model and the impact it has had on their lives. The social model takes the approach of focusing on structures and the barriers that disabled people experience (for example, inaccessible transport, housing and education provision), and provides tools for dismantling and preventing these. Adopting the social model approach challenges authorities to move from a solely medical approach to disability, which concentrates on medical impairments as the main reason for the difficulties experienced by disabled people, to a social model approach which recognises the negative impact on

disabled people of a society designed for non-disabled people, and takes active steps to promote equality for disabled people.

4.9 The Human Rights Act 1998

4.9.1 Every person in the world is entitled to basic human rights and freedoms. They are based on core principles such as dignity, fairness, equality, respect and autonomy and are relevant to everything we do in our day to day lives. Human rights protect our freedom to control and take part in decisions taken by public bodies which impact on our rights and help us to get fair and equal services and outcomes from public bodies.

4.9.2 The Human Rights Act came into force in the UK in October 2000 and has two key aims:

- To bring most of the human rights contained in the European Convention on Human Rights into UK law. This basically makes it possible for people to raise or claim their human rights within the complaints and legal systems operating in the UK.
- To bring about a new culture of respect for human rights in the UK. The Act was intended to place human rights at the heart of public service delivery, and because of this, to make rights a reality for everybody in the UK.

4.9.3 The Human Rights Articles are:

- The right to life
- The right not to be tortured or treated in an inhuman or degrading way
- The right to be free from slavery or enforced labour
- The right to liberty
- The right to a fair trial
- The right to no punishment without law
- The right to respect for private and family life, home and correspondence
- The right to freedom of thought, conscience and religion
- The right to freedom of expression
- The right to freedom of assembly and association
- The right to marry and found a family
- The right not to be discriminated against in relation to any of the rights contained in the European Convention
- The right to peaceful enjoyment of possessions
- The right to education
- The right to free elections

5.0 OUR FRAMEWORK FOR EQUALITY

5.1 The Trust's Single Equality Scheme (SES) is based on eight core areas, these are:

- **Leadership and Corporate commitment** – Board level commitment to equality which champions the core diversity strands and supports our corporate aim to become the care giver of choice for the community we serve.
- **Strategy and Service** – To include making better use of technology and to look at solutions to ensure there is equitable access to services for everyone.
- **Patient and Public Involvement** – Involve Trust representatives and members of minority groups including local disability and BME forums and hard to reach groups, to advise and steer the direction of involvement initiatives.
- **Health and Assessment** – By engaging with hard to reach groups, the Trust becomes more knowledgeable about the health and inequalities of minority groups and can build on and modernise the service we deliver.
- **Workforce & Training** – To include the recruitment and retention of minority groups. Ongoing-targeted training and information for all staff for the provision of a better service and ensure that staff fully understand their responsibilities in relation to equality legislation and the SES. Targeted training and development will be made available for BME staff.
- **ICT Information and Monitoring** – Gather and analyse qualitative data about patients experience in relation to Equality.
- **Partnership** – Strengthen existing partnership working with other organisations to develop an outward looking and inclusive approach to everything that we do.
- **Finance and Procurement** – The Trust will invest to promote equality and through this investment, will meet the requirements of the new Equality Bill and support our corporate aims to achieve Foundation Trust status.

6.0 RESPONSIBILITIES FOR EMPLOYERS UNDER THE EQUALITY LEGISLATION

6.1 The equality legislation makes it unlawful to discriminate against employees or job applicants on the grounds of their disability, sex, race, marital status, ethnic origin, sexual orientation, religion or age. It is unlawful to discriminate against people in relation to:

- Recruitment

- Terms and conditions
- Training
- Promotion
- Benefits
- Dismissal

6.2 Under the Disability Discrimination Act 2005, we have a responsibility to make reasonable adjustments including:

- Re-allocation of duties
- Transfer
- Altering hours/place of work
- Time off for treatment
- Modifying equipment
- Training
- Providing assistance, reader, personal assistant or interpreter
- Adjustments to premises

7.0 RESPONSIBILITIES FOR SERVICE PROVIDERS UNDER EQUALITY LEGISLATION

7.1 The UK anti-discrimination legislation covers six key equality strands: gender and gender identity; disability; race; sexual orientation; age; religion and belief, with the additional area of Human Rights. It has been recognised that some progress has been made within the public sector, but this has been slow. Sometimes action to remedy inequalities is only taken as a result of time consuming and costly legislative action, taken against an organisation to seek redress to inequality.

Under Equality legislation it is unlawful to discriminate against people by: refusing to provide a service without justification; refusing to provide services which meet the needs of the BME communities; providing a service to a lesser standard without justification; providing a service on worse terms without justification; failing to make reasonable adjustments to the way services are provided for disabled people and failing to make reasonable adjustments to the physical features of service premises, to overcome physical barriers to access.

The public sector equality duties take a fundamentally different approach. Public authorities are now legally obliged to promote equality of opportunity and to eliminate discrimination for service users and staff. This is a positive and proactive approach and enhances and underpins our vision to ensure inclusivity and see equality at the heart

of everything we do, rather than waiting for a complaint before we take action.

8.0 HOW WILL WE MEET THE EQUALITY DUTIES

8.1 Equality Impact Assessments

8.1.1 It is a statutory duty under the Race Relation (Amendment) Act 2000, the Disability Discrimination Act 2005 and The Sex Discrimination Act, as amended by the Equality Act 2006, for public authorities to undertake Equality Impact Assessments to assess whether the policies and procedures that guide our day-to-day practices are likely to have a positive or negative impact on different groups within our diverse community. We are responsible for publicising the assessments that have been undertaken.

8.1.2 A Negative or Adverse Impact: is any impact that could disadvantage one or more of the equality groups. This could be proportional and may mean that one equality group could be more disadvantaged than another.

8.1.3 A Positive Impact: is an impact that may have a positive effect on one or more of the equality groups. An example of this could be of a specific training programme designed to develop BME staff. This could have a positive impact for this group of people, but it would not necessarily mean a negative impact for non BME staff. This would need to be monitored.

8.1.4 An impact assessment will guide changes in practice and will be used specifically for:

- Developing a new strategy or function
- Starting a project
- Writing or revising policies
- Commissioning or procuring services

An action plan will be developed to address any gaps i.e. where we are now, where we want to be and how we will get there.

8.1.5 The Trust will co-ordinate and monitor it's Equality Impact Assessments (Appendix 6 of the *Equality and diversity policy and procedure (incorporating Single Equality Scheme (SES))*).

8.2 Access to Information

8.2.1 We will publish and release all information using language appropriate to the intended audience and ensure that our information is available in different formats. Standard information will make it clear whom to

contact to get different information in different formats. We will ensure that requests for this can be made in various ways and not just by telephone, so that those who have a hearing impairment can contact us. Information wherever possible will be distributed through front line staff and therefore given to patients and service users.

8.3 Monitoring for Equality

8.3.1 Employment Monitoring: We currently monitor recruitment statistics by ethnic group, gender, age and disability. The SES action plan identifies the need for further work in this area to look in more detail at monitoring statistics for training opportunities, promotion, grievances, performance management and pay.

8.3.2 Service Planning Monitoring: We also monitor patient activity by ethnic group and this information can be taken into account in developing our services. We are developing the use of patient data to better inform consideration of equality issues.

8.4 Training

8.4.1 We will develop an Equality Training Strategy, which will identify our strategic equality training needs.

8.4.2 In line with our Trust Values, Competencies and Performance Standards we will identify how staff can show that they are meeting the Equality and Diversity requirements/standards for their role. Equality and Diversity training is logged as part of our Statutory and Mandatory training records so that we can monitor compliance on a monthly basis.

8.4.3 All staff are required to update their knowledge by attending Equality & Diversity training every 3 years and/or by completing the Trust's e-learning training.

8.5 Procurement and Partnerships

8.5.1 Maidstone & Tunbridge Wells NHS Trust has various contracts with other private, voluntary and statutory organisations for goods, works, services and staff.

8.5.2 As part of the procurement agreement, the Trust will ensure that organisations contracted comply with all aspects of equality legislation and the Trust's policies and procedures.

8.6 Consultation and Involvement

8.6.1 The Trust recognises the importance of consultation in the development and implementation of the scheme and in creating a

culture of equality of opportunity, is committed to a continued, full and effective consultation on its Single Equality Scheme (SES). The development of this scheme is intended to ensure equal opportunities for all our staff and to improve service delivery of health care by minimising health inequalities for patients. The draft version of the SES has been circulated to staff within the hospital and will be shared with groups and organisations within the community we serve. The consultation undertaken is recorded in Appendix 2 of the *Equality and diversity policy and procedure (incorporating Single Equality Scheme (SES)),* of which this SES document is Appendix 4*.*

8.6.2 A programme of consultation and involvement with external stakeholders will take place and continue to be developed at a strategic level. This will involve inviting feedback on our plans, which aim to provide equality of opportunity and eliminate discrimination of any kind. It is essential that we seek and listen to the views of both our staff and the community that we serve before we agree and sign off the SES. The SES incorporates a working and evolving action plan setting out how we will fulfil our duties and meet the needs of our communities. It is therefore essential that we consider how we continue to engage with established local groups and how we can identify and engage with hard to reach groups in helping us to identify the impact of the SES. Working in partnership will all stakeholders will enable us to amend the SES accordingly and to monitor the implementation of our action plan.

8.6.3 The Trust commits to publishing the results of consultation on the SES and on any subsequent consultations that are undertaken, both as a result of action being taken by the Trust in meeting its equalities duties or for functions or services that are identified as affecting a minority group.

8.7 <u>Involving the Communities</u>

8.7.1 As part of the Trust's on-going commitment to consult and engage with the diversity of groups within the communities that we serve, the Trust has developed an Action Plan [RWF-OPPM-CORP143] to help us identify and reach traditionally 'hard to reach' groups. We are keen to seek regular feedback from our community groups with regard to our equality and diversity plans. The Action Plan is initially to support consultation on the SES, but will be used for the regular cycle of feedback and review.

Groups to be involved include:

- Disability Forums

- Access Groups
- Staff Side
- Volunteers
- BME staff network & local BME communities
- Gender specific groups
- Representatives from other established minority groups and communities
- Representatives from areas of social deprivation which may currently be under-represented at Trust forums

8.8 Involving Staff

8.8.1 The Trust has established various staff involvement groups to support our commitment to being both an employer of choice and healthcare provider of choice. We recognise that we can achieve this through acknowledging and embracing diversity. The Trust will establish a strategic equality steering group to oversee the effective implementation of the SES. The Equality Steering Group will be led and chaired by the Director of Strategy & Workforce, reporting to the Board and will be supported other Executive Directors/Senior Managers with a special interest in diversity and are keen to provide leadership and direction in this area.

8.8.2 The Trust will re-launch its Disability Equality and BME forums and is keen to continue to work in partnership with these groups to identify and take action to address inequalities. It is important that we work closely with colleagues representing minority groups to gain an understanding and insight from their perspective around issues that affect them at work. Other minority group forums and networks will be established to ensure we engage fully and enhance the diversity agenda.

8.8.3 We ensure that we reach consensus on matters that have an impact on all groups of staff through our Joint Staff Council which meets quarterly. This group is led by Human Resources and membership includes both management and staff side representatives covering the cross section of staff employed by the Trust.

8.9 Governance

8.9.1 The Trust's Clinical Governance Group is responsible for ensuring that we meet our statutory duties. This includes the general and specific equality and diversity duties that are required to meet legislative duties, as well as NHS specific duties such as: Care Quality Commission and NHSLA.

8.10 Publication of the Single Equality Scheme

8.10.1 The Trust will make the SES and its associated action plan available to all service users, carers and staff. Equality Impact Assessments (EIA's) will also be published on the Trust intranet site. For all ratified new or amended policies, EIA's can already be found as Appendix 2 of the policy / procedure when published on Q-Pulse. The internet and intranet sites will be used to promote the Scheme and associated activities. The Equality Steering Group will promote the Scheme across the Trust via management teams, Chief Executive's briefings, team meetings and within the Staff Newsletters. There will be an annual summary report of equality and diversity activities/monitoring and evaluation which will be published on the staff intranet. The Trust will ensure that any information published is made available in a range of accessible formats.

8.11 Performance Management

8.11.1 The objectives and targets relating to the statutory duties will be integrated into the Trust's strategic and operational plans, the workforce strategy and the performance development review (appraisal) process.

8.11.2 Progress on meeting the range of performance objectives will be monitored and reported via the Equality Steering Group on an annual basis; Directorate business meetings and other forums as detailed in the action plan.

9.0 COMPLAINTS OF CONCERNS ABOUT NON-COMPLIANCE WITH THE SES

9.1 Where complaints are received from users or communities (external complaints) about the implementation of our SES, our complaints procedure will apply. The complainant is encouraged to raise their concern with the person or the service they are dealing with, so their concern can be resolved quickly. If this is not possible or the complainant remains unsatisfied, they should make a formal complaint. Complaints about the Trust's services should be made to:

Chief Executive
Trust Management Offices
Maidstone & Tunbridge Wells NHS Trust
Maidstone Hospital
Hermitage Lane
Maidstone
ME16 9QQ

9.2 Complaints can be made in person or by telephone, letter or email. If an individual is unable to pursue the complaint individually, someone else can communicate the complaint on their behalf.

9.3 Individuals can also obtain advice and support from PALS (Patient Advisory and Liaison Service) if they wish to make a complaint.

9.4 Staff complaints: where a complaint is made internally, staff should use the *Grievance and Disputes Policy and Procedure*, which is available on Q-Pulse [RWF-OPPPCS-NC-WF27] or from the HR Business Partnering team.

10.0 MONITORING AND REVIEW

10.1 The SES is a 'living' document and will be constantly reviewed by the HR Business Partnering team. The implementation of this scheme will be monitored within mainstream business planning processes and Directorate workforce plans.

10.2 An Equality and Diversity report will be presented to Trust Board on an annual basis.

SINGLE EQUALITY SCHEME ACTION PLANS 2014/15

LEADERSHIP & CORPORATE COMMITMENT

Requirements	Actions	Expected outcomes	Responsibility	Completion date	Evidence
The Board individually and together systemically identifies and then eliminates any discriminatory practice (in employment or service provision) and positively promotes equality of opportunity	Trust Values require that all staff, patients and visitors are treated with respect and dignity The Board and Workforce Committee receive equality updates including gender, race and disability and other equality legislative obligations	All equality obligations are met and equality and diversity becomes part of core business Statistics are collected for all patients to reflect their gender and ethnicity Staff are aware of the needs of minority groups including cultural and religious needs, and the specific needs of individuals with a disability, and they work positively to ensure these are addressed	Board Director of Workforce & Communications Directorate Management Teams Corporate Information team Patient Experience Matrons Staff	Ongoing	Staff Survey Patient Survey PRIDE Equality Impact Assessments Training compliance reports ER reports to Workforce Committee

The Board individually and together ensures equality is part of the main business of the Trust at all levels and across all relevant activities	Equality & Diversity training for all staff is part of the Statutory & Mandatory training, and regular workshops are provided by HR as well as being included in Induction training	Through Equality Impact Assessments, new and amended policies and services meet the equality and diversity needs of our staff and service users	HRBP team All policy writers and policy approvers	Ongoing	Induction fortnightly E&D forms part of Stat & Man training requirement
	Equality Impact Assessments for all new and amended policies and services are effectively completed, gaps identified and action plans developed to meet the gaps	The Single Equality Scheme is effectively implemented, evaluated and reviewed annually	Directorate Management Teams	Ongoing	Equality Impact Assessments completed for all policies & service reviews
	A report on the Single Equality Scheme action plan is presented to Trust Board on an annual basis		Director of Workforce & Communications	March 2015	Workforce Committee report

STRATEGY AND SERVICE

Requirements	Actions	Expected outcomes	Responsibility	Completion date	Evidence
There are equitable and accessible services for all minority groups and other sections of the community	Analyse gender, ethnicity and disability data to identify gaps	Access of minority groups to services is improved Policies and functions reviewed and adjustments made as required	Director of Strategy Chief Operating Officer Chief Nurse	Ongoing	Patient Survey
Services are experienced by all sections of the community as: • Fair • Meeting their needs • Respecting their cultural identity • Providing choice	Establish an action plan to address how we can improve access to services e.g. nursery facilities, car parking, outreach Discuss service needs with community groups to establish the impact of our policies to help influence the action plan Action plan is reported annually to the Trust Board through the Workforce Committee as part of the SES review	Patient surveys demonstrate year on year improvement All groups are able to access our services equitably Experience of our services improves	Chief Operating Officer Chief Nurse	Ongoing	Patient Survey

All sections of the community find the complaints system transparent, straightforward and easy to use and their concerns are addressed appropriately. Outcomes of treatment are similar across all groups regardless of gender or ethnicity	Establish an action plan to address how we can improve access to services e.g. nursery facilities, car parking, outreach Discuss service needs with community groups to establish the impact of our policies to help influence the action plan Action plan is reviewed at Quality & Safety Committee and Patient Experience Forums and reported annually to the Trust Board through the Workforce Committee Code complaints by gender, ethnicity and disability to identify patterns/incidents specifically citing harassment/biased treatment. Analyse date	All sections of the community are able to follow the complaints process Services are appropriate to the needs of all sections of the community	Chief Nurse Director of Estates & Facilities Chief Operating Officer	Ongoing	Regular complaints reporting and monitoring, reported to Board through Board sub-committees

	and establish action plan to address any issues arising Ensure any changes in services are the subject of an Equality Impact Assessment				

PUBLIC & PATIENT INVOLVEMENT

Requirements	Actions	Expected outcomes	Responsibility	Completion date	Evidence
Local people, from all minority groups, know what is available from the local health service Local people from all minority groups have similar levels of satisfaction with services and consider that services work with their needs in mind Local people from all groups know about and actively use opportunities available to influence the development, delivery and monitoring of health services	Equality and Diversity is embedded in PPI strategies and plans Staff, local community and voluntary groups are actively engaged and involved in service planning and changes to services Equality is embedded in all strategies and plans including the annual report Community consultation arrangements are accessible to all Action plan for engagement with hard to reach groups is implemented, regularly reviewed and revised to include new minority groups as they become known to the Trust	PPI strategies and action plans are met The requirements of the CQC Essential Standards for Quality & Safety continue to be met and are further developed The Trust will continue to design and reconfigure services to meet the needs of minority groups and modernise/ensure our strategy meets specific needs to ensure that the full range of health care provision can be given	Director of Strategy Head of Clinical Governance PALS Manager Board Secretary Chief Nurse Head of Communications Chief Operating Officer & Associate Directors/Heads of Nursing	Ongoing	Draft Engagement strategy and open meetings, including Board meetings

The Trust has systems in place to ensure that staff treat patients with dignity and respect	Incidents relating to gender, ethnicity or disability are recorded and reported by following the relevant policy	Directorate meeting agenda items and minutes reflect incidents reported and actions taken to mitigate risk	Directorate Management Teams Risk team	Ongoing	Crucial role of patient experience matrons and the leadership they provide to the teams.
The Trust makes information available to patients and the public on their services, providing patients with suitable and accessible information on the care and treatment they receive and where appropriate, inform patients on what to expect during treatment, care and after care	Policies are regularly reviewed and Equality Impact Assessments undertaken incidents are reported and acted upon Information is available in different formats and languages An interpreting and translation service is provided on request Provide better signage to direct patients/visitors Train staff to be aware of individual communication needs and to ask questions not make assumptions Staff communicate face to face to appropriately inform patients	Policies are up to date and relevant Patient and staff surveys demonstrate improved satisfaction year on year Patients receive suitable and accessible information Patients are able to access services more effectively Users are more satisfied with the services provided	Chief Nurse Head of Clinical Governance Director of Workforce & Communications Patient Experience Matrons Directorate Management Team	Ongoing	Patient information leaflets and the trust internet site.

	of what to expect during treatment, care and after care				

HEALTH AND ASSESSMENT

Requirements	Actions	Expected outcomes	Responsibility	Completion date	Evidence
The Trust is knowledgeable about the health and inequalities experienced by the local people of all minority groups and particularly in relation to gender, ethnicity and disability	Monitor and analyse changes in the population and health experienced by ethnicity	Implementation plans to take account of diversity of the local population are developed, implemented, reviewed and evaluated	Director of Strategy Chief Operating Officer Chief Nurse	Ongoing	Annual planning round, based upon local demographic data and associated analysis. Responsive to the needs of commissioners
Priorities are influenced by the health needs of the local community	Ensure specific issues highlighted in the Commissioning intentions are clearly identified and an action plan to meet them developed Identify priorities as having most relevance to gender, race and disability equality	Commissioning intentions are inclusive of equality issues A co-ordinated service across the Trust for those with	Chief Operating Officer Clinical Directors	Annual round concluded by the contract between commissioner and Trust	Patient satisfaction scores recorded through FFT and other patient feedback vehicles.

		specific needs is identified	Patient Experience Matrons		
Evidence based strategies and action plans are used to reduce health inequalities	Identify trends in health inequalities Trust enhances access to communications	Access to effective service is available to all Resources effectively Targeted to reduce health inequalities Evidence of better access and information to equality groups	Director of Strategy Chief Operating Officer		

WORKFORCE AND TRAINING

Requirements	Actions	Expected outcomes	Responsibility	Completion date	Evidence
Staff from all backgrounds experience the Trust as a fair and rewarding place to work and want to stay; Staff will be proud to work at the Trust	Use existing frameworks to support diversity e.g. HR strategy, HR Policy framework	Policies support and promote equality and diversity Performance management arrangements reflect embedding equality and diversity in core business	Director of Workforce & Communications	Ongoing	Staff Survey Trust Policies & Procedures Staff Appraisal

	Evaluate and review relevant HR policies and undertake Equality Impact Assessments for all new and reviewed policies Ensure the Equality Impact Assessment Policy identifies transsexuals as a minority group to ensure their needs are considered when reviewing policies and services	Staff survey results demonstrate year on year improvement	Director of Workforce & Communications	Ongoing	Equality Impact Assessments for all staff policies & procedures Policies developed & reviewed in partnership with staff-side Staff Survey
Staff reflect the community they serve at all levels in the organisation where the skills can be obtained, and nationally where posts are recruited from national media	Promote services, employment, work experience and volunteering amongst local communities Analyse workforce data by gender, ethnicity and disability to identify any employment inequalities in access, opportunity or treatment	Improved relationship with the local communities. Workforce profile reflects the local community Staff profile up to date and relevant Inequalities are addressed	Director of Workforce & Communications Deputy Director of Workforce	Ongoing	Recruitment activity & campaigns Two Ticks accreditation Workforce Committee reports Staff Surveys

					Partnership working
Staff across the Trust actively promote equality and diversity and are confident in their ability to challenge discrimination or harassment on any grounds	Monitor and review recruitment outcomes, turnover rates, sickness rates, exit interviews, grievances, disciplinaries, capabilities, appeals, employment tribunals and results of staff survey by gender, ethnicity and disability Review the findings of the Staff Survey and establish actions to address any issues	Staff from minority groups are representative across the organisation and at all levels	Directorate Management teams Deputy Director of Workforce	Ongoing	Staff Survey PRIDE Training compliance reports ER reports to Workforce Committee Exit interviews Development of Trust Engagement Strategy
Staff are aware of their individual responsibilities with regard to equality and diversity and treating patients, colleagues,	Equality and diversity to be mainstreamed into existing Statutory and Mandatory training programmes and delivered through both e-learning and face to face workshops to all staff	The Trust values are experienced by all staff	Director of Workforce & Communications	Ongoing	Development of Trust Engagement Strategy PRIDE

and visitors to the Trust with dignity and respect Ensure staff at all levels and in all areas are aware of the Equality & Diversity Policy and the requirements of the SES and associated action plans	Trust Values relating to dignity, equality and respect are reflected in competencies and performance standards which are measured as part of staff appraisal and any weaknesses addressed in performance development plans for staff Staff awareness raised through communications such as CE briefing, staff newsletters, training programmes, staff intranet and working groups				Staff Appraisal Code of Conduct E&D Training

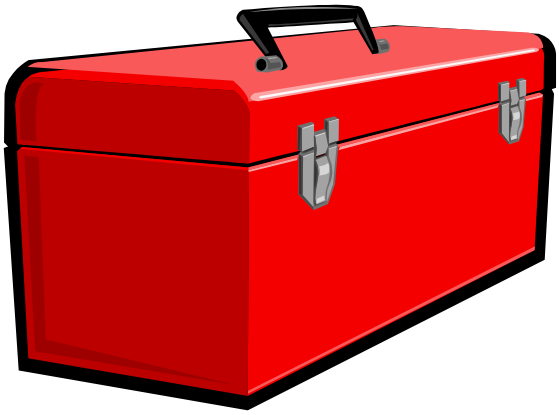
PARTNERSHIP

Requirements	Actions	Expected outcomes	Responsibility	Completion date	Evidence
Local and other partners recognise the Trust as a champion for equality in all its services/activities	The Trust works collaboratively with local partners, e.g. CCG's, Kent County Council The Trust is an active partner in the local strategic plan and appropriate groups to champion health and inequalities	Actively participate in local events The Trust is recognised as an effective partner within the health economy Exchange information and learn good practice	Executive Directors Associate Directors & Heads of Nursing	Ongoing	Relationships with partner organisations
The Trust successfully exercises its influence outside its direct partnership activities e.g. with local private sector employers and the local media to challenge discrimination and promote equality	Sustain links with national and local networks e.g. SEC BME group, religious leaders, schools, colleges, Disability forum, MIND	Promote the Trust as a model employer Views on the SES are obtained and the action plan amended to reflect these where appropriate	Executive Directors Board Secretary	Ongoing	

FINANCE AND PROCUREMENT					
Requirements	**Actions**	**Expected outcomes**	**Responsibility**	**Completion date**	**Evidence**
The Trust invests to promote the equalities framework	Financial plans take account of the investment needed to implement our statutory requirements	Finance and procurement staff are aware of their responsibilities under the equality legislation	Director of Finance Head of Procurement	Ongoing	
The Trust ensures authorised contractors are aware of their responsibilities	Ensure authorised contractors are aware of the equality legislation and the SES	All SLA's and procurement contracts incorporate equality requirements in order to meet current and Equality Bill requirements	Director of Estates & Facilities Head of Procurement SLA Lead	Ongoing	

Equality Impact Assessment

Toolkit



A guide for staff who need to complete Equality Impact Assessments

Chairman: David Highton Chief Executive: Miles Scott
Trust Headquarters: Maidstone Hospital, Hermitage Lane, Maidstone, Kent ME16 9QQ
Telephone: 01622 729000 / 01892 823535

Equality Impact Assessment Toolkit

1.0 Introduction

1.1 The duty to undertake impact assessments is a requirement of the Equality Act.

1.2 Equality Impact Assessments (EIAs) provide a systematic way to ensure legal obligations are met and are also a practical way of examining new and existing services, policies, and practices, to determine what effect they may have on equality for those affected by the outcomes.

1.3 By ensuring that equality is embedded within their objectives from the outset, Equality Impact Assessments will assist organisations in achieving their business objectives. EIAs enable organisations to identify problems and make the necessary changes.

2.0 What is an Equality Impact Assessment?

2.1 Equality Impact Assessments are a way of examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address real or potential inequalities resulting from policy and practice development. EIAs should cover all of the nine strands of diversity and ensure that all receive equitable attention.

2.2 Impact assessments will help to gain an understanding of the functions and services of an organisation and the way decisions are made by:

- considering the current situation
- deciding what is to be achieved - i.e. the objectives and intended outcomes of a function or policy
- considering what evidence there is to support the decision
- where the gaps are in terms of evidence to support the decision
- making an informed decision
- reporting / publishing that decision

3.0 Why do I need to do an Equality Impact Assessment?

3.1 The duty to undertake Equality Impact Assessments is a legal requirement under the Equality Act and covers nine protected characteristics on the grounds upon which discrimination is unlawful, the protected characteristics are:-

Age	A person belonging to a particular age (e.g. 32 year olds) or range of ages (e.g. 18 - 30 year olds).
Disability	A person has a disability if s/he has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities.
Gender	A man or a woman.
Gender re-assignment	Medical term for what transsexual people often call gender-confirmation surgery; surgery to bring the primary

	and secondary sex characteristics of a transsexual person's body into alignment with his or her internal self perception. Trans man – someone who has transitioned from female to male. Note that some people, following treatment, strongly prefer to be thought of as simply a woman. Trans woman – someone who has transitioned from male to female. Caveats as per trans man.
Marriage and Civil Partnership	Marriage is defined as a 'union between a man and a woman'. Same-sex couples can have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters.
Pregnancy and maternity	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.
Race	Refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.
Religion and belief	Religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.
Sexual orientation	Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes

3.2 Equality Impact Assessments can assist organisations in the delivery of their business objectives to achieve equal outcomes for their staff and local community.

3.3 General duties within equality legislation apply the principles of **relevance** and **proportionality**. Therefore, the time and resources given to EIAs and consultation will differ according to the relevance of the function and proposed policy to equality and diversity.

3.4 Examples of impacts

3.4.1 Negative or adverse impact - This occurs when a policy, function or proposal disadvantages one or more of the equality groups. Not all equality groups will be impacted to the same level.

3.4.2 Positive impact - Sometimes a policy or service may be intentionally exclusive e.g. positive action schemes. This assessment will enable you to test out whether such policies and schemes are appropriate and justified.

3.5 Accessible information and communication, cultural sensitivity, physical access, mobility, consultation are just some of the areas that should be considered when carrying out an EIA.

4.0 Stages of Equality Impact Assessments

4.1 Preparation

4.1.1 The person developing the policy or service will need to undertake some information gathering in order to complete the screening stage (Stage One). This will enable them to identify any impacts or gaps in the Trust's knowledge about the likely impact. This will include evidence of consultation and existing monitoring information in terms of current usage (ethnicity, gender, disability, age etc). This information would start to indicate under or over representation which would then determine whether a Stage Two assessment is required.

4.2 If no monitoring data is available, it is likely this would need to be compiled in order to be able to understand what the likely impact may be.

4.3 Using the EIA form (attached) the lead for the function, policy or proposal will need to undertake an impact assessment which will help to identify if:

- any of the nine protected characteristic groups would be affected
- the proposal would cause significant disproportionality
- an impact is identified, it may be unintentional
- it is illegal - or possibly illegal

5.0 Consultation

5.1 The information gathered to support the change in policy, service or process should be shared with any relevant groups and checked and feedback sought. Any local regional or national consultation or research information may also help with developing the policy, service or process.

5.2 The EIA should be carried out in two parts:

- 5.2.1 To assess at Stage One, the evidence for a possible negative impact on any of the nine protected characteristic groups. It ensures policy, strategy and project teams have researched and consulted with equality groups that may be affected.
- 5.2.2 Completes the Stage Two assessment of the proposal and leads to an action plan that will aim to minimise any negative impacts and maximise positive impacts.

5.3 Under the Disability Equality Duty, there is a requirement for measuring the level and importance of a policy. Therefore, where any significant policies or services are being reviewed or developed, there must be involvement from disabled people at the initial stages rather than

relying on consulting after the policy has been written or the service designed.

6.0 Co-ordination of EIA's and monitoring

6.1 Any Equality Impact Assessments that have taken place should be forwarded to the Equality Lead, Human Resources Department. The Assessment will be posted on the Trust's internet site in a timely and appropriate way. All Equality Impact Assessments undertaken as part of a new or policy revision must be incorporated as Appendix 3 of the policy/procedure document and become part of the ratification process.

6.2 Ratification is agreed by the Workforce Committee which comprises of Non-Executive Directors and Executive Directors of the board.

EQUALITY IMPACT ASSESSMENT FORM – Stage One

Name of policy, service, function, project or proposal	
Department	
Lead officer for assessment	
What is the main purpose of the policy / service / function / project / proposal?	
List the main activities of the policy or service redesign (e.g. manual handling would relate to health and safety of patients; health and safety of staff; compliance with NHS and Government legislation or standards etc).	
Is the policy or service relevant to: - **Promoting good relations between different people?** **Eliminating discrimination?** **Promoting equality of opportunity?**	 **Yes/No** **Yes/No** **Yes/No**
Which groups of the population do you think may be affected by this proposal? **Minority ethnic people** **Women and men** **People in religious / faith groups** **Disabled people** **Older people** **Children and young people** **Lesbian, gay, bisexual and transgender people** **People of low income** **People with mental health problems** **Homeless people**	 **Yes/No** **Yes/No** **Yes/No** **Yes/No** **Yes/No** **Yes/No** **Yes/No** **Yes/No** **Yes/No** **Yes/No** **Yes/No**

Staff **Any other group (please detail)**	

Do you have any information that tells you of the current use of this service? Yes/No (if yes please detail). **Is it broken down by the protected characteristics, i.e. ethnicity, gender, disability, age, religion and sexual orientation, etc? Yes/No (please detail).**
Does this information reflect the proportions from the 2001 Census? Yes/No **(If no, can you explain why?)**
If there is no information available or if this is patchy, specify the arrangements that will make this available.
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?
Where do you plan to publish the results of your Equality Impact Assessment?

Using the information above, please complete the following grids…

How will the policy etc affect men and women in different ways?					
Gender	**Positive impact**	**Negative impact**	**Neutral**	**Reason / Evidence**	**Don't know**
Women					
Men					
How will the policy etc affect black and minority ethnic people?					
Race	**Positive impact**	**Negative impact**	**Neutral**	**Reason / Evidence**	**Don't know**
White					
Mixed					
Other ethnic group					
Black/Black British					
Asian/Asian British					
How will the policy affect people with disabilities?					
Disability	**Positive impact**	**Negative impact**	**Neutral**	**Reason / Evidence**	**Don't know**
Visually impaired **Hearing impaired**					

Physically disabled					
Learning disability					
Mental health related					
How will the policy affect people of different ages?					
Varying ages	**Positive impact**	**Negative impact**	**Neutral**	**Reason / Evidence**	**Don't know**
How will the policy affect people of different sexual orientation?					
Sexual orientation	**Positive impact**	**Negative impact**	**Neutral**	**Reason / Evidence**	**Don't know**
How will the policy affect gender reassignment people?					
	Positive impact	**Negative impact**	**Neutral**	**Reason / Evidence**	**Don't know**
Transgender					
Transsexual					
How will the policy affect people of varying religious beliefs?					
	Positive impact	**Negative impact**	**Neutral**	**Reason / Evidence**	**Don't know**
Varying beliefs					
How will the policy affect those with pregnancy and maternity responsibilities?					
	Positive impact	**Negative impact**	**Neutral**	**Reason / Evidence**	**Don't know**
How will the policy affect marriage and civil partnerships?					
	Positive impact	**Negative impact**	**Neutral**	**Reason / Evidence**	**Don't know**

Considering your responses above, what are the areas that have a positive and / or negative impact?

	Positive + / Negative -	**Reason given for impact**
Gender		
Race		
Disability		
Age		
Sexual orientation		
Religious belief		
Gender reassignment		

Marriage and civil partnership		
Pregnancy and maternity		

Has there been any consultation about this policy etc? If there has, what were the key issues identified?

Consultation	Date	Summary of key issues to be addressed
Gender		
Race		
Disability		
Age		
Sexual orientation		
Religious belief		
Gender reassignment		
Marriage and civil partnership		
Pregnancy and maternity		

If consultation is planned, when will it happen and what are the key themes for consultation?

How do you intend to consult staff?

What does local / regional / national research show with regards to these groups and the likely impact?

Group	Sources	Key Issues
Gender		
Race		
Disability		
Age		
Sexual orientation		
Religious belief		
Gender reassignment		
Marriage and civil partnership		
Pregnancy and maternity		

As a result of consultation / information gathering, what changes do you intend to make to the policy etc? If 'None', please state as relevant:

	Action required	Lead Officer	Timescale	Outcome measure	Review date
Gender issue					
Race					

issue					
Disability issue					
Sexual orientation issue					
Religious belief issue					
Age issue					
Gender reassignment					
Pregnancy and maternity issue					
Marriage and civil partnership issue					

Please outline the monitoring and reviewing process and timescale

Signed by: Policy / service author

……..……

Date:

Agreed review date:

Gender identity transitioning at work frequently asked questions (FAQs)

Q. How is sexual orientation different from gender identity?
A. Sexual orientation and gender identity have no connection with each other. Sexual orientation describes a person's sexual attraction to other people or lack thereof. Gender identity describes a person's internal sense of their own gender, whether male, female or something else which may or may not correspond to the sex assigned at birth.

Q. What does gender transition involve?
A. Gender transition is different for every person. Some people may change the way they dress, their appearance, their name and the pronoun used to address them (he, she, they, ze). Some people change their identification documents, like their driving licence and passport. Some people undergo hormone therapy or other medical procedures to change their physical characteristics. No specific set of steps is necessary to 'complete' a transition – it's a matter of what is right for each person.

Q. Will a trans person's sexual orientation change with their identity?
A. Not necessarily. A trans person may be attracted to all or none, the same as prior to their transition.

Q. If I knew a person before they transitioned, is it OK to tell their work colleagues?
A. Absolutely not. Sharing personal details about a trans person before they underwent their transition is an invasion of privacy and could be regarded as a breach of the Equality Act 2010. Disclosure of a trans person's position or intended outcome is a trans hate crime and prosecution may result if this is witnessed. Unless that person has given you permission to share this information, you should not communicate it with anyone.

Q. How do I know which pronoun to use?
A. Ask what pronoun the person would like to be used – whilst it may seem a little awkward, it is far more preferable than using the wrong pronoun. You could always listen to the pronoun used by other people – in particular someone who knows the person well will probably use the correct pronoun. If you do accidentally use the wrong pronoun, make sure you apologise and try not to make the same mistake again. The continued intentional use of incorrect pronouns is a trans hate crime and prosecution may result if witnessed and would be managed under the 'Disciplinary policy and procedure' within the Trust.

Q. What is the law around treatment of trans people?
A. All trans people are entitled to be treated with dignity and respect – as all people are. Transpeople must not be discriminated against on the grounds of their gender identity.

Q. What is a trans hate crime?

A. A hate crime is any criminal offence that is motivated by a prejudice or hate. This can include anything that focuses on the victim's gender or sexual orientation.

Q. How much information can I ask a transgender person about their transition?
A. You should not ask for any information – the person will share whatever information they feel suitable with others. It is not appropriate to ask where they are in their transition, about reassignment surgery or about their life prior to transitioning.

Q. What sort of things should I avoid saying to a trans person?
A. The same sort of things you would avoid saying to a cisgender person (a person who identifies with the gender they were assigned with at birth). Examples might be "I would never have known you were trans – the surgery is amazing"; "You're so brave"; "You would pass much better if you wore less/more make-up"; "You look just like a real man".

Q. What is the right age to transition?
A. There is no 'right' age – it is purely down to the individual whether they are in their early years or later in life.

Q. Is being trans a mental illness?
A. In 2019 being trans ceased to be classified as having a mental disorder by the World Health Organisation.

Q. Is there a difference between being a transvestite and being transgender?
A. Transvestites generally dress in clothes of the opposite sex, maybe wearing makeup and accessories for pleasure. Transgender people are in a state of transition and moving from one gender to another. They tend to be at different states in their transition with some living their new identity full time and some not.

Q. I don't feel comfortable sharing the female/male toilet or changing area with a trans person – what can I do to stop them using it?
A. The trans person would use the facilities that correspond to their Identity. Trans people are using these facilities to carry out the same needs as others and for no other reason. If you do not feel comfortable, you should use another facility.

Gender identity transitioning at work policy and procedure

Target audience:	All Trust staff
Main author:	Head of Staff Engagement and Equality **Contact details**[redacted]
Other contributors:	Trans staff member Stonewall
Owner:	Director of Workforce
Division:	Corporate Services
Directorate:	Workforce
Specialty:	Human Resources
Supersedes:	Gender identity transitioning at work policy and procedure (Version 1.0: July 2017)
Approved by:	Senior HR Meeting, 20th April 2017
Ratified by:	Policy Ratification Committee, 7th July 2017

Pro forma review completed: October 2020

Review date:	October 2024

This policy has been written for implementation during periods of standard functioning within the Trust. Outside of those periods (such as major incidents or national emergencies) other 'emergency' policies may be written to supersede or run alongside this policy.

Document history

Requirement for document:	The purpose of this policy is to provide guidance for the support of staff transitioning from the gender assigned at birth to their gender identity. • The Equality Act 2010 • The Gender Recognition Act 2004 • Employment Rights Act 1996 • Health and Safety at Work Act 1974 • Trade Union and Labour Relations (Consolidation) act 1992 • Protection from Harassment Act 1997 • Human Rights Act 1998 • National Terms and Conditions for Medical Staff
Cross references (external):	1. Gender Identity Research and Education Society (GIRES) (July 2016) http://gires.org.uk/index.php 2. Stonewall charity (www.stonewall.org.uk) 3. The Gender Recognition Act 2004 4. Data Protection Act 1998 5. The Human Rights Act 1998
Associated documents (internal):	• Bullying and harassment policy and procedure [RWF-OPPPCS-NC-WF24] • Changes to employee personal details form [RWF-OPF-NC-WF19] • Dress, uniform and identification badge policy and procedure [RWF-OPPPCS-NC-WF26] • Equality and diversity policy and procedure (incorporating Single Equality Scheme (SES)) [RWF-OPPPCS-NC-WF70] • Managing attendance at work (formerly sickness absence) policy and procedure [RWF-OPPPCS-NC-WF5]

Keywords:	Transition	Gender identity	Sexual orientation
	Transgender	Gender expression	LGBT
	Trans	Gender fluid	Gender variance
	Gender neutral	Non-binary	Cisgender

Version control:		
Issue:	**Description of changes:**	**Date:**
1.0	This policy has been introduced to support staff transitioning their gender identity in the workplace.	July 2017
2.0	Completed the pro forma review process as set out in the 'Policy and procedure for the production, approval and ratification of Trust-wide policies and procedures ('Policy for policies') - RWF-OPPPCS-NC-CG25.	October 2020

Summary for

Gender identity transitioning at work policy and procedure

This policy applies to all Trust staff to enable them to support staff who are transitioning from the gender assigned to them at birth to their gender identity.

Included is the process for managers to enable them to effectively manage an employee through their transition ensuring adherence to all associated laws and best practice.

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1.0 Introduction, purpose and scope

Maidstone and Tunbridge Wells NHS Trust (MTW) embraces equality and diversity in the workplace and provides equal opportunity for all staff regardless of age, disability, gender assignment, marriage and civil partnership, pregnancy and maternity, race (including colour, nationality and ethnic or national origins), religion or belief, and sex and sexual orientation.

MTW welcome diversity because it recognises that workforce diversity, when fully utilised, leads to inclusion of more ideas and viewpoints, which in turn leads to more creativity and innovation. When individuals are able to bring their whole selves to work, they thrive, and MTW thrives. The Trust aims to attract, utilise and retain the best talent which includes being viewed as an employer of choice for a diverse workforce.

The purpose of this document is to help foster an understanding of transgender issues in the workplace and to provide guidance to all MTW staff on how to achieve a welcoming and supportive environment for MTW employees undergoing gender transition in the workplace.

2.0 Definitions / glossary

The definitions provided here are not intended to label staff but rather to assist in understanding this policy and the legal obligations of all staff. Employees may or may not use these terms to describe themselves.

Term	Definition
Bi	An umbrella term used to describe a romatic and/or sexual orientation towards more than one gender. Bi people may describe themselves using a variety of terms including (but not limited to) bisexual, pan and queer.
Cisgender or cis	Someone whose gender identity is the same as the sex they were assigned at birth. Non-trans is also used by some people.
Deadnaming	Calling someone by their birth name after they have changed their name.
Gay	Refers to a man who has a romantic and/or sexual orientation towards men. Some women define themselves as gay rather than lesbian.
Gender dysphoria	Used to describe when a person experiences discomfort or distress because there is a mismatch between their sex assigned at birth and their gender identity.
Gender expression	How a person chooses to outwardly express their gender, within the context of societal expectations of gender.
Gender identity	A person's internal, deeply-felt sense of being male, female, or something else, which may not correspond to the sex they were assigned at birth.

Term	Definition
Gender reassignment	Another way of describing a person's transition. To undergo gender reassignment usually means to undergo some sort of medical intervention but it can also mean changing names, pronouns, dressing differently and living in their self-identified gender.
Gender Recognition Certificate (GRC)	This enables trans people to be legally recognised in their affirmed ender and to be issued with a new birth certificate. Not all trans people will apply for a GRC and the lower age limit to apply is 18. A GRC is not required to change gender markers at work or to legally change gender on other documents such as a passport.
Intersex	A term used to describe a person who may have the biological attributes of both sexes or whose biological attributes do not fit with societal assumptions about what constitutes male or female. Intersex people may identify as male, female or non-binary.
Lesbian	Refers to a woman who has a romantic and/or sexual orientation towards women.
LGBT	The acronym for lesbian, gay, bi and trans.
Non-binary	This is an umbrella term for people whose gender identity doesn't sit comfortably with 'man' or 'woman'
Orientation	An umbrella term describing a person's attraction to other people. This attraction may be sexual (sexual orientation) and/or romantic (romantic orientation). These terms refers to a person's sense of identity based on their attractions or lack of.
Pan	Refers to a person whose romantic and/or sexual orientation towards others is not limited by sex or gender.
Pronoun	Words used to refer to people's gender in conversation. For example 'he' or 'she'. Some people may prefer others to refer to them in gender neutral language and use pronouns such as they/their and ze/zir.
Queer	A term used by those wanting to reject specific labels of romantic orientation, sexual orientation and /or gender identity.
Trans	An umbrella term that can be used to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth. Trans people may describe themselves using or more of a wide variety of terms, including (but not limited to) transgender, transsexual, gender-queer, gender fluid, non-binary, gender variant, trans man, trans women.

Term	Definition
Transgender man	A term used to describe someone who is assigned female at birth but identifies and lives as a man. This may be shortened to trans man or FTM – an abbreviation for female to male.
Transgender woman	A term used to describe someone who is assigned male at birth but identifies and lives as a woman. This may be shortened to trans woman or MTF– an abbreviation for male to female.
Transitioning	The steps a trans person make take to live in the gender with which they identify. Each person's transition will involve different things. For some this involves medical intervention, such as hormone therapy and surgeries, but not all trans people want or are able to have this. Transitioning also might involve things such as telling friends and family, dressing differently and changing official documents.

2.1 Summary of the law

- **The Equality Act 2010**
  This act specifically protects trans people as well as the other protected characteristic groups. We have a duty to have due regard to the following:
  - Eliminating discrimination, harassment, victimisation and any other conduct that is prohibited under the Equality Act.
  - Advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
  - Fostering good relations between people who share a relevant protected characteristic and persons who do not share it.

- **Protected characteristics**
  People must not be discriminated against should they come under one or more of the following characteristic groups which are protected by the Equality Act 2010
  - Age (refers to a person belonging to a particular age or range of ages)
  - Disability (refers to a person with a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day to day activities)
  - Gender reassignment (a person's transition
  - Marriage and civil partnership (marriage now includes same sex couples. Same sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples)
  - Pregnancy and maternity (Being pregnant or expecting a baby. Maternity refers to the period after the birth. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth and this includes breastfeeding).
  - Religion and belief (includes religious and philosophical beliefs including lack of belief)

- Sex (a man or a woman)
- Sexual orientation (a person's sexual attraction to other people or lack of.

- **Direct discrimination**
  Occurs when a person is treated less well because they have a protected characteristic. This applies when a person is discriminated against because they are perceived to be trans – even if they are not. Those associated with trans people such as partners, spouses, other family members or carers are also protected against discrimination.

- **Indirect discrimination**
  Occurs when a rule that is neutral as it applies to most people, creates a disadvantage for a person with a protected characteristic. It is not enough for a manager to say that they are treating a trans person in the same way as they would any other employee if that treatment puts a trans person at a disadvantage.

- **Harassment**
  Is any unwanted behaviour that violates a person's dignity or creates a hostile environment.
- **Victimisation**
  Occurs when someone is badly treated as a direct result of having complained, either themselves, or someone else has complained on their behalf about discriminatory treatment under the Equality Act.

- **The Gender Recognition Act (2004)**
  This act allows those who have changed their gender role permanently to obtain a gender recognition certificate (GRC). This means that they have their new gender status 'for all purposes' – the person automatically qualifies for a birth certificate if the birth was originally registered in the UK. If a person has a GRC, information about the person's gender history is described as 'protected information' so must not be passed on to anyone without the permission of the person concerned. This information includes records held by the Inland Revenue and Healthcare Records (health records pre and post transition are merged).

  A GRC is not needed in order for change one's name, pronouns or the way one dresses at work. Trans people must have lived in their 'affirmed' gender (what it is after they change their gender role) for at least two years before being granted their GRC.

- **Data Protection Act (1998)**
  All records of the individual's personal life and medical history (sensitive personal data) must be secured in accordance with the Data Protection Act including password protection and should be kept for no longer than is absolutely necessary.

- **The Human Rights Act (1998)**
  This act underpins all equality legislation that relates to employers in the public sector and those for whom we provide services. Article 8 requires that all people must be treated with respect, dignity and fairness and to

protect their privacy in family life and correspondence. Article 3 creates an absolute ban on degrading treatment.

3.0 Duties

Person/Group	Duties
Trust Board	• Responsible for ensuring that this policy is adhered to by all staff in the Trust.
Human Resources (HR)	• Responsible for providing advice and guidance to both line managers and employees on the interpretation of this policy and their rights and obligations.
Head of Staff Engagement and Equality	• Responsible for providing advice and support to all staff to support the gender transition of individuals within the Trust.
Occupational Health	• Responsible for advising managers on fitness for work issues as well as appropriate advice on any medical issues which may impact on an individual's ability to carry out the full scope of their job; this may include suggesting temporary adjustments to help those returning to work. Confidential support and/or counselling may be offered.
Line managers	Managers are responsible for: • Ensuring staff are made aware of this policy. • Meeting with transitioning individuals to create 'Workplace transition plans'. • Fulfilling all requirements of the 'Workplace transition plan' including completion of appropriate HR documentation. • Ensuring confidentiality is met. • Utilising the advice of the HR Business Partner when required.
Transitioning individuals	• Responsible for working with their managers and HR Business Partners (where required) to complete the 'Workplace transition plan'.

All Trust staff	• Are responsible for treating all trans staff with respect, dignity and fairness.
	• All Trust staff must be aware that they must:
	  ○ Not discriminate against trans people
	  ○ Not harass trans people or create a hostile environment by using transphobic language (whether or not this is in the presence of a trans person)

Person/Group	Duties
	○ Not comment on someone's appearance or "assess" whether someone "passes" as their gender identity ○ Not make assumptions about trans people ○ Not interrogate or speculate on someone's gender identity or orientation ○ Ensure the correct pronouns are used when addressing or mentioning a trans person; intentional and/or consistent mis-gendering is not acceptable. ✓ Correct pronouns – ask the individual how they would like to be addressed ✓ Use 'her' and 'she' for trans women ✓ Use 'he' and 'him' for trans men ✓ Use 'they' and 'their' or 'ze/zir' for non-binary, gender fluid and/or gender non-conforming ✓ Use 'they' if there is any doubt about the gender – do not speculate and get it wrong ○ Not victimise a trans person who has complained about a transphobic incident ○ Ensure that if a person takes time off for treatment associated with gender reassignment, this must not be used against them, e.g. as a reason for not promoting them ○ Maintain the privacy and dignity of trans people ○ Ensure that measures are in place to support a person who is undergoing transition

4.0 Training / competency requirements

No training/competency requirements at this time. However, advice and guidance is available from:

Head of Staff Engagement and Equality [redacted]

5.0 Procedure

Transitioning employees have the right to be open and to experience a workplace free of discrimination, including harassment. All employees have the right to express gender identify without fear of consequences.

5.1 Preparing for transition

The Trust recognises that trans people may be concerned about how their manager and colleagues will react to them when they disclose their intention to transition. This is likely to make it hard for them to perform as well as they might, so it is important for the manager and for the individual to have confidence in the transition policy.

Each trans person's journey is unique and it is imperative that the process is led by the person transitioning. The manager should not make any

assumptions about how the individual might want things to progress, e.g. how they wish to dress or use of toilets and changing facilities.

The first action is for the manager and the individual to meet to discuss how the individual wants to proceed. Actions will be agreed before the transition occurs and plans made together about how to proceed to ensure that the transition is successful. Sometimes this will not be possible as the transition may take place ahead of a discussion with the manager. A support meeting between the manager and the member of staff should take place as soon as possible.

A 'Workplace transition plan' must be developed, covering a number of possible topics outlined in Appendix 4. This plan shows commitment to supporting the employee at all stages but can be amended if necessary. Initial plans may not always work out as expected so there must be flexibility.

5.2 Workplace transition plan

The 'Workplace transition plan' is a confidential document. It does not represent a binding and unchangeable document but rather a commitment to engage with, and support, the employee at all stages. Hard copies must be secured in a sealed envelope and then another sealed envelope with the name(s) of the person(s) who are allowed to open them, clearly marked. Authorised people would normally be the line manager and HR Business Partner and this should be agreed with the individual. The document must not be accessible to unauthorised personnel – it should be in a locked drawer or file. Any information held in computer files must be password protected as part of the overall data protection.

The plan should be reviewed at least every three months, but reassured at each significant stage of the process, and at any time that the member of staff asks for this to be done. Discussions will pinpoint any likely problem areas. Steps must be taken to avoid these rather than deal with them after they have arisen. Action will not be taken without first seeking the insights and consent of the individual.

The initial meetings and the drafting of the plan may be undertaken by the line manager in collaboration with the HR Business Partner. The trans member of staff should be offered the support of a colleague and/or union representative at all the meetings where transition is discussed, the plan is developed, agreed, and subsequently reviewed. The trans member of staff and the line manager (or other senior member of staff) should sign this plan once it is agreed.

All participants in the meetings will keep these discussions in complete confidence.

Issues which may be considered by the individual and the line manager include:

- The date when the transition will officially occur
- The change of name, personal details and gender markers
- How the individual would like to be addressed – i.e. the appropriate use of pronouns

- Determine what updates should be made to the transitional employee's records and when they will be made
- Determine dates of any leave that may be needed for pre-scheduled medical procedures
- Determine whether there are duties within the role that should not be undertaken at specific times within the process; risk assessments
- Agreeing any dress code requirements. Flexibility and compromise may be required for those who cannot meet any departmental code taking into consideration health and safety requirements and personal protective equipment (PPE) requirements.
- Use of toilets and changing facilities
- What the implications are for pensions
- Decide how and in what format the transitioning employees colleagues are made aware of the individual's transition; it is up to the transitioning employee to decide if they would like to make some colleagues aware of their transition on a one-to-one basis before it is officially announced
- Decide what, if any, training will be given to colleagues
- Record keeping of sensitive information

5.3 Name and title change

After discussion with the individual, the manager agrees how and when the name change is to occur. Name change can occur without any legal process, informally, upon request by the trans person. The manager should not insist on being provided with more than a simple signed statement saying that they are changing from the old name and title to the new one. In addition, driving licences and passports can be presented; these are easily changed with a doctors' letter or the doctor's letter itself may be used as evidence of the individual's intention to transition.

The trans person's records and name badges must be updated to show the current name and title.

An employee has the right to be addressed by the name and pronoun that correspond to their gender identity. The intentional or persistent refusal to respect an employee's gender identity (e.g. intentionally deadnaming (referring to the employee by a previous name) or pronoun that does not correspond to the employee's gender identity) can constitute harassment and is a violation of this policy.

The changes to the individual's records are managed under the Data Protection Act 1998. The line manager must ensure that, in accordance with this Act, previous names, titles and pronouns which appear in old documents cannot be seen except by the small number of people who are authorised to see them (see 'Workplace transition plan').

Relevant and non-gender specific information should be transferred to a new set of personnel records, for example sickness records, disciplinary investigations.

The line manager must complete a 'Changes to employee personal details form' detailing the change to name and title and send to the Recruitment

Department at Maidstone Hospital. The Recruitment staff will amend the individual's ESR record which will not retain previous name and title on ESR. Changes to IT systems such as PAS, Theatres, Radiology and the IT network should be made through the Head of Staff Engagement and Equality who will ensure that the minimum number of people are involved.

5.4 Time off for medical treatment

Time off for treatments associated with gender reassignment are specifically protected under the Equality Act 2010 so that absences cannot be used against them when, for instance, considering promotion. Trans people may need to have time off during their transition that is not in accordance with MTW's 'Managing attendance at work (formerly sickness absence) policy and procedure'. For further advice, please contact the Head of Staff Engagement and Equality or an HR Business Partner.

It is good practice to discuss as far as possible in advance the time away from work that an individual will need. The plan can only be a general guide initially. Timescales may change over time and be unpredictable.

5.5 Dress code

It is good practice to allow enough flexibility in the MTW dress code to accommodate the process of transition. Where a uniform requires trousers to be worn by all sexes, trans women may prefer to wear a skirt so that others are clear about their gender status. This should be supported where possible and available. Where necessary, a new uniform should be ready well in advance of the change of gender. Flexibility must be extended to those who live androgynously (neutral gender expression) and would not be comfortable in a clearly female or male mode of dress.

It is important that consideration is given to gender fluid people who may present sometimes in one gender and sometimes in another. They may need both uniforms in order to meet the gender specific dress code at all times, taking into consideration health and safety and PPE requirements.

Please refer to the 'Dress, uniform and identification badge policy and procedure' or seek advice from the Head of Staff Engagement and Equality or an HR Business Partner.

5.6 Use of toilets and changing facilities

Facilities such as toilets and changing rooms should be accessed according to the gender identity of the employee. It is never appropriate to insist that a person who has transitioned use only the toilets that are meant for disabled people or gender-neutral toilets unless these are the only facilities available or they are preferred by the trans person. If others do not wish to share the 'ladies' or 'gents' facilities with a trans person then it is they who must use alternative facilities and not the trans person.
Gender-neutral facilities may be available as an alternative for any person, whether trans or not, who does not wish to share with others. This may be especially important for some trans individuals (non-binary for instance) who do not identify either as men or as women and would be uncomfortable entering facilities designated 'ladies' or 'gents'.

All users of all facilities should be properly prepared to welcome any trans person who is starting to use the appropriate facilities.

5.7 Pensions and retirement

Everyone born after April 1955 now receive state pension at 65. Women born on or before 5 April 1950 were entitled to a pension at 60. Those born between 1950 and 1955 can claim it at a point between 60 and 65. For state pension purposes, trans people can only be regarded as the sex recorded at birth until they have obtained a new birth certificate under the provisions of the Gender Recognition Act 2004. Otherwise, those born before April 1955 can only claim state pension in accordance with the sex on the original birth certificate – that is for trans women at age 65 and for trans men at 60. Under recent case law, a trans woman is entitled to receive a state pension from the age of 60 without a Gender Recognition Certificate if she reached that age before 4 April 2005 when the Gender Recognition Act came into force.

It is the responsibility of the Trust to take steps to keep confidential the reason for an individual's apparently early or late retirement.

5.8 Informing colleagues

The line manager and the transitioning individual should work out together how best to inform work colleagues about their plan to transition. Trans people are not obliged to inform their employer about their trans history as a condition of employment or promotion. So if a person transitioned before joining the Trust, no information about this should be passed on to the Trust unless absolutely necessary and then only with the permission of the person concerned.

This information is difficult to keep secret when a person changes their gender in the workplace, so careful planning must be done in the run up to that happening. It may not be necessary to inform the entire work team. A case by case decision on the extent of the disclosure of this information should be agreed by the person concerned and the line manager. External clients or agencies that the trans individual is currently working with may also need to be informed.

The wishes of the transitioning individual are most important although line managers and the HR department have a responsibility to see that the process of informing others is safe and respectful. In some circumstances the trans person may wish to disclose these matters personally to some or all of their contacts. If this is the case the manager will need to know when this is going to happen and what kind of information will be given to work colleagues so that support is available to the members of staff concerned.

5.9 Team transition meeting

Should the individual agree for the line manager to disclose information regarding their transition, it may be appropriate to host a work team transition meeting. This may include the transitioning employee, their line manager, their colleagues and any other team or department if they are able to attend where appropriate. It may be worth considering the use of remote conferencing facilities for those unable to attend the meeting in person. This meeting may be supported by the Head of Staff Engagement and Equality and the HR Business Partner.

If the transitioning employee thinks it would be useful, the 'Gender identity transitioning at work FAQs' (Appendix 5) can be provided at this meeting. It is up to the transitioning employee whether they feel comfortable attending or would prefer not to be there.

The line manager or Head of Service should announce the transition and must:

- State that the Trust is supportive of the individual's transition
- Indicate that the transitioning employee will be presenting themselves in accordance with their gender identity and this should be respected
- Advise colleagues about the transitioning employees new name and preferred pronoun
- Be prepared to manage any potential negative reactions, referring to appropriate Trust policies where necessary
- Be a behavioural model by using the transitioning employee's new name and pronoun in all communication – written and oral, formal and informal
- Make a point that the transition will not change the workplace and that everything should go on as it did previously
- Solicit any questions, referring any that cannot be answered to the Head of Staff Engagement and Equality or an HR Business Partner
- Ensure that staff know where they can go to understand more about gender transition (Head of Staff Engagement and Equality)

5.10 Buddy system

It may be useful to consider the use of a buddy should a trans person want this support. This would be an individual who may or may not be a member of the trans person's team who would provide encouragement and assistance. This would be a relatively informal arrangement, relying on the listening skills and absolute discretion of the buddy. A buddy may be formally identified through the Trust's Ally Programme – more information can be obtained from the Head of Staff Engagement and Equality.

5.11 Storage of protected information

Hard copies of any old documents relating to the trans member of staff that cannot be altered or replaced must be stored securely in a sealed envelope and then in another sealed envelope and marked strictly confidential. The names of those who are allowed to open these envelopes must be clearly written on the outer one.

5.12 Religion and belief

Should any member of staff who has particular religious beliefs or cultural views about gender identity claim that their protected characteristic of 'religion or belief' under the Equality Act allows them to refuse to work with or share facilities with a person who is trans – the situation must be managed.

There is no hierarchy among protected characteristics and whilst a person's religion or belief must be respected, it must not be used to discriminate against another person with a protected characteristic.

Therefore, any member of staff discriminating against another with a protected characteristic must be managed in accordance with the 'Bullying and harassment policy and procedure'.

Appendix 1

Process requirements

1.0 Implementation and awareness

- Once ratified, the Chair of the Policy Ratification Committee (PRC) will email this policy and procedure to the Corporate Governance Assistant (CGA) who will upload it to the 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.
- This policy and procedure will be made available on the Equality & Diversity pages on the Trust intranet and will be discussed at the LGBT network meeting.

2.0 Monitoring compliance with this document

Allegations of bullying and harassment linked to breaches of this policy and procedure will be investigated appropriately.

3.0 Review

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

4.0 Archiving

The policy 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: Gender identity transitioning at work policy and procedure (Version 1.0)

Please return comments to: Head of Staff Engagement and Equality

By date: 11/11/16

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:				
Clinical Governance Assistant	20/10/16	26/10/16	Y	Y
Chief Pharmacist (if pharmacy/prescribing issues are included in the document)	N/A			
Staff-Side Chair	20/10/16			
Emergency Planning Team	20/10/16			
Head of Staff Engagement and Equality	N/A	N/A	N/A	N/A
Health Records Manager	20/10/16			

Transgender staff member (Subject Matter Expert)	02/08/16	09/08/16	Y	Y
Medical Director	10/02/17	16/02/17	N	
Workforce Director	20/10/16			
Senior HR Business Partner	20/10/16			
Head of Communications	10/02/17			
Heads of Services	10/02/17			
General Managers	10/02/17			
Matrons	10/02/17			
Chief Nurse	10/02/17			
Clinical Directors	10/02/17			
Head of Employee Services	10/02/17			
HR Business Partners	10/02/17			
Medical Staffing Manager	10/02/17			
All members of the approving committee: Senior HR Meeting	20/04/17	20/04/17	Y	Y
Stonewall Account Manager	08/08/16	24/08/16	Y	Y
The following staff have given consent for their name to appear within this policy and any appendices:				
[redacted]				

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 policy or practice	Gender identity transitioning at work policy and procedure
What are the aims of the policy?	The purpose of this policy is to provide guidance for the support of staff transitioning from the gender assigned at birth to their gender identity.
Identify the data and research used to assist the analysis and assessment	Staff consultation as defined in Appendix 2
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	Yes – staff will be supported to ensure that their gender identity is protected

People of different ages	No
People of different ethnic groups	No
People of different religious beliefs	Yes – staff will receive training to ensure that their religious beliefs do not adversely impact on trans staff
People who do not speak English as a first language (but excluding Trust staff)	Yes – interpreters can be made available
People who have a physical or mental disability or care for people with disabilities	Yes – support can be provided to ensure that they have a full understanding of the policy
People who are pregnant or on maternity leave	No
Sexual orientation (LGB)	Yes – staff will receive training to ensure that their sexual orientation does not adversely impact on trans staff
Marriage and civil partnership	No
Gender reassignment	Yes – staff undergoing gender reassignment will be fully supported by managers and staff to ensure that discrimination is avoided
If you identified potential discrimination is it minimal and justifiable and therefore does not require a stage 2 assessment?	No
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

No.	Title	Unique ID	Title and unique id of policy that the appendix is primarily linked to
4	Gender identity - Workplace transition plan	RWF-HUM-HUM-FOR-2	This policy
5	Gender identity transitioning at work – frequently asked questions (FAQs)	RWF-HUM-HUM-GUI-1	This policy

Gender identity workplace transition plan

Item	Responsibility Name or job role and action	Deadline
The date when the transition will officially occur		
The change of name, title and gender		
Determine what updates should be made to staff records and when they will be made *(Staff change form)*		
Determine dates of any leave that may be needed for medical procedures		
Agree dress code requirements		
Use of toilets and changing facilities		
Pension implications		

Item	Responsibility Name or job role and action	Deadline
Informing colleagues of staff transition		
Decide what training (if any) is required for colleagues		
Record keeping and confidentiality		

Signature (individual) _____ **Signature (line manager)** _____

Date _____

Appendix 1 - Statutory Equality Duties

Equality Duty	General Duty	Specific Duty	Enforcement
Gender	1. Eliminate unlawful discrimination and harassment 2. Promote equality of opportunity between man and women	1. Prepare and publish a gender equality scheme 2. Consider the need to include objectives to address the causes of any gender pay gap 3. Gather and use information 4. Consult stakeholders 5. Assess the impact of our current and proposed policies and practices on gender equality 6. Implement actions set out in the scheme 7. Report against the scheme every year and review the scheme at least every 3 years.	Enforcement by judicial review and/or compliance notice. Annual Health Check and inspection process. Enforcement by EOC, CRE, DRC respectively.
Race	1. Eliminate unlawful discrimination; 2. Promote equality of opportunity between persons of different racial groups, and; 3. Promote good relations between persons of different racial groups.	1. To publish a race equality scheme. 2. This must set out our arrangements for; i. Assessing and consulting on the likely impact of proposed policies on the promotion of race equality. ii. Monitoring policies for any adverse impact on the promotion of race equality. iii. Publishing the results of assessments and monitoring. iv. Ensuring public access to information and services it provides. v. Training staff to comply with the general and specific duties. 3. The employment duty. This requires us to monitor, by racial group, the numbers of: i. Staff in post ii. Applicants for employment, training and promotion iii. Staff who receive training iv. Staff who benefit or suffer detriment as a result of its performance assessment procedures v. Staff who are involved in grievance procedures vi. Staff who are the subject of disciplinary procedures vii. Staff who cease employment 4. We are required to publish the results of this monitoring annually. 5. The employment duty is not just about collecting numbers and counting staff. Authorities must ensure they are meeting the general duty in exercising its employment functions. Therefore in order to meet the general duty we should use the above monitoring information to: i. See if there are differences in the way racial groups are treated ii. Investigate the underlying reasons for the differences iii. Deal with any unfairness, disadvantage or possible discrimination	

Disability	1. Eliminate unlawful disability discrimination. 2. Eliminate harassment of disabled people that is related to their disabilities. 3. Promote equality of opportunity between disabled people and others. 4. Take steps to take account of disabled people's disabilities even where that involves treating disabled people more favourably. 5. Promote positive attitudes towards disabled people. 6. Encourage participation by disabled people in public life.	1. Publish a disability equality scheme which shows how we intend to meet our obligations under the general duties. 2. In developing the scheme we must involve disabled people who are staff, patients or from the local community. 3. The scheme should include a statement of: i. The ways in which disabled people have been involved in its development ii. That authority's methods for assessing the impact of its policies and practices, or the likely impact on its policies and practices, on equality for disabled people. iii. The steps that authority proposes to take towards meeting the general duties. iv. The arrangements for gathering information on the effect of its policies and practices on disabled persons and in particular its arrangements for gathering information on recruitment, development and retention of disabled employees, service provision and public functions more generally and making use of this information in complying with the general duty. 4. Within 3 years of publishing the scheme an authority must take the steps set out in the scheme which aim to meet the general duty and gather and use the information as described above. 5. We must report annually on the steps taken, the results of the information gathering and the use made of the information.	

FAMILY NAME:	
Given name:	
Preferred name:	
Title: Gender:	
NHS number:	
Hospital number:	
Date of birth: _ _ / _ _ / _ _ _ _	
Complete above in full or affix patient label	
Location:	

NHS
Maidstone and Tunbridge Wells
NHS Trust

Best Interest Decision Making Meeting

Best interest decision making meeting		
1. Introductions, names and roles (please complete attendee/distribution list and attach)		
2. Clarify purpose of meeting / decision (s) to be made:		
a. Does the decision (s) need to be made today?	Yes ☐ No ☐	
b. Decision-maker full name:		
c. Decision-maker role:		
3. Steps taken to help the person make the decision themselves:		
4. Confirm determination of lack of capacity in relation to decision:	Yes ☐ No ☐	
a. mental capactity assessment attached to this document?	Yes ☐ No ☐	
5. Patient's previous wishes, feelings, cultural preferences, values and beliefs:		
6. Is there an advance decision for this decision?	Yes ☐ No ☐	

Patient's full name: ……..…… NHS no.: ……..……..

7. Other views to be taken into account (from relevant parties):

8. Options and their potential outcomes (complete the risks and benefits matrix below)

Option	Option to be considered	Risks related to this option	Benefits related to this option	Outcome from meeting agreed or not agreed	Person responsible to ensure decision is followed
1					
2					
3					
4					
5					

Patient's full name: ……..…… NHS no.: …… ……..…..

9. Summary of decision (s) and proposed actions:			
Attendees at meeting:			
Full name:		Full name:	

Designation: Signature: Date:		Designation: Signature: Date:	

Deprivation of Liberty Safeguards (DoLS) Policy and Procedure

Target audience:	All clinical staff and non-clinical staff in patient facing positions
Author:	Matron for Safeguarding Adults **Contact details:** Ext. 24821
Other contributors:	n/a
Executive lead:	Chief Nurse
Directorate:	Corporate Nursing Team
Specialty:	Safeguarding Adults
Supersedes:	Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure
Approved by:	Safeguarding Adults Committee, 25th April 2019
Ratified by:	Policy Ratification Committee, 28th August 2019
Review date:	August 2023

Document history

Requirement for document:	The Mental Capacity Act (MCA) 2005 is a statutory framework for people who lack capacity to make decisions for themselves, and sets out who can take decisions in which situations and how. The Code of Practice provides guidance to anyone who is working with and / or caring for adults who lack capacity to make particular decisions. Staff cannot do anything in relation to Deprivation of Liberty assessment and applications without adherence to the Mental Capacity Act 2005. This document sets out how staff can lawfully deprive a patient of their liberty in their best interests for admission to hospital for care and treatment.
Cross references (external):	1. Mental Capacity Act 2005 2. Deprivation of Liberty Safeguards enacted through Mental Health Act 3. Human Rights Act 1998 4. NICE Guideline: Decision-making and mental capacity (NG108) October 2018. 5. Mental Capacity Act Code of Practice 2007 6. Deprivation of Liberty Safeguards Code of Practice 2008 7. Ferreira vs HM Coroner 2017 8. Adult Safeguarding: Roles and Competencies for Health Care Staff (intercollegiate document) August 2018
Associated documents (internal):	• Care of the Dying Patient Policy and Procedure [RWF- OPPPCSS-C-CAN2] • Consent to Examination and Treatment Policy and Procedure [RWF-OPPPES-C-SM5] • Delirium Policy and Procedure [RWF-NUR-NUR-POL-2] • Dementia Policy and Procedure [RWF-OPPPCS-C-NUR10] • End of Life Care (EoLC) Strategy [RWF-ONC-PAL-STR-1] • Mental Capacity Act Policy and Procedure [RWF-OPPPCS-C-NUR1] • Operational Discharge Policy and Procedure [RWF-OPPPES-C-AEM6] • Restraint Policy and Procedure [RWF-OPPPCS-C-NUR4] • Safeguarding Adults at Risk Policy and Procedure [RWF-OPPPCS-C-NUR5]

Keywords:	Deprivation of Liberty Safeguards	Deprivation	Liberty
	DoLS	Mental capacity	

Version control:		
Issue:	**Description of changes:**	**Date**
1.0	This policy is being introduced as a stand-alone policy separated out from the Mental Capacity Act Policy and Procedure [RWF-OPPPCS-C-NUR1], as significant changes to this process are expected in the next year or so.	August 2019

Summary for

Deprivation of Liberty Safeguards (DoLS) Policy and Procedure

The Deprivation of Liberty Safeguards (DoLS) are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only.

The Mental Capacity Act allows restraint and restrictions to be used for people who have been assessed as lacking mental capacity to make the decision to remain in a certain place for care and treatment – but only if they are in a person's best interests.

Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are called the Deprivation of Liberty Safeguards.

The Deprivation of Liberty Safeguards can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings the Court of Protection can authorise a deprivation of liberty.

Care homes or hospitals must ask the supervisory body (the local authority) if they can deprive a person of their liberty. This is called requesting a standard authorisation. In some circumstances e.g. unplanned admissions an urgent application will be required along with the standard application.

There are six assessments which have to take place before a standard authorisation can be given. These assessments are completed by a Best Interest Assessor and a Section 12 doctor.

If the Local Authority authorises a DoLS, one key safeguard is that the person has someone appointed with legal powers to represent them. This is called the relevant person's representative and will usually be a family member or friend.

Other safeguards include rights to challenge authorisations in the Court of Protection, and access to Independent Mental Capacity Advocates (IMCAs)

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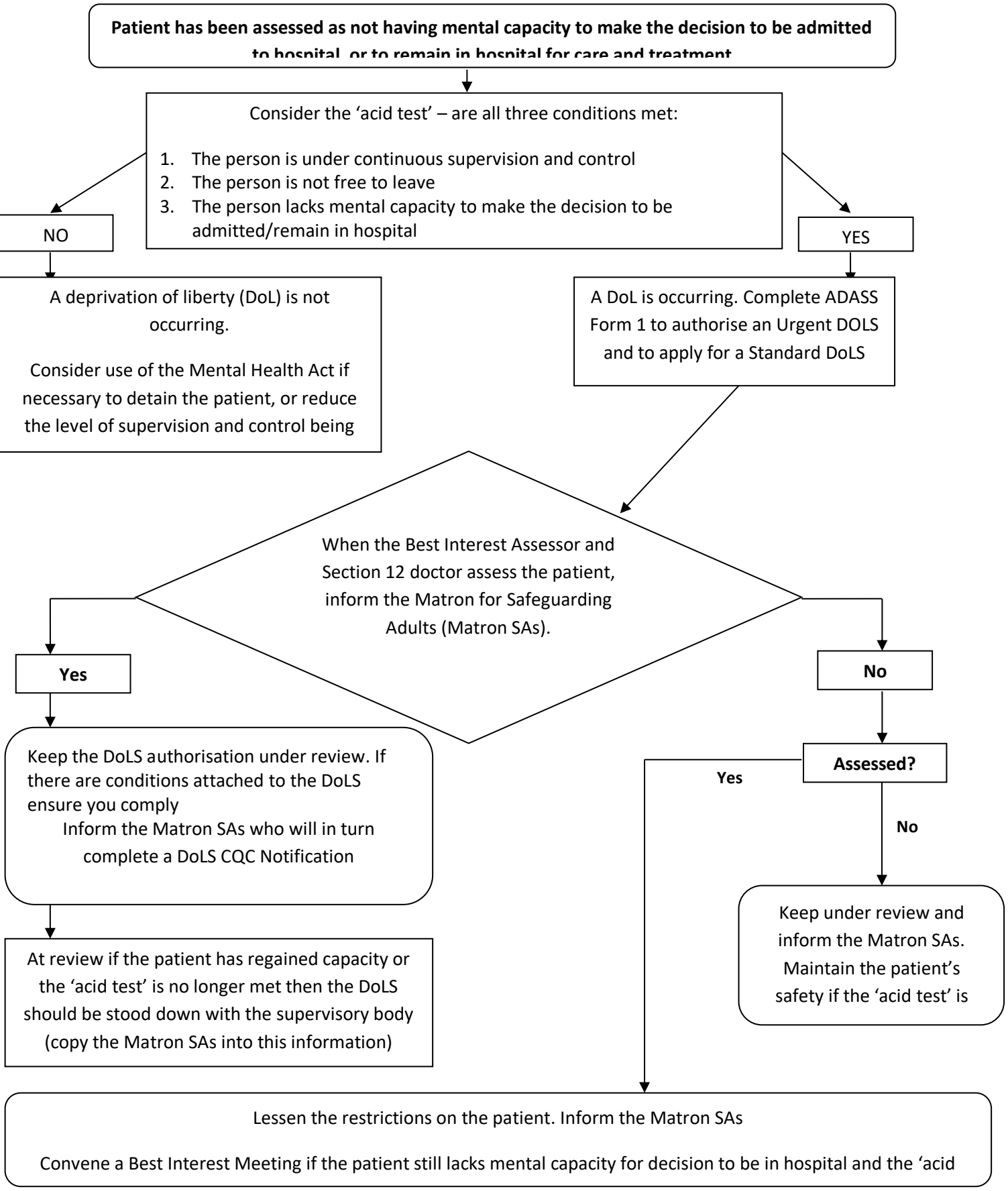
Flowchart / diagram of procedure to be followed



1.0 Introduction, purpose and scope

1.1 This policy and procedure is required to ensure that Trust staff will work within the legal framework of the Mental Capacity Act (MCA) 2005 when it is recognised that someone who lacks Mental Capacity is being deprived of their liberty at one of the Trust's hospitals, or units for care and treatment.

1.2 As part of their duties staff must ensure that they discharge their duties under the Deprivation of Liberty Safeguards (DoLS) 2007. This provides a framework for DoLS compliance and aims to set out the processes and procedures that should be followed by Trust staff when providing care for a person who is, or may become, deprived of their liberty.

1.3 This policy is in accordance with, and should be read in conjunction with, the Mental Capacity Act Code of Practice and the DoLS Code of Practice.

1.4 Implementation of this policy will ensure that:

- All clinical staff are able to assess if someone lacks the mental capacity to make the decision to be in hospital for the proposed care and treatment (see the Mental Capacity Act (MCA) Policy and Procedure).
- All clinical staff are able to recognise when a patient is potentially being deprived of their liberty, by applying the 'acid test'.
- All clinical staff are aware of how to assess the restrictions in place for a patient.
- Relevant clinical staff are aware of how to complete a DoLS application if they believe a patient is being deprived of their liberty.
- Non-clinical staff to understand their role when someone is trying to leave, who is likely to be unsafe to leave until an assessment can be carried out under MCA and DoLS.
- Staff can identify when the local authority will need to appoint an Independent Mental Capacity Advocate.
- The Trust is compliant with the CQC standards relating to the Deprivation of Liberty Safeguards.

1.5 This document applies to all clinical staff within the Trust including permanent, temporary, locum, agency and bank staff and managers. Whilst the policy outlines how the Trust will manage DoLS it does not replace the personal responsibilities of staff with regard to issues of professional accountability for practice and governance.

The policy also applies to any non-clinical staff in patient facing positions. This includes reception staff, contracted security staff, porters and/or ward clerks who might find themselves in a position of having to stop a patient from leaving until assistance can be gained from qualified clinical staff.

1.6 The DoLS applies to all clinical inpatient areas and in certain circumstances will apply in the Emergency Department (ED). Whilst staff are acting in an emergency situation delivering emergency treatment, actions will be viewed as appropriate and in the patient's best interests. However, staff will need to start to consider applying for a DoLS for patients who lack capacity, who are kept in the ED beyond four hours; or if the conditions they remain in amount to meeting the 'acid test' (refer below to definitions). However, this will not include patients who are recovering from intoxication.

1.7 Staff should seek advice from the Nurse in Charge of inpatient areas, Ward Managers, Matrons, Clinical Site Managers, and out of hours the Manager On-call. In complex cases or disputed cases, the advice of the Matron for Safeguarding Adults, Legal Services Manager or the Deputy Chief Nurse and Chief Nurse should be sought.

1.8 Case Law in relation to DoLS in Intensive Care Units (ICUs) ***(Ferreira v Coroner of Inner South London)*** declared that a DoLS will not apply in relation to the administration of 'life-saving treatment'. See below for further details.

1.9 A DoLS is a lawful mechanism that allows a hospital (or care home) to:

- Keep a patient in hospital for a specified amount of time
- Or until their capacity returns and they can make their own decision
- Or the need for them being in hospital no longer exists
- Or until they move to another care provider

The DoLS Authorisation provides safeguards for those aged 18 years and over by:

- ✓ Enabling the patient to be represented by a nominated representative
- ✓ Giving the patient (or their representative) the right to challenge a deprivation of liberty through the Court of Protection
- ✓ Providing a mechanism for deprivation of liberty to be reviewed and monitored regularly.

DoLS does not:

- ✗ Give any legal right to treat (Practitioners should use Best Interest processes under the MCA 2005 – refer to the Trusts MCA Policy and Procedure)
- ✗ Transfer a DoLS between organisations or postal addresses
- ✗ Give any legal right to move a person to another establishment

2.0 Definitions/glossary

Term	Definition
Acid test	The key points from the Supreme Court judgment were a revised 'acid test' for deprivation of liberty. The Supreme Court clarified that there is a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights in the following circumstances: • The person is under continuous supervision and control **and** • Is not free to leave, **and** • The person lacks capacity to consent to these arrangements. The Supreme Court held that factors which are NOT relevant to determining whether there is a deprivation of liberty include the person's compliance or lack of objection and the reason or purpose behind being in hospital. If a person is subject to continuous supervision and control AND they are not free to leave, then they are deprived of their liberty and, if the person is unable or unwilling to consent to their situation, this should either be authorised (by the Mental Health Act (MHA), DoLS or by an order from the Court of Protection); or the person's care should be changed immediately to either reduce the level of supervision and control, or to allow them to leave should they wish.
Advance decision	This is a decision made by a person aged 18 years or over with capacity to refuse specific medical treatment in advance. The decision will apply at a future date when the person lacks the capacity to consent to or refuse the treatment specified in the advance decision. It has the same effect as a contemporaneous refusal of the specified medical treatment.
Advance decision to refuse life sustaining treatment	For an advanced decision to refuse life sustaining treatment to be valid the: • Patient has to be 18 or over and have capacity when the decision is made • Decision should be in writing, signed and witnessed • Statement should include that the advance decision is to apply "even if the person's life is at risk." • Person has not, since the advance decision was made, appointed a Lasting Power of Attorney for Personal Welfare (health and care decisions) to make decisions on their behalf • Person has not done anything clearly inconsistent with the terms of the advance decision • Circumstances that have arisen match those envisaged in the advance decision.
Best Interest Assessor (BIA)	The assessor appointed by the supervisory body (local authority) to attend the department to assess that the requirements for a DoLS to be applied and authorised are met.

Term	Definition
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 someone's best interests. These are set out in section 4 of the Act, and in the non-exhaustive checklist in the MCA Code of Practice Chapter 5.13.
Capacity	The ability to make a decision about a particular matter at the time the decision needs to be made. The legal definition of a person who lacks capacity is set out in section 2 of the Act
Conditions	Any requirements that a supervisory body (local authority) may impose when authorising an urgent or standard deprivation of liberty, after taking account any recommendations made by the Best Interest's Assessor.
Continuous supervision and control	This is currently not defined in law or in case law but the Supreme Court Judges in March 2014 said "I believe that we should err on the side of caution in deciding what constitutes a deprivation of liberty." Therefore in situations where you are unsure whether or not you are providing 'continuous supervision and control', assume that you are.
Court of Protection	The specialist court for all issues relating to people who lack capacity to make specific decisions.
Decision maker	Under the Act, different people/practitioners may be required to make decisions or act on behalf of someone who lacks capacity to make their own decisions. The person making the decision is referred to throughout the Code of Practice as the 'decision maker'. It is the decision maker's responsibility to work out what would be in the best interests of the person who lacks capacity.
Deprivation of Liberty (DoL)	Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice is continuously being defined through case law.
Deprivation of Liberty Safeguards (DoLS)	The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home, in their best interests, for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.
Deprivation of Liberty Safeguards Assessment	There are six assessments that need to be assessed against as part of the standard deprivation of liberty authorisation process. These assessments are carried out by BIAs and Section 12 assessors.
Donor	The person creating the Lasting Power of Attorney and donating the decision making powers to the attorney.
Independent Mental	This is a person who supports and represents a person who lacks capacity to make a specific decision, where that person has no one

Term	Definition
Capacity Advocate (IMCA)	else who can support them. They make sure that major decisions for a person who lacks capacity are made in accordance with the Mental Capacity Act 2005. IMCAs appointed under DoLS are required to have additional DoLS specific training. They will be appointed by the supervisory body (the local authority).
Lasting Power of Attorney (LPA)	This is a power of attorney created under the Mental Capacity Act 2005. It enables a person initially with capacity to appoint another person to act on their behalf in relation to decisions about the donor's financial and/or personal welfare (including healthcare) at a time when they no longer have capacity. An LPA must be registered with the Office of the Public Guardian before it can be used. An appointed LPA must adhere to the tenets of the Mental Capacity Act 2005.
Local authority (LA)	A local authority is an organisation. The structure of local government varies from area to area in England. In some areas there are two layers or tiers: a County or Shire Council as the upper tier and. a District, Borough or City Council as the lower tier. Local Authorities usually dealt with by the Trust in relation to DoLS applications are Kent, East Sussex and Medway.
Managing authority	The place that the relevant person is receiving care or treatment and is responsible for applying for an authorised DoLS. This is the Trust or the care home.
MCA 2005	Mental Capacity Act 2005
Relevant Person	A person who is, or may become, deprived of their liberty in a hospital or care home (the patient).
Restraint	The use or threat of force to undertake an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.
Section 12 Assessor	Medical doctor experienced in mental health who assesses whether the person meets the mental health assessment criteria for a DoLS to be applied for.
Section 12 doctor	A **doctor** trained and qualified in the use of the Mental Health Act 1983, usually a psychiatrist. They may also be a responsible clinician, if the responsible clinician is a **doctor**.
Standard authorisation	An authorisation given by a supervisory body, after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in the relevant hospital or care home when planning for an admission in the next 28 days.
Supervisory body	The local authority where the person resides is the supervisory body who are responsible for ensuring the appropriate assessments are carried out and who will arrange for the DoLS to be authorised.

Term	Definition
The Trust	Maidstone and Tunbridge Wells NHS Trust
Urgent authorisation	An authorisation given by the managing authority to deprive a person of their liberty in an urgent situation, whilst awaiting the assessment from the supervisory body to authorise the deprivation of liberty that is in place.

3.0 Duties

Person/Group	Duties
Trust Board	• Ensure that the DoLS are fully implemented within the Trust, to ensure that the rights of persons lacking capacity are respected and lawfully upheld.
Chief Executive	• Ensure that the Trust complies with relevant legal and statutory requirements related to the DoLS.
Chief Nurse (Safeguarding Adults Executive Lead)	• Ensure that the Trust fulfils its responsibilities in protecting adults rights, who lack capacity and meet the 'Acid Test' within the Trust to have the safeguards put into place on their behalf. • Ensure that the DoLS are fully implemented within the Trust, to ensure that the rights of persons lacking capacity are upheld.
Non-executive Lead Safeguarding Adults	• Champion patients' rights • Maintain focus on the application of Mental Capacity Act and DoLS • Provide independent scrutiny • Hold executive directors and Boards to account
Medical Director	• Maintain focus on the application of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards with the Chiefs of Service • Hold Chiefs of Service to account for ensuring that MCA and DoLS are adhered to by the Trust's Consultant Body.
Chief of Service	• Actively promote the appropriate application of the Mental Capacity Act and Deprivation of Liberty Safeguards with Clinical Directorates. • Hold Clinical Directors to account for practice in the Directorates in relation to the application of the Mental Capacity Act and application of the DoLS in their everyday practice. • Ensure the highest standards of clinical effectiveness are achieved in relation to MCA and DoLS in their Directorates in line with the law, case law and all relevant guidelines.
Clinical Directors	• Actively promote the appropriate application of the Mental Capacity Act and DoLS with Consultants in their Directorates. • Hold Consultants to account for practice in their directorates in relation to the application of the Mental Capacity Act and application of the DoLS into everyday practice.

Person/Group	Duties
	• Ensure the highest standards of clinical effectiveness are achieved in relation to MCA and DoLS in their directorates in line with the law, case law and all relevant guidelines.
Consultants	• To ensure that their knowledge and skills are up to date and in line with applying the Mental Capacity Act and DoLS into their everyday practice • Hold the Clinical Staff to account for their practice in relation to the Mental Capacity Act and the application of DoLS.
Divisional Director of Nursing and Quality (DDNQ)	• Will hold their Matrons and Nursing staff to account for appropriate application of the principles of the Mental Capacity Act and DoLS into practice when these issues affect patients in their care. • Will challenge the Chiefs of Service in relation to the application of the MCA and DoLS in their Clinical Directors' practice.
Clinical Director of Therapies	• Will hold their Therapy Leads to account for appropriate application of the principles of the Mental Capacity Act and DoLS into practice when these issues affect patients in their care.
Matron for Safeguarding Adults	• The Matron for Safeguarding Adults (Matron SAs) has responsibility for ensuring the process and procedures are consistent for implementing the DoLS. • Attend local and regional Mental Capacity Act Multi-agency meetings. • Develop internal structures to provide assurance to the organisation that DoLS issues are considered and dealt with in a consistent and lawful way • Provide systems and structures to support DoLS to be monitored and audited • Design and deliver trust training in relation to the DoLS legislation and processes in the Trust • Audit of the DoLS processes each year • Will advise staff in relation to applying the DoLS for patients in their care • Will chair complex Best Interest Meetings when consideration of DoLS is likely and there is dispute about the mental capacity of the patient or the DoLS application is being disputed. (It is for the Directorate to arrange said meetings).
Matrons	• Complete checks on those patients in their areas who have a DoLS in place, to review the DoLS and to ensure the appropriate mental capacity assessments have been completed prior to the application for a DoLS. • Complete checks on patients within their areas who might now meet the acid test for a DoLS to be applied for.

Person/Group	Duties
	• Ensure that the ward staff are conversant with applying for DoLS • Ensure that ward staff and clinical area staff are able to apply the MCA into their practice.
All clinical staff	• The health professional carrying out the procedure or intervention or other situation when documenting and discussing consent, is responsible for ensuring that consent to treatment is valid and that full discussions are recorded in the patients' healthcare record. • Where the patient may be deprived of their liberty the health professional must make a DoLS application
Non-clinical staff in patient facing areas	• Assist clinical staff in relation to using distraction techniques and diversion techniques to encourage a patient who is wandering back to the ward. • Alert clinical staff if they come across a patient who has wandered off the ward and does not appear able to keep themselves safe.

4.0 Training/competency requirements

4.1 The Trust welcomed the publication of the Intercollegiate document (Adult Safeguarding: Roles and Competencies for Health Care Staff, August 2018) and will use this document as the guidance to ensure staff complete the correct level of training commensurate with their roles and responsibilities. Individual staff members are responsible for identifying and logging individual training sessions that will enable them to be up to date with training in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

- Level 1 – Trust staff on Level 1 training will not require training in relation to applying a DoLS.
- Level 2 – Clinical Update Training includes Mental Capacity Act and Deprivation of Liberty Safeguards awareness training. All clinical staff intervening with patients who meet the acid test, will need to have completed this training.
- Level 3 Safeguarding Adults Training includes a higher level of detail in relation to the application of the Mental Capacity Act and Deprivation of Liberty Safeguards. All clinical staff including doctors, nurses and Allied Health Professionals who have the duty to assess, plan, intervene and evaluate the needs of adults where there are safeguarding concerns will need to complete face to face Level 3 Safeguarding Adults Training. This is equivalent to eight hours every three years.
  - Multi-agency MCA and DOLS training can be accessed via this link https://www.kent.gov.uk/social-care-and-health/information-for-professionals/training-and-development#tab-3

    If staff access this training this will need to be registered with the Learning and Development Department and will go towards the requirements set out in the Intercollegiate Document.

5.0 Framework

5.1 What is a Deprivation of Liberty?

On 19th March 2014, the Supreme Court handed down a judgment in respect of an on-going Deprivation of Liberty Safeguards (DoLS) Case. The judgment was significant in clarifying whether arrangements made for the care and/or treatment of an individual lacking capacity to consent to those arrangements amounted to a deprivation of liberty or not. The key point from the Supreme Court judgment was a revised 'acid test' for determining a deprivation of liberty. The Supreme Court has clarified that there is a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights in the following circumstances:

- **The person is under continuous supervision and control**
  and
- **Is not free to leave**
  and
- **The person lacks capacity to consent to these arrangements.**

This is called the 'acid test'.

The Supreme Court held that factors which are **not** relevant to determining whether there is a deprivation of liberty include the person's compliance or lack of objection and the reason or purpose behind being in hospital.

If a person is *subject to continuous supervision and control* **and** they are *not free to leave*, then they are deprived of their liberty and, if the person is unable or unwilling to consent to their situation, this should either be authorised (by the Mental Health Act, DoLS, custodial sentence, or via an order from the Court of Protection). If neither of these options applies then the patient's care should be changed immediately to either reduce the level of supervision and control, or to allow them to leave should they wish.

It is important to understand that if a person lacks capacity to consent to the supervision/control and there is an inability to leave, they may still be deprived of liberty even if they are 'compliant' and making no attempt to leave whatsoever. The Chair of the Supreme Court said '*A gilded cage is still a cage.*'

If staff think that a 16 year old or 17 year old is being deprived of their liberty an approach must be made to the Court of Protection via the Trusts Head of Legal Services.

5.2 What is continuous supervision and control?

This is currently not defined in law or in case law but the Supreme Court in March 2014 said "I believe that we should err on the side of caution in deciding what constitutes a deprivation of liberty." Therefore in situations where staff are unsure whether or not they are providing 'continuous supervision and control', they should assume that they are and, if the person is also not free to leave, they should either issue an urgent DoLS authorisation, or request a Mental Health Act assessment if relevant.

A pragmatic way of answering the question is for staff to ask whether the person(s) or body responsible for the patient has a plan in place, which means, that they need always to broadly know:

- where the patient is
- what they are doing at any one time.

If the answer is yes to both parts of the above, it is a strong indication that the patient is under continuous and complete supervision and control. This is particularly so if the plan sets out what the person(s) or body responsible for the patient will do in the event that they are not satisfied that they know where the patient is and what they are up to.

Guidance also suggests that it is clear that the test for continuous and complete control will also be met without *every* decision being made on behalf of the individual. In other words, the patient may well be able to take quite a number of decisions for their own activities (for instance what they would like to have for breakfast) but they will still be subject to continuous supervision and control if the patient is in an overall structure in which aspects of decision-making are being allowed to them at the discretion of those in control of their care.

5.3 What does free to leave mean?

This is not defined in law or case law. Importantly whether or not the patient is trying to leave is irrelevant. Freedom to leave is not judged by whether the person is actually asking to leave but rather by what would happen if they did ask to leave. It is based upon whether staff would allow them to leave or not. It is vitally important not to confuse '*freedom to leave'* with '*ability to leave'* or '*attempts to leave.'*

In this context the focus should be upon the actions (or potential actions) of those around the individual, rather than the individual themselves. In other words, the question may well be a hypothetical one – if the person manifested a desire to leave (or a family member properly interested in their care sought to assist them to leave), what would happen?

If the answer is that steps would be taken to enable them to leave, then that points in one direction – that a deprivation of liberty is not occurring; if the answer is that steps would be taken to prevent them leaving this points to the fact that a deprivation of liberty is occurring. Crucially, it would not matter in this regard if the steps to prevent the person leaving were said to be 'in their best interests'.
Approaching matters on that basis helps make clear that, for example, whether or not there are locks or keypads on the doors is not the answer. It is what would be done by the staff with the ability to unlock the door if the individual were to seek to open that door, and leave that is important.

5.4 What is now <u>not</u> relevant in identifying a DoL

Previous considerations that should **not** influence the decision as to whether a deprivation of liberty is occurring include:

1. The person's compliance or lack of objection to their placement – if they lack capacity they cannot consent to their placement so apparent compliance cannot be taken into account;
2. The relative normality of the placement – this applies no matter how severe their disability i.e. just because someone would need constant supervision and support to live their life, does not mean such factors should influence the objective decision about whether a deprivation of liberty is occurring;
3. The reason or purpose behind their placement – no matter how well intentioned the restrictive measures are, this should not have a bearing on the objective decision about whether a deprivation of liberty is occurring.

5.5 Deprivation of Liberty in the intensive care setting

The ***Ferreira v Coroner of Inner South London*** remains the leading case in relation to DoLS and ICU settings. The Judge indicated that:

> "…any deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside Article 5(1) [the right to liberty] … so long as [it is] rendered unavoidable as a result of circumstances beyond the control of the authorities and is

necessary to avert a real risk of serious injury or damage, and [is] kept to the minimum required for that purpose". (para 89).

"The treatment must be given in good faith and is materially the same treatment as would be given to a person of sound mind with the same physical illness" (para 93).

However there will be some exceptions to this. In cases where significant coercion is required to provide treatment, it will be prudent to seek legal advice and wider support from within the Trust.

When the period of 'life saving treatment' has ended but the person remains in ICU and still meets the 'acid test' then a DoLS must be considered and applied for. However, if there is a record that they consented to this level of care and treatment ***prior*** to the ICU admission then a DoLS will not be required.

If in doubt seek out advice from Matron SAs, Matrons, Clinical Site Managers and Legal Services Manager.

5.6 The supervisory body

The local authority is the supervisory body responsible for managing the applications and having an overview of the DoLS,. The local authority assesses and authorises DoLS applications. Therefore the county council, where the person normally resides, is the supervisory body covering the managing authorities (hospitals) of the Trust. (This is usually Kent County Council and East Sussex County Council).
The supervisory body will consider all DoLS applications and will commission the statutory assessments to be completed by a Best Interest Assessor and a Section 12 doctor. Where all the assessments agree, the supervisory body will authorise the requested deprivation of liberty safeguards to be put into place. The supervisory body will maintain a register of all granted authorisations.

5.7 The managing authority – the hospital Trust

The DoLS Code of Practice indicates that all care homes and hospitals are classed as a managing authority. Therefore the Trust is regarded as a managing authority.

When a patient lacks capacity and will be receiving care, where levels of restriction and restraint are assessed as amounting to a deprivation of liberty, the Trust **must** apply for a standard authorisation from the supervisory body.

Where a deprivation of liberty needs to commence before a standard authorisation can be obtained, the Trust is able to grant itself an urgent authorisation whilst, at the same time, applying for a standard authorisation.

5.8 Key responsibilities of the Trust in its role as a managing authority

- To ensure that care is delivered in the least restrictive way that is possible and that it is proportionate and necessary to prevent harm to the patient.
- To ensure that consideration is given to the mental capacity of all patients and their ability to consent to services/treatment which are provided, and whether care actions are likely to result in a deprivation of liberty.
- To ensure staff are aware of the MCA and DoLS legal framework.
- To ensure that procedures for an application for urgent and standard authorisations are followed.
- To ensure a new authorisation is applied for prior to the expiry of the current authorised DoLS.
- To keep all authorised DoLS under review.

- To maintain a DoLS database detailing whether an authorisation has been applied for, is authorised or refused, where notified of such (this will be kept by the Matron for SAs).
- To maintain a system to keep copies of all DoLS forms that the staff complete and the Matron for SAs receives.
- To liaise with the supervisory body when requested by the body to give an update as to whether the patient still requires a DoLS assessment.

5.9 Use of restraint

Restraint covers a wide range of actions, Section 6(4) of the Mental Capacity Act states that someone is using restraint if they:

- Use force – or threaten to use force – to make someone do something that they are resisting, **or**
- Restrict a person's freedom of movement, whether they are resisting or not. Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:
    - The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity, **and**
    - The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm (see paragraphs 6.44 to 6.48 of the MCA Code of Practice for more explanation of the terms 'necessary', 'harm' and a 'proportionate' response).

Trust staff should also refer to the Trust's Restraint Policy and Procedure.

The more restraint that a patient is subject to, the more likely that a DoLS should be applied for. However, the Trust's Mental Capacity Act Policy and Procedure and Physical Restraint Policy and Procedure should be used when considering whether or not a restraint is necessary.

In addition to the requirements of the MCA, the common law imposes a duty of care on healthcare and social care staff in respect of all people to whom they provide services. Therefore if a person who lacks capacity to consent is presenting with challenging behaviour, or is in the acute stages of illness causing them to act in way which may cause harm to others, staff may, under the common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else. However, within this context, the common law would not provide sufficient grounds for an action that would have the effect of depriving someone of their liberty.

Using excessive restraint could leave staff liable to a range of civil and criminal penalties and a Kent Adult Safeguarding Alert will be raised for investigation.

5.10 Deprivation of Liberty Safeguards (DoLS) process

The DoLS process can be summarised in the following six steps:

Step 1	In the first instance, an assessment of the patient's Mental Capacity **must** be undertaken to determine whether or not there is any lack of mental capacity for the patient to consent to being in hospital and to receiving the planned care or treatment. Staff should refer to the Mental Capacity Act Policy and Procedure for guidance on conducting a mental capacity assessment and use the Mental Capacity Assessment template form (see Appendix 4).
Step 2	If a patient is assessed as lacking mental capacity to consent to being in hospital and to receiving care or treatment staff should apply the 'acid test' to the situation and the patient - i.e. is the

	person is under continuous supervision and control and is the patient not free to leave. If the Acid Test is met then a Deprivation of Liberty is occurring and the Safeguards will need to be applied for.
Step 3	Staff should address any restrictions on the patient by attempting to minimise them and ensuring that decisions are taken with the involvement of the relevant person and their family, friends and carers. The processes for staff to follow are: • Make sure that all decisions are taken (and reviewed) in a structured manner with reasons for decisions recorded in the patient's healthcare record. • Follow established good practice for care planning. • Complete an assessment of whether the person lacks capacity to decide whether or not to be in hospital and to accept the care or treatment proposed, in line with the principles of the Mental Capacity Act (see chapter 3 of the MCA Code of Practice and the Trust's Mental Capacity Act Policy and Procedure). • Before admitting a person to hospital in circumstances that may amount to a deprivation of liberty, consider whether the person's needs could be met in a less restrictive way. • Any restrictions placed on the person while in hospital must be kept to the minimum necessary, and should be in place for the shortest period of time. • Take steps to help the relevant person retain contact with family, friends and carers. Where local advocacy services are available, their involvement should be encouraged to support the person and their family, friends and carers. • Review the patients care plan on an ongoing basis.
Step 4	**Complete ADASS DoLS Form 1 (Appendix 5)** At present this form covers both Urgent DoLS applications and Standard DoLS applications. **This form must be signed by a Band 7 or above, doctor, or Clinical Site Manager.** • Complete the form if the person is currently being deprived of their liberty and is likely to be deprived for more than seven days, • This form will need to be completed to request a standard authorisation signing page 5 is the request for a standard authorisation to be applied for. • At the same time the remainder of the form must be completed to authorise an urgent DoLS application with a signature on page 7. • The applicant must extend this urgent authorisation by signing page 8. This is because the Supervisory Body (the local authority) is unable to send a Best Interest Assessor out to assess the patient within the first seven days (this is due to the high volume of applications being made to the supervisory body since the Supreme Court Judgement). If it becomes apparent, when planning a patient's admission to hospital, that the manner in which they will be admitted will amount

	to a deprivation of their liberty then this form will need to be completed up to page 5 so that the supervisory body can plan their assessments of the patient accordingly (this can be up to 28 days prior to the planned admission). Staff should try to give a copy of this form to the patient and a copy to their relatives and/or friends.
Step 5	If the DoLS application is authorised by the supervisory body (i.e. a Best Interest Assessor and Section 12 doctor have assessed and agreed that the DoLS is lawful and the supervisory body has sent the authorisation back to the Ward), staff must inform the Matron for Safeguarding Adults that the DoLS has been authorised. The Care Quality Commission (CQC) will be informed of this by the Matron for Safeguarding Adults. If the above assessments have been completed but the DoLS is not authorised, staff should review the care arrangements to lessen the restrictions on the patient. Staff should consider the use of the Mental Health Act if appropriate or if the patient is wishing to leave, enable the patient to leave safely.
Step 6	The DOLS application and/or authorisation must be kept under review. If the patient regains mental capacity the DoLS will need to be stood down by emailing the supervisory body and the Matron for Safeguarding Adults. If it has been authorised with conditions applied, these will need to be kept under review by the Ward Manager and the Matron.

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.
- Matron for SAs will send communication to the Chiefs of Staff, DDNQs, Matrons and Ward Managers alerting them to the fact that this has been revised and is now a standalone policy procedure.
- Trust mandatory Safeguarding Adults training will include this information in the first year of publication.

2.0 Monitoring compliance with this document

- Healthcare records will be reviewed by the Matrons for each area to ensure that Wards practice complies with this policy
- The Matron SAs will complete an audit once each year and this will consist of a random healthcare record audit of current DoLS cases for the chosen month.
- Internal audits will be undertaken via the Trust's Internal Audit Service.

3.0 Review

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

[Full review of this policy and procedure will take place when the Liberty Protection Safeguards come into force.]

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: Deprivation of Liberty Safeguards Policy and Procedure

Please return comments to: Matron for Safeguarding Adults

By date: 24th April 2019

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	08/04/19	16/04/19 07/06/19	Y Y	Y Y
Counter Fraud Specialist Manager (tiaa)	08/04/19			
Energy and Sustainability Manager	08/04/19			
Chief Pharmacist and Formulary Pharmacist	08/04/19			
Staff-Side Chair	08/04/19			
Complaints & PALS Manager	08/04/19			
Emergency Planning Team	08/04/19			
Head of Staff Engagement and Equality	16/04/19			
Health Records Manager	08/04/19			
All individuals listed on the front page	08/04/19			
The relevant lead for the local Q-Pulse database	N/A			
All members of the approving committee - Safeguarding Adults Committee	08/04/19			
Other individuals the author believes should be consulted				
Medical Director	08/04/19			
Chiefs of Service 1 response	08/04/19	08/04/19	Y	Y
Consultants	08/04/19			
Chief Operations Officer	08/04/19			
DDNQ's 1 response	08/04/19	09/04/19	Y	Y
Head of Therapies	08/04/19			
Matrons 1 response	08/04/19	08/04/19	Y	Y
Ward Managers	08/04/19			
Learning Disability Liaison Nurse	08/04/19			
Lead Falls Nurse	08/04/19			
Lead Dementia Nurse	08/04/19	18/04/19	Y	Y
Lead Mouth Care Matters Nurse	08/04/19			
Lead TVN	08/04/19			
Deputy Chief Nurses 1 response	08/04/19	03/05/19	Y	Y
Head of Discharge Liaison	08/04/19			
Head of Security	08/04/19			
Named Nurse Safeguarding Children	08/04/19			

Job title:	Date sent dd/mm/yy	Date reply received	Modification suggested? Y/N	Modification made? Y/N
Divisional Director of Operations	08/04/19			
Clinical Site Managers	08/04/19	11/04/19	Y	Y
Trust Ethicist	08/04/19			
Chief Executive	08/04/19			
Associate Director Quality and Governance	08/04/19	16/04/19		
The following staff have given consent for their names to be included in this policy and its appendices:				

APPENDIX 3

Equality impact assessment

Title of document	Deprivation of Liberty Safeguards
What are the aims of the policy?	The aims of the policy are for Trust staff to lawfully deprive a patient of their liberty in line with the Law and the case law pertinent to a DoL.
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	16 year olds and 17 year olds who are thought to be deprived of their liberty will need to go through to the Court of Protection to have their DoLS approved.
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?	It is justifiable through law
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

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.

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	Mental capacity assessment	RWF-OWP-APP65	Mental Capacity Act Policy and Procedure RWF-OPPPCS-C-NUR
5	ADASS DOLS Form 1	RWF-OPF-CS-C-NUR14	This policy

When the DOLS application is assessed and either authorised, or not, send a copy of the outcome paperwork to this email box so that CQC can be informed of the outcome by the Matron SA.

Case ID Number: Click here to enter text.				
DEPRIVATION OF LIBERTY SAFEGUARDS FORM 1 **REQUEST FOR STANDARD AUTHORISATION AND URGENT AUTHORISATION**				
Request a **Standard Authorisation** only ***(you DO NOT need to complete pages 6 or 7)***				☐
Grant an **Urgent Authorisation** ***(please ALSO complete pages 6 and 7 if appropriate/required)***				☐
Full name of person being deprived of liberty	Click here to enter text.		Sex (choose an item).	
Date of birth (or estimated age if unknown)	Click here to enter text.		Est. age (Click)	
Relevant medical history (including diagnosis of mental disorder if known) Click here to enter text.				
Sensory loss	Click here to enter text.	Communication requirements	Click here to enter text.	
Name and address of the care home or hospital requesting this authorisation		Click here to enter text.		
Telephone number	Click here to enter text.			
Person to contact at the care home or hospital, (including ward details if appropriate)	Name	Click here to enter text.		
	Telephone	Click here to enter text.		
	Email	Click here to enter text.		
	Ward (if appropriate)	Click here to enter text.		
Usual address of the person, (if different to above)	Click here to enter text.			
Telephone number	Click here to enter text.			
Name of the Supervisory Body where this form is being sent	Click here to enter text.			
How the care is funded	Local Authority *please specify*	☐ Click here to enter text.		
	NHS	☐	Local Authority and NHS (jointly funded)	☐

	Self-funded by person	☐	Funded through insurance or other	☐

REQUEST FOR STANDARD AUTHORISATION

THE DATE FROM WHICH THE STANDARD AUTHORISATION IS REQUIRED: *If standard only – within 28 days* *If an urgent authorisation is also attached – within 7 days*	Click here to enter text.

PURPOSE OF THE STANDARD AUTHORISATION

- *Please describe the care and / or treatment this person is receiving or will receive day-to-day and attach a relevant care plan.*
- *Please give as much detail as possible about the type of care the person needs, including personal care, mobility, medication, support with behavioural issues, types of choice the person has and any medical treatment they receive.*

Click here to enter text.

- *Explain why the person is or will not be free to leave and why they are under continuous or complete supervision and control.*
- *Describe the proposed restrictions or the restrictions you have put in place which are necessary to ensure the person receives care and treatment. (It will be helpful if you can describe why less restrictive options are not possible including risks of harm to the person.)*
- *Indicate the frequency of the restrictions you have put in place.*

Click here to enter text.

INFORMATION ABOUT INTERESTED PERSONS AND OTHERS TO CONSULT		
Family member or friend	Name	Click here to enter text.
	Relationship to relevant person	Click here to enter text.
	Address	Click here to enter text.
	Telephone	Click here to enter text.
Family member or friend	Name	Click here to enter text.
	Relationship to relevant person	Click here to enter text.
	Address	Click here to enter text.
	Telephone	Click here to enter text.
Family member or friend	Name	Click here to enter text.
	Relationship to relevant person	Click here to enter text.
	Address	Click here to enter text.
	Telephone	Click here to enter text.
Family member or friend	Name	Click here to enter text.
	Relationship to relevant person	Click here to enter text.
	Address	Click here to enter text.
	Telephone	Click here to enter text.
Anyone named by the person as someone to be consulted about their welfare	Name	Click here to enter text.
	Relationship / Professional role	Click here to enter text.
	Address	Click here to enter text.
	Telephone	Click here to enter text.
Anyone engaged in caring for the person or interested in their welfare	Name	Click here to enter text.
	Relationship / Professional role	Click here to enter text.
	Address	Click here to enter text.
	Telephone	Click here to enter text.
	Name	Click here to enter text.

Anyone engaged in caring for the person or interested in their welfare	Relationship / Professional role	Click here to enter text.
	Address	Click here to enter text.
	Telephone	Click here to enter text.
Anyone engaged in caring for the person or interested in their welfare	Name	Click here to enter text.
	Relationship / Professional role	Click here to enter text.
	Address	Click here to enter text.
	Telephone	Click here to enter text.
Anyone engaged in caring for the person or interested in their welfare	Name	Click here to enter text.
	Relationship / Professional role	Click here to enter text.
	Address	Click here to enter text.
	Telephone	Click here to enter text.
Any donee of a Lasting Power of Attorney granted by the person	Name	Click here to enter text.
	Type of Attorneyship	Click here to enter text.
	Address	Click here to enter text.
	Telephone	Click here to enter text.
Any Deputy appointed for the person by the Court of Protection	Name	Click here to enter text.
	Type of Deputyship	Click here to enter text.
	Address	Click here to enter text.
	Telephone	Click here to enter text.
Any IMCA instructed in accordance with sections 37 to 39D of the Mental Capacity Act 2005	Name	Click here to enter text.
	Reason for IMCA involvement	Click here to enter text.
	Address	Click here to enter text.
	Telephone	Click here to enter text.
I HAVE INFORMED ANY INTERESTED PERSONS OF THE REQUEST FOR A DoLS AUTHORISATION *(Please sign to confirm)*		

WHETHER IT IS NECESSARY FOR AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) TO BE INSTRUCTED *Place a cross in EITHER box below*	
Apart from professionals and other people who are paid to provide care or treatment, this person has no-one whom it is appropriate to consult about what is in their best interests	☐
There is someone whom it is appropriate to consult about what is in the person's best interests who is neither a professional nor is being paid to provide care or treatment	☐

WHETHER THERE IS A VALID AND APPLICABLE ADVANCE DECISION *Place a cross in one box below*	
The person has made an Advance Decision that is valid and applicable to some or all of the treatment	☐
The Managing Authority is not aware that the person has made an Advance Decision that may be valid and applicable to some or all of the treatment	☐
The proposed deprivation of liberty **is not** for the purpose of giving treatment	☐

THE PERSON IS SUBJECT TO SOME ELEMENT OF THE MENTAL HEALTH ACT (1983)				
Yes	☐	No	☐	*If **Yes** please describe further e.g. application/order/direction, community treatment order, guardianship*
Click here to enter text.				

OTHER RELEVANT INFORMATION
Names and contact numbers of regular visitors not detailed elsewhere on this form: Click here to enter text.
Any other relevant information including safeguarding issues: Click here to enter text.

PLEASE NOW SIGN AND DATE THIS FORM			
Signature	If signing in this box please also complete digital signature section at the end of the form.	Print Name	Click here to enter text.
Date	Click here to enter text.	Time	Click here to enter text.

RACIAL, ETHNIC OR NATIONAL ORIGIN *Place a cross in one box only*			
White	☐	Mixed / Multiple Ethnic groups	☐
Asian / Asian British	☐	Black / Black British	☐
Not Stated	☐	Undeclared / Not Known	☐
Other Ethnic Origin (*please state*)	Click here to enter text.		

THE PERSON'S SEXUAL ORIENTATION; *Place a cross in one box only*			
Heterosexual	☐	Homosexual	☐
Bisexual	☐	Undeclared	☐
Not Known	☐		

OTHER DISABILITY

While the person must have a mental disorder as defined under the Mental Health Act 1983, there may be another disability that is primarily associated with the person. This is based on the primary client types used in the Adult Social Care returns.

To monitor the use of DoLS, the HSCIC requests information on other disabilities associated with the individual concerned. The presence of "other disability" may be unrelated to an assessment of mental disorder or lack of capacity.

Place a cross in one box only

Physical Disability: Hearing Impairment	☐	Physical Disability: Visual Impairment	☐
Physical Disability: Dual Sensory Loss	☐	Physical Disability: Other	☐
Mental Health needs: Dementia	☐	Mental Health needs: Other	☐
Learning Disability	☐	Other Disability (none of the above)	☐
No Disability	☐		

RELIGION OR BELIEF *Place a cross in one box only*			
None	☐	Not stated	☐
Buddhist	☐	Hindu	☐
Jewish	☐	Muslim	☐
Sikh	☐	Any other religion	☐
Christian (includes Church of Wales, Catholic, Protestant and all other Christian denominations)			☐

ONLY COMPLETE THIS SECTION IF YOU NEED TO GRANT AN URGENT AUTHORISATION BECAUSE IT APPEARS TO YOU THAT THE DEPRIVATION OF LIBERTY IS ALREADY OCCURING, OR ABOUT TO OCCUR, AND YOU REASONABLY THINK ALL OF THE FOLLOWING CONDITIONS ARE MET	
URGENT AUTHORISATION ***Place a cross in EACH box to confirm that the person appears to meet the particular condition***	
The person is aged 18 or over	☐
The person is suffering from a mental disorder	☐
The person is being accommodated here for the purpose of being given care or treatment. ***Please describe further on page 2***	☐
The person lacks capacity to make their own decision about whether to be accommodated here for care or treatment	☐
The person has not, as far as the Managing Authority is aware, made a valid Advance Decision that prevents them from being given any proposed treatment	☐
Accommodating the person here, and giving them the proposed care or treatment, does not, as far as the Managing Authority is aware, conflict with a valid decision made by a donee of a Lasting Power of Attorney or Personal Welfare Deputy appointed by the Court of Protection under the Mental Capacity Act 2005	☐
It is in the person's best interests to be accommodated here to receive care or treatment, even though they will be deprived of liberty	☐
Depriving the person of liberty is necessary to prevent harm to them, and a proportionate response to the harm they are likely to suffer otherwise	☐
The person concerned is not, as far as the Managing Authority is aware, subject to an application or order under the Mental Health Act 1983 or, if they are, that order or application does not prevent an Urgent Authorisation being given	☐
The need for the person to be deprived of liberty here is so urgent that it is appropriate for that deprivation to begin immediately before the request for the Standard Authorisation is made or has been determined	☐

AN URGENT AUTHORISATION IS NOW GRANTED
This Urgent Authorisation comes into force immediately.

It is to be in force for a period of: Click here to enter text. days

The maximum period allowed is seven days.

This Urgent Authorisation will expire at the end of the day on: Click here to enter text.

Signed	If signing in this box please also complete digital signature section at the end of the form.	Print name	Click here to enter text.
Date	Click here to enter text.	Time	Click here to enter text.

REQUEST FOR AN EXTENSION TO THE URGENT AUTHORISATION

If Supervisory Body is unable to complete the process to give a Standard Authorisation (which has been requested) before the expiry of the existing Urgent Authorisation

An Urgent Authorisation is in force and a Standard Authorisation has been requested for this person.

The Managing Authority now requests that the duration of this Urgent Authorisation is extended for a further period of Click here to enter text. DAYS (***up to a maximum of 7 days***)

It is essential for the existing deprivation of liberty to continue until the request for a Standard Authorisation is completed because the person needs to continue to be deprived and exceptional reasons are as follows (please record your reasons):

Click here to enter text.

Please now sign, date and send to the SUPERVISORY BODY for authorisation

Signature	If signing in this box please also complete digital signature section below.	Date	Click here to enter text.

DIGITAL SIGNATURE SECTION

X

on behalf of the Managing Authority

Name	
Position	

Send the completed form to:-
dols.office@nhs.net for patients who normally reside in Kent
dols@eastsussex.gov.uk for patients who normally reside in East Sussex
Copy the completed form to mtw-tr.saar-dols@nhs.net
When the DOLS application is assessed and either authorised or not, send a copy of the outcome paperwork to this email box so that CQC can be informed of the outcome by the Matron for Safeguarding Adults

Developed in response to:	
CQC Fundamental Standards:	

Consulted With:	**Post/Committee/Group:**	**Date:**
Lynn Gray	Deputy Chief Operating Officer	August 2020
Neil Bedford	Divisional Director of Operations	Via Senior Ops Group
Sally Foy	Divisional Director of Nursing & Quality	
Claire Cheshire	Divisional Director of Operations	
Laurence Maiden	Chief of Service	
Sarah Davis	Divisional Director of Operations	
Sharon Page	Divisional Director of Nursing & Quality	
Greg Lawton	Chief of Service	
Claire Chalmers	Chief of Service	
Kym Sullivan	Divisional Director of Operations	
Sarah Blanchard-Stow	Divisional Director for Midwifery, Nursing & Quality	
Sarah Flint	Chief of Service	
Katie Goodwin	Divisional Director of Operations	
Charlotte Wadey	Divisional Director of Nursing & Quality	
Henry Taylor	Chief of Service	
John Weeks	Director of Emergency Planning & Communications	
Nick Sinclair	Director of Operations	
Exec Team	Via Lynn Gray through Exec papers.	September 2020

Professionally Approved By:		
Sean Briggs	Chief Operating Officer	

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Ratified by: Ratified on:	
Trust Executive Board Date Implementation Date	
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Author/Contact for Information	Darren Palmer Head of Incident Co-ordination Centre
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Distribution Method	
Related Trust Policies (to be read in conjunction with)	

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Version 1.9	Amendments received from Laurence Maiden following discussion at CDs meeting.	September 2020
Version 1.9	Amendments received from Greg Lawton regarding to escalation plan and the ability to maintain day case activity. Included in reiteration.	September 2020

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1. Purpose of Protocol

1.1. The provision of 'High Quality, Safe Healthcare' leading to good patient experience is a key organisational priority. This should be at the forefront of our work at all times, however, organisational pressures and operational workload can limit the ability of key areas to provide this along with expected patterns of care. When this pressure inhibits normal daily functioning, it significantly increases the risk of failure in care occurring.

1.2. When the Trust begins to operate at a heightened escalation status, the Trust as a whole needs to adapt and operate differently. This balances and shares the clinical risk across the whole of the Trust as risk mitigation is part of the organisation's key action in upholding its duty of care to patients. Escalation of the Trust's response however should begin independently of the Trusts Operational Pressures Escalation Levels (OPEL) status depending on the apparent risk, rather than waiting for a specific escalation status or level.

1.3. Unlike many departments and clinical areas, the Same Day Emergency Care (SDEC) and in particular the Emergency Department (ED) is unable to cap demand and close its doors when all available patient care spaces are occupied. The risk of serious incidents happening not only increases with every additional patient that arrives over and above capacity but this is concentrated in one geographical area. This represents a significant risk to all that is described above. As such the risk needs to be shared across the whole organisation and the Trust response is one from the whole organisation and not just the ED.

1.4. The purpose of this protocol is to describe the mandated actions necessary when the Emergency Department (as the main point of entry for emergency admissions) has more patients than it can potentially safely care for.

1.5. While a key aim of this protocol is to prevent from triggering unsafe levels of escalation at OPEL 4 / Black; although the Trust recognises and accepts that, during periods of extreme operational capacity pressures the Trust's employees will be required to accept a higher level of risk in relation to patient care than would usually be the case under normal circumstances and will subsequently be obliged to make decisions that would potentially not be made during 'business as usual'. Any form of triage presents ethical and moral dilemmas to clinicians; and a balance has to be struck between the interests of an individual patient and the 'common good' or interests of the wider patient population served by the Trust. The greater the common need, the greater the urgency of decision making and need for triage and this should change the emphasis of a clinician's prioritisation accordingly. Clinicians finding themselves in an ethically difficult position should discuss the matter with a senior colleague such as the Clinical Director, Chief of Service or Divisional Directors of Nursing and Quality (DDNQ) or Senior Manager on Call out of hours via switchboard. Provided that such decisions are properly recorded, the Trust will support such decisions and will accept responsibility for any consequence arising from such a decision.

2. Aims and Objectives

2.1. This protocol is a default list of actions to be taken when the Trust is operating at full capacity. It is not necessarily exhaustive. Other measures or situations could still affect the operational safety of the hospitals and are not specifically described here and so should not be excluded. It should also be appreciated that some measures should be adopted early at relatively lower levels of escalation in order to prevent the risks from occurring in the first place.

2.2. The document aims to deliver safe and improved patient flow through the organisation incorporating measures which, as far as possible, have a reasonable evidence base for being effective nationally or locally. Innovation, or the implementation of a new idea to improve patient flow, is often poorly measured and ineffective so the focus in this document is on measures which are known good practice and considered to be helpful. There should be an optimisation of:

- Front-end assessment and initial treatment activities (and also admission avoidance).
- A focus on discharge to consistently prioritise discharge activities.
- A focus on workforce presence and skill mix to ensure the right people seeing patients at the right time.

2.3. Specifically this protocol aims to deliver:

- Early identification of capacity problems;
- Proactive rather than reactive responses;
- Concise and clear actions for staff;
- Defined roles and responsibilities;
- Early escalation to community partners for support;
- Feed into system level escalation and response;
- Minimise OPEL 4/ Black escalation by recovering earlier.

2.4. Objectives

The specific objectives of this protocol are to provide:

- Optimisation of clinical care and patient safety throughout the Trust
- Ensure systems and processes are present to identify staffing levels at times of escalation and ensure safe skill mix
- Enhance the patient experience through the Same Day Emergency Care Pathways
- Maximise and maintain patient flow
- Release emergency ambulance vehicles to enable a response to patients in the community
- Reduce the risk from of overcrowding in the ED & SDEC areas`
- Achieve and maintain the national standard of 95% of patients assessed, treated and discharged or transferred within four

hours
- Avoid 12 hour trolley waits (Decision to Admit)

Maintaining key indicators as below:

Indicator	Operational Standard
Four hour access	95%
Ambulance Handover	<15 minutes 95%
Bed Occupancy	<92%
Cancelled elective surgery relating to bed capacity	<1%
Patient Flow	SAFER

3. Scope

3.1. This protocol is relevant for all staff working in patient facing areas. This Protocol is also relevant for all other clinical areas of the Trust and non-clinical support services. It applies to all permanent, locums, agency, bank and voluntary staff of the Trust, and external partners such a G4S and IC24, whilst acknowledging that for staff other than those directly employed by the Trust the appropriate line management or chain of command will be taken into account. Whilst the protocol outlines how the Trust will manage escalation levels, implementation does not replace the personal responsibilities of staff with regard to issues of professional accountability for governance. The protocol covers all patients, 'in hours' and 'out of hours' discharges and delayed transfers of care.

3.2. In the event of an infection outbreak, flu pandemic or major incident, the Trust recognises that it may not be possible to adhere to all aspects of this document. In such circumstances, the advice of the infection control team via the Incident Coordination Centre (ICC) will be sought and all possible action will be taken to maintain ongoing patient and staff safety throughout the Trust.

4. Responsibilities

4.1. Chief Executive

- The Chief Executive has overall responsibility for ensuring and supporting the development, implementation and monitoring of the Protocol, to meet its legal obligations and to adopt policies and practices which promote safe practice.

4.2. Chief Operating Officer

- The Chief Operating Officer is the delegated lead for this protocol. In hours the activation of the protocol will be the responsibility of the Chief Operating Officer / Deputy Chief Operating Officer or their delegated Senior Manager.

4.3. Director On-Call

- When out of hours the request will be escalated by the ED on-call Consultant/Nurse in Charge through to the Clinical Site Team who will discuss early interventions with Senior Manager on call.

- The decision to instigate the protocol will be made by the Director on-call.

- The Clinical Site Manager will act as the facilitator fulfilling the role of the Operational lead in support of Senior Manager on-call manager.

- The Director On-call is responsible for leading the activation of the protocol and procedure for out of hours.

4.4. Senior Clinicians and Managers

- Input from the Divisional Directors and Heads of Departments is also expected, along with the Directorate Managers of the day and Clinical Directors. These members of the team (or nominated deputies) will be present within the Trust during normal working hours.
  (Refer to Appendix 2 for a full list of responsibilities for ALL staff)

4.5. Emergency Department Escalation

- The Emergency Department (ED) has a published escalation and surge plan which will inform the full capacity process, site team and duty managers as to the status of the department at any time. This is published in Appendix 5 for reference.

- 4 Hourly board rounds are held in the ED as standard throughout the 24 hour period. Increasing these board rounds to 2 hourly conveys no benefit over the 4 hourly processes and instead takes clinicians away from treating

patients and improving patient flow. However what does yield increased efficiency are the rounds being joined by the Specialty teams as described below in Acute Assessment and SDEC in reach.

4.6. When the ED has reached its maximum number or is rapidly approaching this safety of the patients and staff may be at risk and therefore the delivery of safe effective care is not possible. It should be noted that a decision to escalate and activate the 'Full Capacity Protocol' should not be made by one individual alone but made together with the clinical site team liaising with the Site Director (in hours) or Senior Manager on Call (out of hours). The Chief Operating Officer / Deputy Chief Operating Officer (in hours) or Director on Call (out of hours) will, in consultation with the Operational and Tactical leads, provide the decision to activate this protocol.

4.7. It is anticipated that all actions have been taken to prevent the ED reaching this point and escalation triggers have been acted upon. A summary of the actions in the Full Capacity Protocol is detailed below

4.8. The Full Capacity Protocol is NOT governed by OPEL status but will be activated when 5 or more of the below apply:

- Majors is full with one space in resus and no ability to de-escalate patients due to acuity
- Ambulance offload is delayed for longer than 60 minutes for >2 patients.
- There are >20 unplaced patients waiting for a bed at 8:00am
- ED areas fully escalated
- Escalated areas of AMU (SDEC, AEC) have more than 4 patient transfers waiting to be moved to a specialty ward.
- Base wards (including AMU / AAU) collectively have more than 10 patients awaiting transfers to Discharge Lounge, Hospital at Home, HomeFirst or Community.
- Any patient in ED >8 hours from attendance without a definitive specialty management plan
- Wait to be seen by ED Clinician >3 hours for >10 patients
- Threat of cancelling (1 list a day) urgent and cancer activity
- Funded capacity and 75% of escalation areas are occupied
- All Critical / High Care areas are full with >1 de-escalated patient awaiting discharge to a base ward.

4.9. All available staff will help with four key elements, any or all of which can be activated independently depending on the circumstances.

These elements are:

- Transfer of triaged patients from AMU or Specialty Care areas to the wards into an empty bed
- Transfer of patients from ED directly to admitting wards
- Transfer of patients from ED to AMU
- Assisting in areas which is experiencing higher than usual activity

4.10. To avoid unnecessary activation of the protocol it is essential to ensure that the capacity issues are not transient as a result of a surge in activity. Therefore, only the COO / DCOO or Director on-call (out of hours) can initiate the full capacity protocol. The COO / DCOO or Director on- call will maintain discussion with Ambulance Service representatives.

4.11. When out of hours, the request will be escalated by the ED on-call Consultant/Nurse in Charge through to the Clinical Site Team (CST). The CST will take all immediate measures as detailed in the ED Escalation Plan and discuss the evolving situation with the Senior Manager on-call. The decision to instigate the protocol will be made in conjunction with the Director on-call. The Clinical Site Manager will act as the facilitator fulfilling the role of the Operational lead in support of the Senior Manager on-call.

4.12. The Full Capacity Protocol may be instigated at lower levels of escalation and/or demand if this is deemed clinically necessary by the ED Consultant in-charge in conjunction with the Site Director (or Senior Manager on-call out of hours). Examples of such situations include considerations of overall levels of acuity of illness in the ED regardless of absolute numbers.

4.13. The decision to deactivate the protocol or step-down certain elements of it will also be made by the COO / DCOO or Director On-Call.

5. Alerting System

5.1. When the Full Capacity Protocol is activated, the following arrangements will be implemented:

5.2. **Switchboard Actions**:

- When alerted, Switchboard will cascade an alert message via the Trusts 'Everbridge' alert system, to all Chiefs of Service, Divisional Directors of Operations, Divisional Directors of Nursing & Quality, Clinical Directors, Clinical Site Leads, Executive Directors, Senior Managers on call, Head of Incident Co-ordination Centre and Emergency Planning and Preparedness on call stating the Full Capacity Protocol has been activated (details of the exact message will be confirmed by the COO/DCOO or Director on- call out of hours).
- The 'Everbridge' system will rapidly alert all those relevant staff on the

pre designed template contacts list (as stated above). It will attempt to reach each individual until it receives a response by cycling through different forms of communication (SMS, Email, Voice, App). Those receiving the alert should choose the appropriate message response and follow their relevant actions for full capacity. Using 'Everbridge' ensures management across the Trust are aware of the hospitals situation quickly and efficiently. Those who receive the alert should then disseminate information to staff within their department/service/area.

5.3. **Divisional Actions**:

- The Chiefs of Service, Divisional Directors of Operations and Nursing in partnership with Clinical Directors and Clinical Site Leads will be required to identify which medical staff within the Divisions will be required to report to the Site Management Office and ensure that the relevant Clinicians are contacted. Out of Hours this role will be undertaken by the Consultants on call for each Specialty at the request of the Senior Manager on-call

5.4. **Communication Team Action**:

- The Communications team will issue a message to all staff via email and will support this using the Trust intranet.

6. Initial Briefing

6.1. Upon activation of the protocol, all teams who have been alerted via the initial Everbridge message must respond to Site Management Office to await further instruction.

6.2. In hours the COO /DCOO or delegated representative and out of hours the Director on-call will be on site. The expectation is that all teams will report within 60 minutes of receiving the initial message. The representation in the out of hours period so that this response can be maintained at all times will lie between the Senior Manager on Call and the Director on Call supported by the Site Manager and Nurse in Charge in ED.

6.3. All necessary tasks will be explained to the relevant teams during the briefing with clear instructions of what is required, when it is required and who to report back to when the task is complete. This will not necessarily have to be via attendance at Site Management Office but may be via Microsoft Teams or telephone. The COO / DCOO or delegated representative (Director on-call out of hours) will chair the meeting supported by the Site Director (Senior Manager on call out of hours).

7. Definitive Actions:

7.1. The following actions must be taken within 30 minutes in addition to usual operating procedures.

8. Delaying transfers of care from Ambulance Service to ED

8.1. As the available capacity within the ED diminishes, the ability for the Trust to take patient handovers from the South East Coast Ambulance Service (SECAmb) within the 15 minute standard can be impaired. This in turn impairs SECAmb's ability to respond to 999 calls within the local area.

8.2. The Trust has agreed to work in partnership with SECAmb by adhering to their ambulance offload protocol and it should be ensured that this is fully instigated at the earliest available opportunity.

8.3. If the ED pressures suggest that Ambulance handover delays may occur >30 minutes then SECAmb should be informed of this situation via their control room at the earliest opportunity. This situation should trigger consideration of activation of the full capacity protocol if not already being implemented.

9. Leadership

9.1. There will be three tiers of leadership for the delivery of the Full Capacity Protocol following national standards of incident management. Further details are outlined in Appendix 3:

1. **Strategic:** Chief / Deputy Chief Operating Officer in hours, Director on call out-of-hours
2. **Tactical:** Head of Care Coordination Centre (CCC) / Incident Coordination Centre (ICC) or Director of Operations -Patient Flow (in hours), Senior Manager On call (out-of- hours)
3. **Operational**: Site Director (in hours) and DDoO & DDNQ's for each respective Division

9.2. Out of hours the Senior Manager on call should be present in the Trust within 60 minutes of activation of the protocol. Where this is not possible, the Senior Manager on call must put in place an agreed equivalent interim solution to ensure the smooth activation of the protocol until arrival to site of usually the Clinical Site Manager in Charge.

10. Specialty In-reach to the Assessment Units

10.1. Each specialty specified below shall provide a senior clinical decision maker (Consultant/ Registrar/nurse specialist) inreach into the ED / AAU / AMU at a minimum of three times daily and liaise with the ED Nurse in Charge (NIC) / Emergency Consultant in Charge (DrIC) and as required AMU/SAU co-coordinators.

10.2. Attend ED in person:

- Acute Medicine / Physician on Call
- General Surgery
- Orthopaedics
- Geriatrics & Frailty

- Paediatrics

10.3. Attend AMU in person:

- Cardiology
- Respiratory Medicine
- Gastroenterology
- Oncology

10.4. Attend SAU in person:

- General Surgery
- Urology
- Upper & Lower GI Surgery
- Trauma & Orthopaedics

10.5. Provision of contact details to site office / In reach to ED by telephone only

- Critical Care
- Obstetrics & Gynaecology
- Radiology
- ENT

10.6. Example times of expected attendance should coincide with ED board rounds and include: 0900, 1300 and 1700. Teams will be expected to provide a rota to the site office; specifying the name and contact details of the responsible decision maker who can make themselves immediately available to attend the ED as required throughout the period of activation of this protocol. This immediate availability is essential to ensure the Full Capacity Protocol is effective and only in place for the minimum period possible.

10.7. Co-ordination and explanation of tasks required by each of the in-reach specialties will be performed by the ED NIC and ED Consultant, in conjunction with the Senior Manager on-call when the full capacity protocol is activated on a weekend or bank holiday.

10.8. The ED NIC and Flow Coordinator will assist with the provision of intelligence to the specialties via a circulated list of what the pressures are for each specialty to help target resources appropriately and avoid clinicians visiting needlessly.

10.9. Potential activities that could be required include the review of specialty-type patients (regardless of a decision to admit, 'straight to specialty'), triage, admission avoidance actions including the provision of early/immediate outpatient/ambulatory care clinic appointments, expediting procedures and investigations, and reviewing patients on the wards aiming to facilitate discharges. Clinical Nurse Specialists will be expected to assist with this in-reach and ward work in association with their medical colleagues.

10.10. The recommendation is that patients from SAU, AAU/AMU, ED should be the first areas for identification of suitable patients for boarding. There will remain direct admissions from ED to Ward 31 (# NOFs) and Ward 33 (Gynaecology) and the Frailty assessment trolleys.

10.11. The CoS in conjunction with Site Director will act as a Clinical Arbiter for cases where there is potential dispute as to which team looks after which patients. Out of hours this will be led by specialty Consultants on call and the Tactical senior manager to agree.

10.12. On-call Consultants will be expected to be present on site in the Trust from at least 17:00 – 20:00 as a minimum during the period of activation of the Full Capacity Protocol. They must check in with the Site Management Office (via telephone or in person) and be directed to the location they can be of greatest use to the whole system. This may be in the Emergency Department or on the wards. The COO / DCOO or Director on-call out of hours may allow specialties and individual teams to step down if they are no longer required.

11. Specialty In-reach to Assessment Units

11.1. To attempt to maintain the flow of patients, available clinicians will be sent to their relevant assessment units to review patients and attempt to clear these areas via appropriate decision making (facilitating discharges or reviewing patients so that they can be transferred from the assessment unit to the ward or investigations/management expedited).

11.2. For the duration that the protocol is implemented, it would be expected that either the on-call team or available clinicians are present within the assessment areas to continue the process of prompt review and decision making.

12. Specialty Diagnostic Plan

12.1. To support the plans to maintain flow of patients a dynamic and flexible Specialty Diagnostics Plan is crucial for decision making in terms of the highest acuity patients and those patients waiting a safe discharge decision.

12.2. On activating the Full Capacity Protocol the Diagnostics teams will be working in close partnership with the clinical teams in the EDs and wards to ensure those patients whose treatment and/or discharge are dependent on imaging are identified and escalated. A priority list will be collated by the Clinical Site Team to ensure that the radiology booking teams have a twice a day update as to those patients needing urgent images. The booking team will liaise directly with assessment areas and wards; keeping them appraised as capacity becomes available to ensure internal delays are minimised.

12.3. The Chief of Service in partnership with CDs will instigate a review of lists of activity for that day, overbook or reschedule less urgent cases and where possible move patients to the IS to liberate internal capacity to support urgent cases.

13. Transfer of Patients to Wards whilst awaiting a Bed (Boarding)

13.1. In extreme circumstances and for the risk-sharing rationale stated above it may be necessary to transfer patients with a clear decision-to-admit to a ward without a bed being immediately available but there is a clear expectation that a discharge has been identified and a bed will become available.

The Boarding of patients should be considered when a number of the following criteria are met.

- No care space in the ED
- The Trust escalation status is >OPAL 3
- The ED escalation status is >AMBER
- More than 20 unplaced patients waiting for a bed at 8am
- Resus is full with level 2 dependency patients with incoming priority call and no immediate allocated bed space
- There are more than 3 ambulances being held for more than 45 minutes.
- Potential 12 hour ED trolley breach.

Levels of Boarding

Level One -

Boarding against identified discharges will be considered when ED has 20-25 unplaced patients with decisions to admit (DTA's), plus 2 of the triggers above

Level Two -

Boarding patients on wards without identified discharges when DTA's are 25-30 and one of the above triggers.

Level Three-

Boarding of patients will occur when there are 35+ patients with a decision to admit unallocated at 08:00.

Note: in the first instance

Matching boarded patients to their specialty will always be considered but may be overlooked at level 4 if the number of DTA's at 08.00 is plus 35

13.2. The nurse-in-charge will explain all of the above to the affected patients, including the rationale described above.

13.3. A central record maintained of any patients placed into clinical areas above the normal capacity and for how long.

13.4. Where possible the patient should be visited by CST in their boarding area to support nursing teams, escalate safety issues and answer any additional questions relatives and families may have about the rationale for this process.

13.5. If the expected bed availability ceases to be the case, then this will be escalated to the CCC immediately and an alternative bed be sought as a matter of priority. The relevant Matron or Lead Matron / DDNQ will be informed.

13.6. In the event of any problems, the nurse-in-charge will escalate the situation immediately to the relevant Matron or Lead Matron / DDNQ.

13.7. The ward areas will take one extra patient each under the circumstances detailed in the 'Boarding Guidance' document (Appendix 4)

14. Daily Senior Review of ALL 'Medically Active' Patients

14.1. The 7 day services ambition describes that every medically active patient in every bed on every ward should be reviewed by a senior doctor (minimum registrar or consultant, ideally consultant) daily, including weekends and bank holidays. Furthermore, every level 2 patient (HDU) should be reviewed twice daily. It is realised with our current medical staffing levels this may not be possible, priority should be given to the patients who are most unwell and those that could potentially be discharged as suggested by the NIC. Activities that should be considered include the early discharge of patients who do not need a hospital bed but who need further investigations or assessment that could be undertaken via an alternative mechanism, including ambulatory care or early outpatient review (even if clinics are over-booked as a result). Consultants (or Registrar) should endeavor to undertake a follow-up board round in the afternoon to ensure tasks have been completed as agreed from the morning ward and board rounds.

15. Admission from Clinics

15.1. All patients who need admission from an outpatient clinic or similar venue must be reviewed by a consultant from the specialty team, fully clerked and have a drug chart, and first-line investigations ordered. A management plan must be clearly documented in the case notes. Ideally, the patient should be transferred to the appropriate specialty bed without going to the Emergency Department, AMU or SAU. It is imperative that a gatekeeper is used in times of extremis so as to ensure beds are not double booked if being accessed from clinic. All requests need to go via the CCC. In the event of any dispute, the final decision will be made by the relevant Divisional Director of Nursing and Quality.

16. Cancellation of Non-Urgent Elective Activity

16.1. A case by case decision will be made about the cancellation of all "non-urgent" elective surgery that is not day-case. It must be appreciated that day- case activity has little impact on patient flow in unplanned care; elective surgery that takes place for seriously unwell patients including cancer cases (urgent elective surgery) cannot be routinely cancelled without a risk- assessment being made. It should be noted in the decision making here those areas that undertake day case activity such as Short Stay Surgery Unit at Tunbridge Wells Hospital will be included in the escalation plan. Decisions to escalate in certain areas will have an impact on the ability to deliver day case surgery. Such decisions are to be made only by the respective Divisional triumvirate leadership teams in conjunction with the specialty teams as appropriate and agreed with the COO / DCOO. The COO / DCOO will seek clinical advice from the Medical Director or Chiefs of Service if required.

16.2. Some lists may also be consolidated releasing staff to assist on the wards, in the ED or elsewhere in the Trust. Staff will continue to facilitate emergency work and labour ward so will prioritise emergency theatre lists, assisting in ITU and then supporting wards.

16.3. A case by case decision will be made about the cancellation of all "non-

urgent" clinics to free up additional staff. It should be remembered however that a number of clinics perform a vital role in preventing admissions from the community to the hospital via ED. Particular examples of these include Cardiology, Respiratory Medicine, Fracture clinic, Urgent General Surgery clinics, and these should be allowed to run. The role of the released staff should also be considered for example the additional benefit from releasing Neurologists and Rheumatologists from clinic to assist in managing the increased pressures is minimal compared to the benefit to their patients from letting them run.

16.4. Cancellation of routine follow up slots in clinic to provide 'Hot slots' that could prevent a hospital admission should also be considered in a case by case basis.

16.5. All staff released from elective work should be redeployed to areas of need. This should be coordinated by the site office ad facilitated by the Divisional management team. It is not acceptable for staff released from elective work to take leave or carry out administrative tasks if they are required clinically elsewhere in the Trust.

17. Portering

17.1. Additional porters should be deployed to the ED to assist with transfers from and within the emergency department.

17.2. The Portering Supervisor will be present in the CCC and will support CCC Supervisor as directed.

17.3. Consideration should be given to the use of Management and Administrative staff in this role (Portering) at the discretion of the COO /DCOO.

18. Opening of Escalation Areas

18.1. By the time a Full Capacity Protocol is activated, a number of escalation beds should have been made available in line with the Escalation Sequence, in the Trust Internal Escalation Protocol. After 20:00 if ED Department remains unsafe, prior to activating Full Capacity Protocol every effort should be made to utilise identified escalation areas:

- Short Stay Surgery (ITU expansion as required)
- Theatres recovery
- Cath lab
- Discharge lounge
- Frailty assessment trolleys (with COO / DCOO or on-call Director approval)

18.2. To mitigate the increased risk of using escalation areas, the following requirements must be put in place at each area:

- Patient requirements

- ✓ NEWS less than 3
- ✓ Not be acutely confused
- ✓ Not receiving continuous cardiac monitoring

- Pharmacy
  - ✓ Provision of emergency drugs / stock drugs to area as required

- Staffing
  - ✓ Adequate for case mix and area
  - ✓ Staff to have swipe card access to the area (Cath Lab)
  - ✓ Staff are orientated to the area and are aware of emergency procedures and nearest available resus trolley and fire exit.
  - ✓ Consideration of additional SHO / SHOs assigned to ward medical teams

- Estates
  - ✓ Provision of food
  - ✓ Linen
  - ✓ Evacuation plan in event of fire (awareness that the area is in use out of hours)

- Site
  - ✓ Number of patients and location recorded on bed board
  - ✓ Telephone numbers for area accessible and passed to on call teams
  - ✓ On call teams made aware of location and number of patients

19. Discretionary Actions:

19.1. The following actions may also be taken if circumstances dictate in addition to all of the above and usual operating procedures:

19.2. ***Cancellation of non-essential meetings*** – Staff should be freed up to respond to the rising demand for hospital services. Accountability, Governance, Complaint meetings with families and Disciplinary meetings should go ahead. All others should be cancelled; diaries cleared and staff to report to their divisional leads to be redistributed to other tasks. These should be reported to the site office as actions that have been taken along with information as to who has become available and where they have been redeployed to.

19.3. ***Cancellation of Consultant SPA Activity*** - The above additional clinical workload involving consultants will be expected to be shared between consultants via mechanisms such as an on-call rota and the cancellation of occasional SPA sessions not requiring Direct Clinical Care. Clinicians will be expected to agree the priorities of the non-elective work flow with their CDs over SPA time. The Trust Medical Director (or deputy) however may judge that all such activity should be cancelled by all consultants such that all consultant expertise is diverted to direct

patient care such as assisting colleagues with ward rounds, clinics or activity on the Emergency Department

19.4. ***Cancellation of Junior Doctor Teaching*** – Regular delivery of teaching is a requirement of having junior doctors train at MTW. In times of extreme pressure it may be permissible to either delay, rearrange, shorten or even cancel teaching sessions. This must be assessed on a case by case basis by the Medical Director or nominated deputy. When considering this action there must be specific tasks required to be immediately performed by the individuals released. The impact must be reviewed with the Director of Medical Education and Guardian of Safe Working after each occasion to ensure the Trust is meeting its minimum training commitments, as failure to do so may impact on our ability to retain doctors in training in the future.

19.5. ***Cancellation of other teaching / training*** – At any one time a variety of on-site courses or training may be taking place. In times of extreme pressure it may be permissible to either delay, rearrange, shorten or even cancel teaching sessions. This must be assessed on a case by case basis by the Medical Director, Chief Nurse or nominated deputies. When considering this action there must be specific tasks required to be immediately performed by the individuals released. Consideration should also be given to the impact on staff and to the trust of not receiving the scheduled training including not achieving mandatory training targets and affect it may have on morale and retention.

19.6. ***Critical Care Department to take over running cardiac arrest teams*** – In times of heightened Trust activity, the pressure often falls unevenly on Directorate groups with the ED, On call & Acute Medicine and On call Surgery teams often taking the brunt of the increased workload. Resuscitation is a required competency for ALL anaesthetic staff and forms a part of their mandatory training compliance matrix. Early liaison between the Clinical Directors (especially Acute Medicine and Critical Care) will facilitate the best use of critical care staff to support the cardiac arrest team. This action takes staff reallocated anaesthetic staff from cancelled lists in theatres (when available) and uses them to relieve some of the pressure on the on call teams, freeing the Acute Medical on call team who mostly make up the majority cardiac arrest team to carry out other duties, improving efficiency and flow within the hospital.

19.7. ***Reallocation of ALL Clinical Staff from office or supernumerary duty*** - During normal working hours and in some areas out of hours there may be a number of clinical staff carrying out administrative or other supernumerary duties. This action mobilises this resource by allowing the divisional teams and their Operational commander to reallocate them to areas of need.

19.8. ***Additional provision of transport services*** – This may need to be purchased or requested from partners to enable transport of increased numbers of patients able to be discharged from the acute Trust to their onward destination.

19.9. ***Formation of a medical outliers team –*** Medical outliers are often reviewed less often and at a later point in the day than those on the base wards. It may be possible for Medicine and Emergency Care Division to create a team consisting of a decision maker (Consultant or Senior Registrar) and an SHO from within their agreed medical staffing teams led by each Medical Site Lead, to facilitate rapid review of all medical outliers with a view to identifying potential discharges and improving patient safety. This will also ease pressure on the base wards staff.

19.10. ***Allocation of Site Directors, and senior staff to support board rounds*** – In times of increased demand on services it may be helpful to provide additional support and challenge to the board rounds. Clinical Directors will often be directly involved in seeing patients at this point so this roll would most usefully be carried out by Site Directors, in addition to Divisional Directors of Operations and Directors of Nursing and Quality for all services.

19.11. ***Maximum use of external support / working with Partners –*** Good escalation management happens when health and social care partners come together to resolve pressure system-wide. ED Performance is one measure of a whole health and social care system experiencing pressure, but it is not the only one. An ED could be experiencing isolated difficulties but the rest of the system is coping well; there are sufficient beds available and there is good flow through the system. Alternatively, an ED could be managing well whilst the rest of the hospital, and the wider system; community beds, community services and social care are experiencing high pressures due to a lack of capacity. Local ED Delivery Boards have aligned their existing systems to the escalation triggers and terminology used within OPEL

- It is important that the Trust is able to assure healthcare partners that all internal measures have been taken before escalating to the highest escalation status
- Full escalation to whole system OPEL 4/Black will be decided in conjunction with Partners
- A list of all required external beds should be constructed with patient level detail ready to pass to partners for action. This should include details of patients waiting for social care, complex POC, equipment, inter-hospital transfers, EoL pathways, anything that could benefit from spot purchasing.
- Communications to local GP surgeries of trusts current status
- Notification of 111 provider of trusts current status
- Support for MTW in widening the criteria for commissioned community beds, enabling more patients to be transferred from the Acute Trust site

19.12. ***Provision of additional emergency operating lists to create surgical ward capacity (Ortho, General surgical & Ophthalmology)*** – At any point the surgical wards have numerous patients admitted awaiting emergency or urgent

surgery. By cancelling elective work, additional emergency lists can be run clearing this backlog and creating surgical beds.

19.13. ***Request ambulance diverts*** - This should be one of the final options when the Trust is in in a critical internal incident. The decision to request a divert can only be made by an Executive Director

19.14. ***'Boarding' Protocol*** – The Trusts Boarding Guidelines define this as "A patient residing on a ward without an allocated bed space". Protocol describes the placing of an additional patient on each ward despite there being no upcoming discharge. It is a far from ideal situation and puts an additional strain on ward staff, poses patient safety risks and delivers poor patient experience. It therefore should only be carried out in extremis, essentially when all other options have been exhausted and the ED is non-functional presenting a greater risk to patient safety within that department. The Boarding of patients should be considered by the Operational and On Call teams when a number of the following criteria are indicated:

- No care space in ED
- Trust escalation status >OPEL 2
- ED escalation status >AMBER
- >20 unplaced patients (DTAs) in ED at 8am
- Resus full with level 2 dependency patients with incoming priority call an no immediate allocated bed space
- >3 Ambulances being held for >45 minutes
- Potential 12 hour ED trolley breach

The full 'Boarding Guidelines' document is included as Appendix 4.

20. Stand Down

20.1. The stand down of the Trusts Full Capacity Protocol response will by necessity be phased across responding departments and areas. Stand down will be led by an executive and or agreed with by the COO / DCOO which will be communicated to staff via the Trusts Everbridge alert system, phone and email.

20.2. Review of the 'Step Down' and final 'Stand Down' of the Full Capacity Protocol will be instigated by the COO/DCOO within 24 hours of activation (or sooner if reasonably practicable) to ensure that all measures are in place and being taken in a timely manner. It remains the responsibility of the COO/DCOO to minimise the time the Full Capacity Protocol is enacted for to ensure the Trust can return and maintain its core business for as long as possible.

20.3. Review will take place after 24 and then 48 hours (or sooner if practicable). It is not expected that the Full Capacity Protocol will be in operation for more than 48 hours in any one time. If this is required then urgent review should be led by the COO/DCOO as to the actions being taken across the Divisions to ensure they are ambitious in terms of outcomes and clinically led in terms of effectiveness.

20.4. Key areas for consideration will include:

- Staff Welfare through response and recovery phases
- The reinstating of any cancelled elective or urgent activity
- The re-opening any closed clinics
- The need to re-stock equipment and consumables used in the response
- The financial impact of the response

20.5. Upon stand down it is the responsibility of local managers to ensure that all responding staff receive a basic immediate debriefed; the department is restocked ready for resumption of 'normal' business and all records and logs created during the response are secured for future reference in the ICC.

20.6. The Incident Coordination Centre will continue to operate with Strategic Command until the hospital is able to return to safe activity levels.

21. Training

21.1. It is an essential element of this plan that all staff members are aware of their role in the Trust's response. It is the responsibility of all managers to ensure that appropriate training is made available to their staff. Support is available for local training at team meetings and regular training sessions.

21.2. It is highly recommended and encouraged for new staff members to spend at least a day with the CST as part of their induction. In addition staff such as Senior Managers on call and Executive on call will have training through a simulation exercise prior to this protocol going live and on a regular basis moving forward.

22. Audit and Monitoring

22.1. When this protocol is activated, at de-escalation there will be a debrief which will include lessons learnt which will form part of the audit process. This will be reviewed every 3 months.

22.2. Key findings and learning points will be disseminated to relevant staff.

23. References

- CQC Fundamental Standards 2014.
- Full Capacity Protocol, Portsmouth Hospitals NHS Trust, 2017
- Full Capacity Protocol, Liverpool and Broadgreen University Hospitals NHS Trust, 2013
- Full Capacity Protocol, Barking Havering and Redbridge University Hospitals NHS Trust, 2014
- ECIP

24. Appendix 1 – Full Capacity Checklist

The COO / DCOO (or Executive on-call out of hours) (or nominated deputy) should be present in the Trust within 60 minutes of activation of the Full Capacity Protocol	
Twice Daily Senior Review of ALL Patients	
Transfer of Patients from Assessment Units to Wards whilst awaiting a Bed	
Specialty In-reach to the Emergency Department – Contact details • Acute Medicine • Cardiology • Respiratory Medicine • Gastroenterology • Obstetrics • Frailty Team • Critical Care • General Surgery • Trauma & Orthopaedics • Urology • ENT • Ophthalmology • Oncology • Gynaecology • Paediatrics • Radiology • Discharge Team • Therapy/Pharmacy Team • Social worker	
Admission from Clinics	
Cancellation of Non-Urgent Elective Activity	
Cancellation of all Non-Urgent Meetings, Sub-Committees and Committees	
Cancellation of Educational Activities	
Additional Nursing Support	
Portering	

25. Appendix 2 - Roles and Responsibilities of Staff

25.1. All Internal MTW Staff

It is the responsibility of **all** Trust employees to adhere to the protocol and deliver the process to the best of their ability and ensure:

- As clinically appropriate, emergency patients requiring hospital admission via the ED are allocated and safely transferred within four hours of attending the ED ensuring compliance with the 4 hour wait access standard (95%).
- No elective admissions are cancelled due to lack of bed availability.
- Ensuring the Trust's ability to receive Critical Care patients which includes; Intensive Care, Respiratory NIV patients and Stroke will be assured at all times.
- Divisions will manage their daily workload - both elective and emergency within their bed base, and will develop strategies for reducing/eliminating reliance on outlying of patients.
- Divisions will have robust processes / a plan in place for ensuring escalation capacity is made available at times when respective Divisional bed base is fully utilised.
- The overarching accountability for the safe movement / transfer of patients is managed and coordinated appropriately by the Site Team and compliance with Infection Control Policies and guidance will be adhered to at all times.
- All requests for patients being transferred from other hospitals, overseas, or those with suspected or confirmed infection must be coordinated via the Site Team.
- Every effort will be made to limit the movement of infectious patients across the hospital site and only do so when the patient's clinical condition requires it.
- That the Trusts' bed stock will be used efficiently and effectively.
- Patients are moved to the wards from ED/Assessment Areas within 30 minutes of the bed being vacated.
- Symphony, Allscripts and TeleTracking will be updated simultaneously and in real time.
- The Trust bed base should remain in positive balance each day (for every patient admitted there needs to be a patient discharged)

- Ensure that patients with an infection prevention and control alert are not transferred to other wards unless clinically indicated or advised by the IPC team.

- Ensure that information about patients is communicated to receiving wards and departments in advance to ensure that appropriate facilities are available and any special arrangements are in place.

- Datix any identified incident as appropriate.

- Undertake risk assessments for patients they identified that need to be moved within the Trust that is not on the patient's usual pathway.

- Risk assessments for patient moves are completed prior to any patient movement taking place.

- Minimise the number of bed moves per patient.

25.2. Chief or Deputy Chief Operating Officer / On Call Director

- Attend Ops meetings at times of heightened Escalation

- Be able to recognise trigger points and strategically plan to mitigate risk of escalating further

- Act as an escalation resource for the Operational Site Director and or the Senior Manager taking the strategic lead and lead decision making to resolve issues

- Early intelligence gathering from Emergency Planning team to ensure current, accurate information for decision making stakeholders

- Lead on external discussions with partners at Director and Chief of Service level

- Authorise use of escalation capacity with Divisions

- Lead discussion and planning of cancellation of elective patients for all surgical and medical specialties

- Responsible for all Capacity and Escalation activity within the Trust and responsible for making the decision to escalate to Trust OPEL 4/Black following conversation with appropriate stakeholders.

25.3. Site Director and Senior Manager on Call

- Attend cross site meetings at all times and at the heightened escalation state base in site office to ensure plans are in place to

manage patient safety and flow.

- Be able to recognise trigger points and work with the site team in mitigating further escalation

- Act as an escalation resource for the Clinical Site Team site team

- Lead on external discussions with partners at senior manager level during heightened escalation

- Escalate where appropriate to the COO / DCOO / On Call Director, keeping them updated on the current position

- Ensure the daily site report is current, accurate and distributed by CST

25.4. Clinical Site Team

- The Clinical Site Team is responsible for overseeing and promoting effective day-to-day operational co-ordination of Trust-wide capacity flow. This includes monitoring of departmental escalation statuses and delivering the overall Trust OPEL actions in partnership with the Site Director.

- During Critical Incidents the CST will advise the Care Coordination Centre (CCC) on the management of the available beds within the Trust, and will be supported by CCC team to maximise patient flow and create additional capacity.

- Lead the 3 x daily cross site meetings and provide a summary of actions and feedback

- To hold an overview of the Trust's position with regards to capacity and to keep the CCC up to date

- Capacity activity data will be entered at least on a four hourly basis at which times the internal escalation status is reviewed, and communicated as appropriate internally and externally and ensure Divisions and partners are working to the same triggers

- To be available to receive escalations from all staff across the Trust

- To liaise with South East Coast Ambulance Service NHS Foundation Trust (SECAmb) in ensuring Ambulances are not being held on the site

- To liaise (and meet regularly) with ED Nurse in Charge, utilising HealthRoster to ensure staffing is addressed if patients are queuing in ED

- To coordinate the resolution of any potential 12 hour DTA breaches

- To undertake /oversee risk assessments for patients that are moved within the Trust that is not on the patient's usual pathway as identified by the non-clinical team.

- All requests for inappropriate patient moves are highlighted and challenged with the person requesting the patient transfer.

- Request that clinical staff also complete risk assessments and transfer of care processes between wards prior to any patient moves taking place, and that all documentation is complete prior to movement.

- Only private ambulances/taxi's may be authorised through the Site Team

25.5. ED Nurse in Charge

- To monitor and escalate following the ED trigger escalation tool and be prepared to initiate further escalation measures alongside the senior ED Doctor responsible for ensuring timely processes: Redeploying staff as appropriate
    - Triage
    - Treatment
    - Referral

- Inputting correct DTA's on the system, anticipating timely patient moves out of the department, (regular liaison and meet with CST)

- Report concerns of operational, clinical or patient safety compromise to the Emergency Consultant in Charge or On Call Consultant, to work in conjunction with the ED teams to mitigate risk and respond to demand and to flag concerns or safety issues to the ED Matron, DDNQ and CST.

- To ensure the continued application of the 15-minute assessment to all ambulance arrivals including those held within ambulance handover and in ambulances

- To follow and implement the ED Triggers and plan to ensure Ambulances are not held with patients and those patients continue to have the required 15-minute assessment.

- Are responsible for implementing internal escalation plan actions when delays to processes are known.

- To liaise with CST to deliver flow of referred patients into the Trust under the Full Capacity Escalation Plans.

- Responsible for escalating to the CST when activating internal ED escalation plan

25.6. Ward staff

- The Nurse looking after the patients is responsible for the proactive management and care including individual discharge arrangements, ensuring that:
- A full assessment of the patients clinical condition including infectious status
- The relevant documentation is completed on admission, and updated throughout the patients stay
- The patients physical 'norm' is identified on admission and when it is achieved so that discharge is not delayed due to non-recognition of their maximum capabilities
- Early communication with relatives, carers and or other internal and external agencies
- Referrals to the relevant multi-disciplinary team members are made in a timely fashion and the team is kept updated regarding the patients progress
- Communicate Expected Date of Discharge to ward clerks for accurate Allscripts recording, aiding accurate capacity planning
- A full assessment of social circumstances is undertaken on admission
- To undertake nurse led discharges as indicated by medical teams (Criteria Led Discharge)
- To promote safe and timely discharges so that the majority of activity occurs before 12:00
- Once a decision to discharge has been confirmed, the ward has 30 minutes to discharge patients directly or utilise the Discharge Lounge. Beds must be used in a timely manner to ensure safe patient flow.

25.7. Ward Managers/Leads/Ward Nurse in Charge

- At the start of each shift, any empty bed must be rung through to the CST immediately to check they're aware of its availability.
- The NIC is clearly identified on ward allocation boards and carries the ward bleep / phone.
- The NIC is responsible for ensuring that accurate, timely information around beds is communicated either by telephone, or in person.

- Follow and achieve the targets within the Patient Flow Bundle SAFER for the ward area

- Ensure flow is maintained by declaring beds within 15 minutes of being vacant, updating Allscripts and TeleTracking and pulling patients into empty beds within 30 minutes

- Ensure any blocks to discharge are escalated to relevant CST team and through to CCC

- To promote the identification of outliers and flag on white boards as appropriate

- Ensure all staff are aware of Trust Escalation status as appropriate

- Follow the relevant Trust Escalation Action Card

- Be prepared to support the medical team to identify outliers, accept off specialty patients, where clinically appropriate and review bringing forward discharge times and dates in times of heightened escalation

- It is imperative that all Trust policies for discharge are followed and that an Expected Discharge Date (EDD) is a confirmed part of the patient journey.

- To promote / request ability for nurse led discharges if medical team happy to instruct (Criteria Led Discharge)

- The NIC must ensure the Discharge Lounge is utilised unless the patient can be discharged directly from the ward within a maximum of 30 minutes.

- The Ward Manager has overall responsibility of ensuring ward staff adhere to the capacity and patient moves principles.

- Capacity Information required will include:
    - Current bed availability
    - Definite discharges planned for that day, and approximate timings of when those beds will be available for use
    - Potential discharges where proactive nursing intervention is required to expedite the process
    - Patients who are suitable for step down / escalation areas upon request and who are identified on the white board.

25.8. Directors of Nursing and Quality / Lead Matrons

- The senior nursing role is to proactively manage issues identified within their areas of responsibility and to promote safe and timely transfers and discharges.

- They also provide support and advice to ward teams and to support those teams in the management of effective discharges and identifying appropriate outliers.

- The senior nurses will work on the wards (as Ward Liaison Officers) when the Trust is experiencing high pressure on capacity to expedite discharges where possible.

- To work with lead medical teams to promote nurse led discharges (Criteria Led Discharge)

- The responsibility for progressing patients journey through MTW once medically fit belong the below nurse groups:

    - Ward Manager~ up to 7 days MFFD to leave acute bed date
    - Matron ~ 7 – 14 days MFFD to leave acute bed date
    - DDNQ ~ over 14 days MFFD to leave acute bed date

- The Trust may deploy a range of methods to resolve unnecessary delays of length of stay that exceeds patients fit to leave acute bed dates. Nursing staff should be aware that actions and attendance at meetings may be required. It is therefore important that nursing teams follow processes and devise ways of highlighting and minimising patient delays.

25.9. Divisional Management Teams

- The designated 'Operational Lead' to attend cross site meetings when alert level dictates or if requested to do so by CST
- Support clinical staff in achieving Patient Flow Bundle SAFER
- Be able to recognise trigger points within the escalation process which affect their own Division and liaise as appropriate
- Hold plans within the Division to mitigate the risk of rising escalation or as a way to recover from heightened escalation
- Receive escalations from the CST within the Division or other stakeholders and act upon them
- Follow relevant escalation action plans
- Ensure robust dissemination and implementation of the patient move process, enforcing key aspects of timely capacity management.
- Identification of any training needs and to ensure training of updated processes.
- Ensuring adequate facilities and resources are utilised to assist with adherence to this protocol. They are also ensuring that any changes in practice are implemented.

25.10. Medical Staff

- To ensure / monitor the management of inpatients adheres to Patient Flow Bundle SAFER
- Wherever possible, it should be indicated that a delegated professional may discharge a patient once criteria are met (Criteria Led Discharge)
- To respond proactively to requests of help in resolving the hospitals capacity state
- To be responsible for recording the Expected Date of Discharge in patients notes within 14 hours of admission and updated regularly thereafter
- A clear medical discharge/management plan must be recorded in the notes and updated regularly
- Support the team to ensure appropriate medical documentation is completed prior to the medical team leaving the area

- To support the outlying process and identify suitable patients when conducting board rounds
- If discharges are planned for a future date and the drug requirements are known, the TTO's and discharge summaries are prepared in advance of that date

25.11. Divisional Directors of Operations and Clinical Directors

- To ensure /monitor the management of inpatients adheres to Patient Flow Bundle SAFER
- To promote 'nurse led discharges' / Criteria Led Discharges where safe and appropriate to do so
- To respond proactively to requests of help in resolving the hospitals capacity state
- To ensure a nominated deputy is known if unavailable
- To communicate and coordinate capacity escalation actions as appropriate
- Ensure that all actions are followed within the relevant escalation plans are completed in a timely manner with any issues being reported back to the Site Director
- To support the decision made by the Trust executive team to utilise escalation areas, convert SPA/admin time to DCC, and to reschedule routine activity as appropriate
- It is imperative that all Trust policies for discharge are followed and that an Expected Discharge Date (EDD) is a confirmed part of the patient journey.

25.12. The Integrated Discharge Team (IDT)

- On a daily basis the Integrated Discharge Team will be identifying those patients whose discharge is delayed. Daily progress assessment will be held with partners in Social Care and the Health Community where all patients with a transfer of care delay will be individually discussed, and alternatives considered.
- It is imperative that all Trust policies for discharge are followed and that an EDD is a confirmed part of the patient journey.
- A senior member of IDT will attend all Site meetings and provide feedback re community capacity and patients identified for resources
- A senior member of the IDT will carry a bleep for escalations

- The IDT team are responsible for ensuring the community transfer list is accurate and maintained in conjunction with ward staff

- They are responsible for liaising with wards and community partners re transfers and encourage ward staff to plan and enable timely transfers to community beds and discharges

- IDT staff will promote effective and timely communication with ward, departmental and own teams as well as external partners and relatives as appropriate.

- All Trust policies for discharge should be followed IDT staff will monitor and enforce this across MTW. The IDT have their own Escalation Plan/Procedure which will be followed at each Escalation status.

25.13. Therapy Responsibilities

- The therapy team contributes to the Multidisciplinary Team (MDT) discharge process using Occupational Therapists, Physiotherapists, Dieticians and Speech and Language Therapists who assess and aid: patient independence; safe mobility; timely discharge; effective nutrition and communication needs. Processes are also in place with other MDT teams in the community to aid the Trust's patient flow and enable effective discharge strategies to be implemented and delivered

- To prioritise new referrals at daily board meeting and respond within 1 working days

- Patients seen by an OT as part of wider MDT care pathway will be seen in line with agreed national and local standards, e.g. stroke patients to be seen within 72 hours from admission and for 45 minutes of rehabilitation per day.

25.14. Portering Team

- To respond proactively to requests from the CST that will enhance or enable particular patient flow pathways

- To ensure prioritisation of patient moves and actions required to expedite our patients journey

- To support the decision made by the Trust executive team to utilise escalation areas as agreed

- To communicate and coordinate capacity escalation level as appropriate and ensure actions are followed timely and fed back as appropriate

25.15. Catering Team

- To respond proactively to requests from the CST to ensure situational awareness.

- To support decisions made to escalate areas to ensure patients nutritional needs are met through timely delivery of catering services

- To communicate and coordinate levels of escalation to the wider team to ensure sustainable solutions are in place and feedback to CST concerns from local teams

26. Appendix 3 - Command and Control in Critical Incident

Strategic Commander : Chief (Deputy) Operating Officer

- Strategic command has overall command of the Trusts resources
- Liaising with partners to develop the stratgey to manage the OPEL 4 / BLACK status and work towards de-escalation.
- Delegate decisions / actions as appropriate to Tactical Commander
- Receive Tactical Commander escalations and aim to resolve at Tactical & Operational level
- Attend / lead Strategic meetings with external partner agencies
- Assist with the resolution of issues reported where ever possible to facilitate better patient flow
- Ensure business continuity at all times.

Tactical Commander : Head of CCC/ICC or Director of Operations – Patient Flow or Tactical on Call

- Responsible for directly managing the hospitals incident response and recovery
- Ensure CCC / ICC suitably resourced, functioning efficiently and commence the incident log
- Develop the plan which will achieve the objectives agreed with Strategic Commander and assist with de-escalation as soon as possible
- Lead Tactical Command / CCC / ICC meetings
- Receive Operational escalations facilitating the actions to resolve
- Be visible and available within CCC / ICC to provide leadership within the room
- Ensure business continuity at all times.

Operational Commanders : Site Director supported by DDoO's & DDNQ's

- Operational Commanders will be responsible for managing the main working elements and practices of the Trusts response
- Established in site office working closely in partnership with CCC
- Liaising closely with ED NIC & ED DrIC to support the agreed plan and convey this through to the wards and Assessment Areas resolving blockages on the way
- Escalate to the Tactical Commander any operational issues that cannot be resolved locally and need greater support (e.g. PPE shortages, Workforce, mutual aid requests, system wide resources)
- Be present and visible in ED and all affected clinical areas to support staff and patient safety decision making
- Assist with the resolution of issues reported where ever possible to facilitate better patient flow
- Ensure business continuity at all times.

27. Appendix 4 – 'Boarding Guidelines'

BOARDING GUIDELINES

In the context of these guidelines, a boarded patient is defined as:

"A patient residing on a ward without an allocated bed space"

Purpose and rationale for these guidelines

The purpose of these guidelines is to ensure there are robust processes in place to provide assurance that patient safety is being maintained when the Trust is experiencing increased challenges managing demand and patient flow.

These new guidelines describes the process of risk sharing across the Trust when the Emergency Department (ED) has more patients than it can safely care for and supports the sites with maintaining patient safety, the provision of high quality care and a good patient experience.

Unlike many departments the ED must remain open. When all available patient care spaces are occupied, the risk of serious incidents happening not only increases with every new patient that arrives, but is concentrated in one area.

NHSI and our own MTW data shows that mortality increases for patients with avoidable long waits in ED. Allocating one extra patient (boarding) to suitable wards will share this risk across the Trust, Improve patient outcomes and reduces the risk in ED.

MTW's Emergency Departments (ED) sees between 360 and 460 patients per day depending upon the time of week, season or weather.

At Maidstone Hospital the department has the capacity to care for 22 adult patients in trolley or bed spaces across 3 areas (majors, resuscitation, minors - excludes pediatrics).

- 9 in majors
- 2 isolation cubicle
- 4 in Resuscitation
- 7 in minors
- Pediatrics in ED have 5 care spaces
- RAP 4 spaces

At Pembury Hospital the department has the capacity to care for adult patients in 33 trolley or bed spaces across 3 areas (majors, resuscitation, minors - excludes pediatrics).

- 18 in majors
- 1 isolation cubicle
- 6 in Resuscitation
- 8 in minors.
- Pediatrics in ED have 6 care spaces
- RAP 5 spaces

When these spaces are full and ambulances are unable to offload it is recognised that there will be times when the hospital needs to operate differently.

27.1. Triggers for activating patient boarding

The Boarding of patients should be considered when a number of the following criteria are met.

- No care space in the ED
- The Trust escalation status is OPAL 3 or 4
- The ED escalation status is RED or BLACK
- More than 20 unplaced patients waiting for a bed at 8am
- Resus is full with level 2 dependency patients with incoming priority call and no immediate allocated bed space
- There are more than 3 ambulances being held for more than 45 minutes.
- Potential 12 hour ED trolley breach.

Levels of Boarding

Level one -
Boarding against identified discharges will be considered when ED has 20-25 unplaced patients with decisions to admit (DTA's), plus 2 of the triggers above

Level two -
Boarding patients on wards without identified discharges when DTA's are 25-30 and one of the above triggers.

Level three-
Boarding of patients will occur when there are 35+ patients with a decision to admit unallocated at 08:00 hrs

Note: in the first instance
Matching boarded patients to their specialty will always be considered but may be overlooked at level 4 if the number of DTA's at 08.00 hrs is plus 35

27.2. Activating patient boarding

The decision to escalate and activate patient boarding is not made by one individual alone but made together with the clinical teams, Chief Operating Officer, Operations Directors, and Divisional Directors of Nursing. OOH the decision is made by the Executive Director on call following discussion with the on call manger.

This decision should be considered seven days a week and should be taken as early in the day as possible, ideally at the 09.00 site meeting, however this decision may need to be made earlier in line with the triggers for boarding (as above). These decisions should be reviewed hourly by the Site Director.

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27.3. Transfer of boarded patients to ward areas

The Site Director in conjunction with Divisional Directors of Nursing will decide, in

conjunction with the Nurse in Charge of ED, Site Managers and the receiving ward, which patients are suitable to be moved to the wards. When a decision to board has been made it is the responsibility of the NIC of ED or senior site manager to ensure that the patient and family are aware that the patients will be boarding on a ward. There should be documentation in the notes that reflects the conversation.

27.4. Criteria for transferring boarded patients to ward areas

- Only patients with a decision to admit (DTA) in ED or CDU will be moved to suitable wards for boarding.

- Referred patients in ED should have a senior review and management plan documented by the on call registrar of the admitting team prior to transfer to the admitting ward.

- When transferring boarded patients it is the responsibility of ED staff to ensure that a comprehensive hand over is given to the nursing team. The patient must be escorted to the ward by a registered nurse.

- Only one patient per ward will be allocated. One ward named nurse (Registered or Support Worker dependent on the patient) must be allocated to care for the patient. In OPAL level 4 we will consider boarding a second patient

- Patients with cognitive impairment (e.g. delirium/dementia/mental health condition) should be given priority for a bed space.

- When the 'boarded' patient is bedded and the ward returns to its agreed bed base further patients can be admitted using the same criteria.

- The patient transferred from ED will be placed into the bed space and the patient awaiting discharge will be boarded outside the room. This allows treatments for the sickest patient to commence treatment without delay.

- The Infection control team should be made aware of any possible infection control risks.

- Screens should be available to maintain privacy and dignity of boarded patients.

- Patients requiring non – invasive ventilation should NOT be boarded, in this instance the patient who is mapped for discharge should be boarded to allow the patient requiring urgent intervention immediate access to a bed space.

- When boarded patients are on the wards any medications with the

patient should be kept in a green pharmacy transfer medication bag and either locked in the wared drugs trolley or in a locked medicine cupboard in the clinical room.

- When boarding has been agreed, site matrons will be responsible for ensuring wards are safely staffed to receive one extra patient – this may mean moving staff from other areas.

- Tracking of boarded patients should be clearly visible in the site office and documented on the daily site reports which will be managed by site managers. An update on boarded patients will be provided at each site bed meeting so that appropriate plans can be put in place.

- Any patient boarded longer than 4 hours should be escalated to site managers and specialty matron. If there are any clinical concerns during the period of boarding these should be escalated to the site managers and matrons. An incident form should be completed when the period of boarding has exceeded 4 hours.

27.5. Monitoring of compliance against guidance

- The frequency of activation will be monitored by operational teams and recorded on site reports and on incident reports when boarding has exceeded 4 hours.

- Speed of transfer and the provision of the additional nursing support will be monitored by the Associate Directors of Nursing.

- Care of the additional patients on the ward will be monitored by the Senior Matron for the specialty.

- These guidelines will be reviewed at the weekly Chief Nurses Midwifery team meeting in relation to impact on provision of patient quality and safety.

- Impact on safety and care of existing patients on wards by reduced staff to patient ratios will be monitored by the Senior Matrons and reported through the Trust Clinical Governance Committee into the Quality Committee

28. Appendix 5 – Emergency Department Escalation

Emergency Department Escalation Process – Full Capacity Protocol

GREEN (OPEL 1) – No Safety Concerns	AMBER (OPEL 2) – Early Escalation	RED (OPEL 3) – Safety Concerns	BLACK (OPEL 4) – Sustained Safety Concerns
	Any one or more of the following: 1. >50 people in the department 2. >3 DTA's ready to leave ED 3. Ambulance handover >15 mins 4. Poor workforce skill mix 5. 2 x 1:1 Specials in department 6.TeleTracking bed state warning 7. >20 patients booked in 2 consecutive hours	Any one or more of the following: 1. >60 people in the department 2. >5 DTA's ready to leave ED 3. Ambulance handover >30 mins 4. ED felt to be 'unsafe' by NIC or DrIC 5. 3 x 1:1 Specials in department 6.TeleTracking bed state <5 beds available	Any one or more of the following: 1. >70 people in the department 2. >10 DTA's ready to leave ED 3. Ambulance handover >60 mins 4. ED felt to be 'unsafe' by NIC or DrIC 5. 5 x 1:1 Specials in department 6.TeleTracking bed state critical
Who do I escalate to?	Who do I escalate to?	Who do I escalate to?	Who do I escalate to?
1. Regular communication between DrIC / NIC / Site team	1. NIC to contact senior support – Matron / Site Team 2. Site teams to advise CCC of change in status	1. NIC to advise site team of change in status and escalate to on call teams. Consider alternate methods of management 2. Site teams to advise CCC of change in status 3. CCC to liaise with on call silver 4. CCC to liaise with SECAmb	1. NIC to advise site team of change in status and escalate to on call teams. As per RED status 2. Site teams to advise CCC of change in status 3. CCC to advise ICC of change of status 4. ICC liaise with LHE partners
Business as usual to support flow	Consider changes in department	Consider changes in department	Consider changes in department
1. 2 hourly board rounds 2. Streaming to GP 3. Fully utilise SDEC 4. Timely Amb handovers and PIN entry	DrIC & NIC Site team meet in ED to review immediate plan, discuss options below: 1. Review distribution of Drs, ENPs, EDPs 2. Consider how GP can support further 3. Majors patients waiting > 2 hours for first assessment – DrIC & NIC refer straight to specialty.	DrIC, NIC, Site Director / Silver, Site team to review immediate plan to make department safe, discuss options below: 1. All options in AMBER 2. ENSURE ALL Majors patients waiting >2 hours have been referred direct to Speciality Teams. 3. COO/DCOO/ Exec on Call to consider instigation of FULL CAPACITY PROTOCOL and opening escalation areas. 4. Focus on Ambulance Handover plan to prevent 'corridor care'. 5. Senior Decision Makers to Triage – SpR/ ENP / EDP	DrIC, NIC, Site Director, Site team meet in ED to review immediate plan to make department safe, discuss options below: 1. All options in GREEN, AMBER & RED 2. Announcement in waiting area and information given to patients. 3. External Comms (Social Media) 4. SPA time redeployed, consider admin staff to support in non clinical tasks. Food / drinks. 5. Senior Decision Makers from ALL specialities in ED 6. On Call Consultants facilitate 5. 7. Critical Care support in ED Resus.

29. Appendix 6 – Quick Reference Action Cards

Chief (Deputy) Operating Officer – Strategic Commander

Normal Working / Low Risk

- Accountable for the management of beds as a Trust resource
- Accountable for confirming decisions on temporary bed usage
- Act as a resource for the Site Director in the operational management of the hospital

Moderate Risk

- Ensure community beds are utilised and available to MTW, challenging senior partners where appropriate
- Liaise with Site Director to ensure any delay are highlighted and acted upon
- Liaise with external partners to increase discharge opportunities
- Liaise with Emergency Planning Advisors to ensure current, accurate and intelligence based decision making

High Risk – as above plus

- Liaise with COO within SECAmb re actions to avoid queue delays
- Follow up actions with CoS, DDoOs & DDNQs to establish how they will be delivering the requirements
- Ensure staff welfare measures are in place at all levels to ensure a sustainable approach

Very High Risk – as above plus

- Agree OPEL 4 status with CEO
- Agree the responsibilities of ICC
- Take Strategic Command Lead for Trust

Director of Operations – Patient Flow & Head of Care Coordination Centre / ICC – Tactical Commander

Normal Working / Low Risk

- Ensure a fully functioning CCC capable of stepping up to an ICC to manage a major / critical incidents and periods of heightened escalation
- Provide the Direction as to how the CCC / ICC will function agreeing key priorities
- Ensure solutions to support and enhance patient flow throughout the organisation for both elective and non-elective patients

Moderate Risk

- Liaise with Site Director to ensure a whole system support mechanism in place from the CCC
- Support the Divisional Triumvirates in the delivery of their escalation action plans
- Liaise with stakeholders to ensure staff safety and welfare measures are in place throughout all decision making

High Risk – as above plus

- Liaise with COO / DCOO to ensure that all Strategic decisions and actions are translated and actioned through the CCC
- Provide pragmatic solutions to Divisional problems via the CCC to support de-escalation actions
- Test Divisional plans to ensure a positive impact on patient flow. Challenge through the agreed structure plans not delivering improvements in flow

Very High Risk – as above plus

- Agree key priorities of the ICC with COO / DCOO
- Communicate the battle rhythm to the CCC / ICC for onward cascade
- Ensure robust Tactical plans in place and test these plans are

impacting on flow positively

- Take Tactical Command Lead for the Trust

Site Director – Operational Commander
Normal Working / Low Risk
Moderate Risk
• Act as point of escalation from Clinical Site Team (CST) • Provide clear direction on decision making on issues above the authority or experience level of the CST • Agree in advance the plan to open escalation areas out of hours as appropriate • Ensure mechanisms in place for staff safety and welfare throughout decision making
High Risk – as above plus
• Advising and signposting colleagues including external whole health and social care system partners, and other external agencies as required in order to prevent movement to OPEL 4 / Black Status • Support the CST / Tactical on call Manager in making decisions on use of escalation bed capacity. Liaise with SECAmb as appropriate re risk of holding ambulances and plans to avoid or mitigate the risk • Closely monitor situation to determine progress or further deterioration • Liaison with On Call Directors for external partners requesting assistance and support
Very High Risk – as above plus
• Liaise with COO/DCOO for sign off of OPEL 4 and activate plan • Liaise with CCC / ICC to update on current situation and actions • Take Operational Lead responsibility for Trust

Clinical Site Team & Senior Manager on call
Normal Working / Low Risk
Moderate Risk
• Act as point of escalation between ED / wards and Site Director • Liaise with ED Consultant and ED NIC to attend 4 hourly huddles in ED 7 days a week • Monitor flow acting on reduction of decision making or flow • Monitor 4 hour standard closely and expedite actions to avoid delays • Escalate to Directorate Triumvirate where discharge decisions are delayed • Promote the use of the Discharge Lounge • Monitor actions in Full Capacity Protocol if risk of delayed Ambulance handovers • Ensure plans are in place to minimize and reduce escalation areas
High Risk – as above plus
• Liaise with Directorate Triumvirates regarding staffing levels • Ensure ward teams are following their action plans • Escalate delays in repatriations to Site Director • Liaise with SECAmb re HALO • Support CCC / ICC in establishing a Command and Control structure as requested
Very High Risk – as above plus
• Take direction from CCC / ICC / Site Director ensuring ED and ward areas are following actions plans • Ensure current status is communicated to all clinical areas

Divisional Directors of Operations & Nursing, Quality
Normal Working / Low Risk
• Ensure that the Division has an up to date escalation and continuity plans • Ensure all staff understand their role in the plan • Ensure visibility of the Divisional leadership rota • Monitor and seek to improve patient flow bundle SAFER principles through internal professional standards
Moderate Risk
• Ensure all specialties have completed ward / board rounds as per SAFER principles. • Support clinical teams to unblock barriers around treatment/ transfer/ discharge • Review specific Directorate problems with GMs and Lead Matrons to resolve quickly • Respond to Site Directors requests for support in decisions affecting flow
High Risk – as above plus
• If elective clinics or theatre lists are cancelled agree how the clinical teams will be redeployed to support flow in partnership with CoS. • Agree Divisional leadership meetings to support completion of actions • Redeploy staff from areas with cancelled activity to support flow / CCC / ICC
Very High Risk – as above plus
• Ensure all elective sessions are cancelled to support flow • Nominate a Divisional lead to operate in CCC/ ICC • Ensure conversion of clinical staff training time and SPA time to direct clinical care activities support ED and Assessment areas

Chief of Service & Clinical Site Leads
Normal Working / Low Risk
• Ensure Medical workforce team understand and support the Patient Flow Bundle SAFER principles through robust internal professional standards • Ensure timely response from the Medical team to ED and Assessment areas as required • EDDs to be agreed by the admitting Consultant with 24hours of admission • Early identification of potential discharges with good criteria led discharge plans • Timely completion of the EDNs • Assist Site Director to unblock any barriers to treatment, transfer, discharge or patient flow
Moderate Risk
• Ensure Consultant body review management plans for all patients, consider alternative pathways and use of H@H • Ensure Consultant body review all outliers daily with clear plans in the notes
High Risk – as above plus
• Agree discharge and admissions thresholds with the Consultant body • Ensure additional Senior Decision Makers can support ED and Assessment Areas • Consider cancelling non-urgent elective activity • Redeploy staff from SPA
Very High Risk – as above plus
• Ensure all non-clinical activity is cancelled and medical teams are redeployed accordingly • Liaise with DDoO to cancel appropriate levels of outpatient activity to release senior staff to ED and Assessment Areas

- Focus the medical team on daily / twice daily ward rounds and the use of community / alternative pathways.

Heads of Performance & General Managers

Normal Working / Low Risk

- Offer support and advice where needed to CST and Site Director regarding patient flow and activity
- Ensure Directorate escalation and continuity plans are robust and current
- Communicate the Trusts key messages around flow to all areas

Moderate Risk

- Take responsibility for decision making in order to enact the actions of the Site Director
- Ensure timely response from all medical teams actions to support flow
- Escalate quickly blockages in terms of flow to Divisional Leadership team

High Risk – as above plus

- Review Directorate specific problems with Divisional Directors to resolve quickly
- Support the Site Director and CST to flex job planned activities / escalation areas
- Produce a plan for cancelling non-urgent elective activity to present to Divisional Directors

Very High Risk – as above plus

- Take direction from Divisional Directors to:
    - Liaise with all clinical and Medical teams to ensure a Directorate wide approach to the current situation
    - Recall staff from SPA, training and admin duties to direct clinical activities
    - Liaise with all Directorate Consultants to ensure the pathways support improving flow through ED and Assessment Areas.

Lead Matrons / Matrons

Normal Working / Low Risk

Support Matrons / Ward Managers to:

- Ensure TeleTracking is accurate and up to date in terms of bed occupancy
- Ensure White Board is current
- Ensure Senior review (SAFER) of new, unwell or potential discharges before 10am
- Ensure accuracy of EDDs within 24 hours of admission
- Ensure all patients have a clear management / discharge plan
- Ensure early use of Discharge Lounge
- Ensure good communication of current status
- Ensure staffing levels to meet demand

Moderate Risk

- Ensure Directorate Triumvirate manage activity levels
- Support changes in practice / scheduled activities to engage in discharge planning
- Facilitate where required escalation space

High Risk – as above plus

- In partnership with GM ensure timely medical reviews of all patients
- Liaise with DDNQ to ensure safe staffing is promoted in all areas
- Supports CNSs providing in reach to ED and assessment Areas

Very High Risk – as above plus

- Directorate Triumvirate to cancel all non-clinical activities and ensure staff are focused on flow
- Take direction from DDNQ to ensure Directorate teams understand the action plans

Middle Grades & Junior Doctors
Normal Working / Low Risk
• Adhere to Patient Flow Bundle SAFER principles • Ensure TTOs are completed the day before to support early discharge. • Ensure all patients have an EDD within 24 hours from admission • Ensure all outlier have a clear plan and are seen daily • Ensure all MFFD patients have a clear plan • Ensure Senior Review happens for all new, unwell and potential discharges before 10am.
Moderate Risk
• Ensure all diagnostics / treatments have been ordered / chased and then acted upon. • Escalate all patient safety / flow / delays to Consultant.
High Risk – as above plus
• Review medical management plans for ALL patients; consider community H@H and alternative pathways. Discuss with Consultant delays in plans. • Cancel non-clinical activities other than mandatory training and ensure presence on ward to support flow.
Very High Risk – as above plus
• Take direction from Consultant body with regards to supporting twice daily reviews and in reach to ED and Assessment Areas

Consultants (in and out of hours)
Normal Working / Low Risk
• Ensure self and junior medical team adhere to agreed Patient Flow Bundle SAFER principles and internal professional standards • Ensure prompt attendance of a 'senior decision maker' to ED from specialties when requested and in line with agreed internal professional standards • Accepted GP referrals to specialty teams and not sent through ED • EDDs to be agreed for all patients within 24hrs of admission • Ensure senior review daily of medical active patients and potential discharges before 10am followed by a mop up board / ward round in the afternoon to ensure all tasks have been acted on • All patient flow is essential to ensure that patients are other in hospital for the optimum amount of time. Delays in decision making significantly impacts on the patients journey and experience • Clear discharge plans to be documented in the notes including 'Criteria Led Discharge' plans when agreed • TTOs must be completed the day before the planned discharge or as the discharge decision is made and NOT 'batched' to the end of the ward round • Assist Clinical Directors, Chiefs of Service, Site Directors, Senior Managers on Call and the Clinical Site Team in unblocking barriers to treatment/transfer/discharge/patient
Moderate Risk
• Review management plans for all patients, consider alternative care plans and use of services such as Home First and Hospital at Home to support ongoing treatment plans. • Ensure the medical on call team is well supported and support with 'take'
High Risk – as above plus
• Liaise with specialty colleagues to review discharge and admission thresholds • Support ED, AMU, SAU and Assessment Areas as requested • Consider with CD and CoS cancelling non-urgent elective work
Very High Risk – as above plus

- Take direction from CD's and Cos with regards to supporting flow generally across the sites
- Focus on simple discharge cases providing clear management plans for the junior medical team and nursing team to enact.

Ward Manager & Nurse in Charge
Normal Working / Low Risk
• Ensure TeleTracking and WhiteBoard are accurate and updated in a timely manner • Ensure Senior Review happens of new, unwell and potential discharges before 10am. Escalate to Matron if this does not happen • Ensure ALL patients have an EDD 24 hours from admission • Ensure ALL patients have a robust clearly documented management plan • Promote use of the Discharge Lounge • Ensure Ward Clerk / Flow Coordinator follow escalation process
Moderate Risk
• Work with Matron / GM and Consultants to ensure the ward can manage the expected activity level • Ensure all outliers have at least a daily review
High Risk – as above plus
• Plan to accommodate off specialty patients including outliers in liaison with Matrons • Liaise with Consultant to plan for alternative care pathways, criteria led discharge and H@H.
Very High Risk – as above plus
• Focus on simple discharges and ensure ALL patients are considered for H@T

AMU & AAU Ward Clerk / Flow Co-ordinator
Normal Working / Low Risk
• All patients to be transferred within 30 minutes of bed allocation. • Ensure TeleTracking is accurate and current • Actively pull patients through from ED • Escalate patients with LOS >48 hours to Ward Manager / NIC who are not due to discharge today • Actively promote TTOs & EDNs for tomorrows discharges • Ensure all patients waiting on discharge dependent diagnostics are made aware to the CST. • Promote adherence to SAFER principles
Moderate Risk
• Work with NIC to ensure a timely review of all patients
High Risk – as above plus
• Review SDEC and Acute Assessment areas to ensure the flexible use of all space • Plan to hand patients over to off specialty wards • Recall staff on admin / study days • Support additional ward rounds
Very High Risk – as above plus
• Prepare to open additional escalation space as directed

Emergency Department – Nurse in Charge (NIC)
Normal Working / Low Risk
• Attend site meeting at 0900 taking an up to date overview of the department • With ED Consultant lead (DrIC) attend 4 hourly huddles in ED 7 days a week • Ensure transfers out of ED within 15 minutes of bed being available from CCC • Fully utilise Discharge Lounge, SDEC and Acute Assessment Areas to manage patient pathways • Escalate patients without 1st assessment within 60 minutes to the DrIC or SpR • Escalate patients at 3 hours without a plan to DrIC and CST • Ensure agreed escalation process is followed for patients referred but not reviewed by Specialty team within 30 minutes. Escalate any intra-professional issues • Liaise with ED Matron to prevent 4 hour breaches
Moderate Risk
• Ensure a systematic review of all patients by Con / SpR or Specialty Dr • Ensure all patients awaiting discharge dependent diagnostics are escalated to Divisional team / CST
• Utilise seated areas and SDEC where possible
High Risk – as above plus
• Prepare staff to meet Ambulance queues • Review staffing and escalate ratio concerns • Ensure CCC aware of current demand • Recall staff from study leave or admin time • Liaise with DrIC to plan for alternative care pathways
Very High Risk – as above plus
• Follow action plan from CCC / ICC to support flow

Emergency Department – Consultant in Charge (DrIC)
Normal Working / Low Risk
• With ED team lead 4 hourly huddles in ED 7 days a week • Prioritise patients without 1st assessment within 60 minutes to the ED medical team • Prioritise patients at 3 hours without a plan to medical team requesting an urgent plan to agree • Prioritise patients referred but not reviewed by Specialty team within 30 minutes. Raise any intra-professional issues with Specialty Consultant for action • Liaise with ED Matron to prevent 4 hour breaches
Moderate Risk
• Prioritise medical teams to provide a systematic review of all patients • Ensure all patients awaiting discharge dependent diagnostics are prioritised and followed up by the requesting Dr • Utilise seated areas and SDEC where possible to stream patient flow
High Risk – as above plus
• Prepare medical to meet Ambulance queues • Review medical staffing and escalate ratio concerns to CD / CoS

• Ensure CCC aware of current demand • Recall medical staff from study leave or SPA time • Liaise with CD / CoS to plan for alternative care pathways
Very High Risk – as above plus
• Follow action plan from CCC / ICC to support flow

Critical Care General Manager / Theatre Team
Normal Working / Low Risk
• Review theatre capacity for emergency and elective lists, ensure plans are in place to utilise resources effectively to avoid cancellations
Moderate Risk
• Review the level of emergency cases ensuring that patients who require surgery today receive their treatment promptly • Review with Divisional leads if patients can move to day case surgery • Facilitate the cancellation of non-urgent elective activity with Divisional leads • Surgical Specialties to agree which patients can go to theatres and liaise with relevant coordinators
High Risk – as above plus
• Surgical Specialties compile a list of those patients who are 'clinically urgent' and must receive surgery on the day. • Liaise with Matrons to ensure staff from cancelled lists are redeployed to support ED, Assessment Areas and wards • Liaise with CST to ensure bed numbers are understood
Very High Risk – as above plus
• Facilitate the use of theatre recovery areas as directed by the CCC / ICC

Integrated Discharge Manager / Team
Normal Working / Low Risk
• Working with external partners to ensure smooth and safe discharge
Moderate Risk
• Increase the pace of pulling patients from ward areas • Escalate promptly delays seen at ward level preventing a patient's timely and safe discharge. • Escalate promptly failure of wards to use Discharge Lounge • Proactively assess transport provisions to ensure capacity without delay • Seek additional support through external partners recommending to Operational and Tactical Commanders levels of community provision required
High Risk – as above plus
• IDT Lead to be present at all site meetings providing sitreps on current and upcoming discharges • Focus on 'quick wins' supporting wards to safely discharge the less complex patients today
Very High Risk – as above plus
• Follow CCC / ICC guidance to ensure IDT working across the site in areas requiring greatest focus • Consider additional workforce requirements to support IDT team members to increase cover

Information Technology & Business Intelligence
Normal Working / Low Risk
• Monitor OPEL status and if escalation status is changed by Operational Commanders share this with Head of IT & BI • Support CCC / ICC with sitreps
Moderate Risk
• Monitor Divisional escalation plan requests for equipment / information to support Divisional attempts to improve flow • Consider level of support in CCC / ICC with increased pressure on Trust
High Risk – as above plus
• Prioritise requests from Divisional leads to support OPEL 3 & 4 actions • Increase workforce requirements to support CCC / ICC escalation status
Very High Risk – as above plus
• Work in partnership with CCC / ICC to support Tactical and Strategic priorities

Estates & Facilities
Normal Working / Low Risk
• Ensure Portering and domestic support present in CCC 24/7
Moderate Risk
• E & F zone supervisors present at site meetings • Liaise with E & F support staff in CCC • Be fully aware of Divisional escalation priorities
High Risk – as above plus
• Prioritise requests from Divisions that support ED and ward flow such as Portering , cleaning and transport. • Leadership team to prepare plan to extend hours and services existing workforce provide during periods of extreme pressure
Very High Risk – as above plus
• Work as directed through the CCC / ICC supporting Tactical and Strategic priorities

Ward Clerks and Receptionists
Normal Working / Low Risk
• Ensure Allscripts and TeleTracking systems are up to date with admission and discharge details • Ensure ALL patients have accurate EDDs recorded from Consultant led board rounds • Be prepared to provide up to date information to CCC as requested
Moderate Risk
• Ensure ward data is current and accurate and easily accessible through Allscripts and TeleTracking systems • Chase and escalate delays in treatment / discharge
High Risk – as above plus
• Prioritise actions from Board rounds to expedite discharges • Support ward staff in chasing and escalating treatment / discharge delays • Prioritise actions with IDT team
Very High Risk – as above plus
• Prioritise actions from CCC / ICC

Corporate
Normal Working / Low Risk
Moderate Risk
• All Corporate teams to monitor Trust escalation status and communicate this to the wider corporate teams
High Risk – as above plus
• Monitor and observe Trust escalation status • Clinical corporate staff to be prepared to support Clinical Operations Divisions as required • Review areas of Workforce and recruitment processes to ensure the Trust works differently to support escalation status
Very High Risk – as above plus
• Corporate / Trust meetings cancelled • Corporate staff to be available to Strategic, Tactical and Operational Commanders to support current pressure • Clinical corporate staff to work in clinical areas with clinical colleagues supporting areas of greatest pressure • Non clinical staff to support CCC / ICC and wards with liaison activities, loggists, portering, general runners and support roles

IMCA REFERRAL

What is the Independent Mental Capacity Advocate (IMCA) Service and how does it work?

The purpose of the IMCA service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about these decisions, or about care reviews or Adult Protection proceedings.

The IMCA service safeguards the rights of people aged 16 years and over who:

- **lack capacity to make a specified decision at the time it needs to be made**

The Mental Capacity Act 2005 (MCA) says everyone has the right to make their own decisions and must be given all practicable help to do so before they are deemed as lacking capacity. The person's capacity must be assessed in relation to the decision to be made. Generic assessments of capacity are not sufficient.

and

- **have nobody else who is willing and able to represent them or be consulted in the process of working out their best interests, other than paid staff**

NHS and Local Authority Decision Makers need to determine if there are family or friends who are willing and able to be consulted about the proposed decision. If not, an IMCA will work with and support people who lack capacity, and represent their views to those who are considering their best interests in accordance with the MCA.

If a decision needs to be taken about a Care Review or Safeguarding case, there is now a statutory duty to refer under the Care Act 2014, and an ICAA referral should be made for an Independent Care Act Advocate.

Please complete a SEPARATE referral PER DECISION

If completing online, click once on relevant box to check. Write in text fields, where required.

Date of Referral:

Professional Referrer's Details

Referrer First Name: **Last Name:**

Organisation:

Job Title:

☐ Doctor ☐ Ward Manager ☐ Care Manager
☐ Care Home Manager ☐ Nurse / Health Professional ☐ Administrator
☐ Other (please state)

Address:

Postcode:

Work Tel No: **Mobile No:**

Email:

Service Group

Is the person requiring an advocate **(check *ONE* box only)**

☐ An Older Person (65+) in the Community ☐ A Carer
☐ An Older Person (65+) in Hospital ☐ A Vulnerable Person ☐ None of these

Is there a *main* disability or impairment considered particularly relevant to this case? **(check *ONE* box only)**

☐ Mental Health Problem	☐ Asperger's /Autism Spectrum Condition	☐ Learning Disability
☐ Physical Disability	☐ Cognitive Impairment	☐ Dementia / Alzheimer's
☐ Sensory (Hearing)	☐ Acquired Brain Injury	☐ Unconsciousness
☐ Sensory (Sight)	☐ Serious Physical Illness	☐ **NO**

Details of the Person requiring an IMCA	
Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Other	**First Name:** **Last Name:**
Date of Birth:	
Permanent Address: **Postcode:**	
Telephone No.	**Mobile No.**
E-mail	

Preferred method of contact:

☐ Any ☐ Telephone ☐ E-mail ☐ Post
☐ Mobile Phone ☐ Text ☐ Cannot be contacted directly

Gender: ☐ Male ☐ Female ☐ Transgender M to F ☐ Transgender F to M
☐ Prefers not to say ☐ Other (specify)

Ethnic Background

White
- ☐ British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other White background (specify)

Mixed Ethnic Groups
- ☐ White & Black Caribbean
- ☐ White & Black African
- ☐ White & Asian
- ☐ Any other Mixed ethnic background (specify)

Black / Black British
- ☐ African
- ☐ Caribbean
- ☐ Any other Black/African/Caribbean background (specify)

Asian / Asian British
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background (specify)

Other Ethnic Group
- ☐ Arab
- ☐ Any other ethnic group (specify)

- ☐ Ethnicity not known
- ☐ Prefers not to say

Does the Client identify themself as Cornish? ☐ Yes ☐ No ☐ Not known

Sexual Orientation

☐ Lesbian ☐ Gay Man ☐ Heterosexual
☐ Bisexual ☐ Other (specify)
☐ Questioning ☐ Not known ☐ Prefers not to say

Marital or Civil Partnership Status

- ☐ Single
- ☐ Co-habiting
- ☐ Married
- ☐ In Civil Partnership
- ☐ Not known
- ☐ Separated (but still legally married / in civil partnership)
- ☐ Divorced or Civil Partnership Dissolved
- ☐ Widowed
- ☐ Surviving partner of Civil Partnership
- ☐ Prefers not to say

Religion or Belief

- ☐ Buddhist
- ☐ Christian (all denominations)
- ☐ Hindu
- ☐ Jewish
- ☐ Not known
- ☐ Muslim
- ☐ Sikh
- ☐ No Religion
- ☐ Other (specify)
- ☐ Prefers not to say

Does the Client have a Military connection?

- ☐ Yes, Serving
- ☐ Yes, Veteran
- ☐ Yes, Carer relationship
- ☐ No
- ☐ Not known
- ☐ Prefers not to say

Does the Client consider themself to have a disability?

- ☐ Yes
- ☐ No
- ☐ Not known
- ☐ Prefers not to say

What types of disability or impairment does the Client have? **(select *all* that apply)**

- ☐ Mental Health Problem
- ☐ Physical Disability
- ☐ Sensory (Hearing)
- ☐ Sensory (Sight)
- ☐ Asperger's / Autism Spectrum Condition
- ☐ Cognitive Impairment
- ☐ Acquired Brain Injury
- ☐ Serious Physical Illness
- ☐ Learning Disability
- ☐ Dementia / Alzheimer's
- ☐ Unconsciousness
- ☐ Other (please specify below)

What is the Client's primary communication method?

- ☐ Spoken English
- ☐ British Sign Language (BSL)
- ☐ Words/Pictures/Makaton
- ☐ Other (specify)
- ☐ Other Spoken Language (specify)
- ☐ Gestures/Facial Expressions/Vocalisations
- ☐ No obvious means of communication
- ☐ Not known

Is English Spoken? ☐ Yes ☐ No

IMCA client location details

Client's current location

- ☐ Own Home
- ☐ Own Home with Support
- ☐ Supported Living
- ☐ Acute Psychiatric Unit
- ☐ Dementia Ward
- ☐ Care / Nursing home
- ☐ Prison
- ☐ Forensic Secure Unit
- ☐ Hospital
- ☐ Other Institution

Is client currently at their permanent address? ☐ Yes ☐ No **If No, give details below:**

Current Address:

Postcode:

Telephone No.

IMCA Referral Details	
Has the person been assessed to lack capacity to make a particular decision?	☐ Yes ☐ No
Is a decision being made about long term care and health moves (more than 28 days in hospital / 8 weeks in a care home)?	☐ Yes ☐ No
Is the person facing a decision about serious medical treatment?	☐ Yes ☐ No
Are there decisions relating to Adult Protection proceedings?	☐ Yes ☐ No
Is there a care/accommodation review where it is felt that the person would benefit from IMCA?	☐ Yes ☐ No
Are there any family and friends? **or** is there anyone (other than paid workers) who are considered willing and appropriate to be consulted about the decision? **(N.B. this does not apply for Adult Protection proceedings – people can have family and still be eligible)** **If YES**, briefly describe any concerns about their involvement:	☐ Yes ☐ No

Is there an Advance Directive or any other form of record of the client's wishes? **If YES**, please give details:	☐ Yes ☐ No / Don't know
Is this a first referral? ☐ Yes ☐ No ☐ Not known	
Please give details of any known risks the advocate should be aware of. If you are not aware of any risks, please write 'no known risks'	

Details of Decision to be made (check ***ONE*** box only)	
☐ **Serious Medical Treatment**	☐ **Change of Accommodation**
☐ **Care Review**	☐ **Adult Protection Proceedings**
Please give brief details:	
Date the decision needs to be made by:	
Details and dates of any meetings already arranged:	
Please summarise the steps taken to assess the lack of capacity (if known): Date of assessment * Who carried out the assessment? *	

Where are the notes held? *

* This information is not essential at the referral stage

Details of Persons Relevant to the Referral

Is the Referrer the Decision Maker? (the person ultimately responsible for this decision)

☐ Yes ☐ No **If No, please give details below:** (If Yes, go to Declaration)

Decision Maker's Details (if different from referrer)

First Name: **Last Name:**

Organisation:

Job Title:

☐ Doctor ☐ Ward Manager ☐ Care Manager

☐ Care Home Manager ☐ Nurse / Health Professional

☐ Other (please state)

Address:

Postcode:

Work Tel No: **Mobile No:**

Email:

Is the Decision Maker aware of this referral? ☐ Yes ☐ No

Declaration:

- I would like to instruct an IMCA and am authorised to do so.
- I am providing this information and making this referral in relation to the Mental Capacity Act 2005.
- In accordance with current Data Protection legislation, I agree to the Kent Advocacy delivery partners holding personal information (including information on this form).
- I understand the provision of an advocacy service is subject to the client meeting eligibility criteria.

Who can make arrangements for initial client meeting?

☐ Referrer ☐ Decision Maker (if different) ☐ Other

If Other, please provide details below:

First Name: **Last Name:**

Organisation:

Job Title:

☐ Doctor ☐ Ward Manager ☐ Care Manager

☐ Care Home Manager ☐ Nurse / Health Professional ☐ Administrator

☐ Other (please state)

Address:

Postcode:

Work Tel No:	**Mobile No:**
Email:	

Please e-mail the completed form to: kent@seap.org.uk (but please note that you will need to add the word "[secure]" in the subject line of a message (with the inclusion of the square brackets).

or post to: P.O. Box 375, Hastings, TN34 9HU

or fax to: 01424 204 687

If you have not received confirmation of this referral within 2 working days, please contact Kent Advocacy on: **0300 34 35 714**

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All records are held by seAp in accordance with current Data Protection legislation.

Kent Advocacy IMCA Independent Mental Capacity Advocacy

Mental Capacity Act Policy and Procedure

Target audience:	All Trust clinical staff
Author:	Lead Nurse Dementia Care **Contact details:** [redacted]
Other contributors:	n/a
Executive lead:	Chief Nurse
Directorate:	Corporate Nursing
Specialty:	Nursing
Supersedes:	Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure (Version 4.0: June 2015) Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedure (Version 4.1: August 2015) Mental Capacity and Consent, Guidance for Staff (January 2007)
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Document history

Requirement for document:	The Mental Capacity Act 2005 is an important piece of legislation. It is a statutory framework for people who lack capacity to make decisions for themselves, and sets out who can take decisions in which situations and how. The Code of Practice provides guidance to anyone who is working with and / or caring for anyone over the age of 16 who lack capacity to make particular decisions. Certain categories of people are legally required to 'have regard to' relevant guidance in the Code of Practice including anyone who is: • Acting in a professional capacity for, or in relation to, a person who lacks capacity. People acting in a professional capacity may include: • A variety of healthcare staff (doctors, dentists, nurses, therapists, radiologists, paramedics etc.) • Social care staff (social workers, care managers etc.)
Cross references (external):	9. Mental Capacity Act 2005. Code of Practice. Office of the Public Guardian. 10. NICE Guideline: Decision-making and mental capacity (NG108) October 2018. 11. The Mental Capacity Act 2005. Guidance for providers. Care Quality Commission. December 2011.
Associated documents (internal):	• Care of the Dying Patient Policy and Procedure [RWF-OPPPCSS-C-CAN2] • Dementia Operational Policy and Procedure [RWF-OPPPCS-C-NUR10] • Delirium Policy and Procedure [RWF-NUR-NUR-POL-2] • End of Life Care Strategy [RWF-ONC-PAL-STR-1] • Operational Discharge Policy and Procedure [RWF-OPPPES-C-AEM6] • Policy and procedure for consent to examination or treatment [RWF-OPPPES-C-SM5] • Restraint Policy and Procedure [RWF-OPPPCS-C-NUR4] • Safeguarding Adults at Risk Policy and Procedure [RWF-OPPPCS-C-NUR5] • Safeguarding Children Policy and Procedure [RWF-OPPPCS-C-NUR6]

Keywords:	Mental capacity	Assessment of capacity	Best Interest Decisions.
	Best Interest Meetings	Lasting Power of Attorney	Advance decisions.
	Test of capacity	Fluctuating capacity	Decision maker
	Court of Protection	Independent Mental Capacity Advocate (IMCA)	MCA

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Issue:	**Description of changes:**	**Date:**
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2.0	Reformatted and reviewed	March 2010
2.1	Appendix 11 under review	October 2010
3.0	Complete overhaul of previous policy	October 2013
4.0	Updated Policy and Procedure in relation to deprivation of Liberty Safeguard	June 2015
4.1	Archived old DOLS form 1 and updated DOLS form 4.	August 2015
5.0	Complete overhaul of previous policy and appendices and separation of Mental Capacity Act Policy and Procedure from Deprivation of Liberty Safeguards Policy	March 2019

Summary for

Mental Capacity Act Policy

This policy and procedure acknowledges the importance that the Mental Capacity Act 2005 (MCA) has in ensuring that patients are empowered, as far as is possible, to make their own decisions.

The Act was 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.

Trust staff are required to follow this policy and procedure to ensure they are working within the meaning of the law and are upholding patients' rights to autonomy to make their own decisions.

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1.0 Introduction, purpose and scope

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 (the Act), 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.

2.0 Definitions/glossary

Term	Definition
Advance decision (or directive).	An advance decision to refuse treatment (sometimes referred to as a living will) is a decision an individual can make when they have capacity to refuse a specific type of treatment, to apply at some time in the future when they have lost capacity. It means that families and health professionals will know the person's decisions about refusing treatment if they are unable to make or communicate decisions themselves.
Artificial nutrition and hydration	Has been recognised as a form of medical treatment. It involves using tubes to provide nutrition and fluids to someone who cannot take them by mouth. It bypasses the natural mechanisms that control hunger and thirst and requires clinical monitoring.
Best interests	Any decision 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 someone's best interests (see Section 6)
Capacity	The ability to make a decision about a particular matter at the time the decision needs to be made.
Child / young person	Anyone who has not yet reached their 18th birthday.
Consent	The voluntary and continuing permission of the person to receive particular treatment or care and support, based on an adequate knowledge of the purpose, nature, likely effects and risks including the likelihood of success, any alternatives to it and what will happen if the treatment does not go ahead. Permission given under any unfair or undue pressure is not consent. A person who lacks capacity to consent cannot consent to treatment or care and support, even if they cooperate with the treatment or actively seek it.
Court Appointed Deputy	A person appointed by the Court of protection who is authorised to make decisions (relating to the person's health, welfare, property or financial affairs) on behalf of someone who lacks mental capacity and who cannot

Term	Definition
	make a decision for themselves at the time it needs to be made.
Court of Protection	The specialist court for all issues relating to people who lack capacity to make specific decisions.
Decision-maker	It is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity.
Enduring Power of Attorney (EPA)	A Power of Attorney created under the Enduring Powers of Attorney Act 1985 appointing an attorney to deal with property and financial affairs. Existing EPAs continue to operate under Schedule 4 of the Act.
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them.
Lasting Power of Attorney (LPA)	A Power of Attorney created under the Act appointing an attorney (or attorneys) to make decisions about the person's personal welfare (including healthcare) and/or deal with the person's property and affairs.
Life-sustaining treatment	Treatment that in the view of the person providing healthcare, is necessary to keep a person alive.
Mental capacity	See capacity
Mental Capacity Act 2005 (MCA)	A law that applies to people aged 16 and over in England and Wales and provides a framework for decision-making for people unable to make some or all decisions for themselves.
Mental Health Act 1983 (MHA)	A law mainly about the compulsory care and treatment of patients with mental health problems. In particular, it covers detention in hospital for mental health treatment.
Office of the Public Guardian (OPG)	The Public Guardian will be supported by the Office of the Public Guardian, which will supervise deputies, keep a register of deputies, Lasting Powers of Attorney and Enduring Powers of Attorney, check on what attorneys are doing, and investigate any complaints about attorneys or deputies.
Personal welfare decisions	Any decisions about person's healthcare, where they live, what clothes they wear, what they eat and anything needed for their general care and well-being. Attorneys and deputies can be appointed to make decisions about personal welfare on behalf of a person who lacks capacity.

Term	Definition
Property and affairs	Any possessions owned by a person (such as a house or flat, jewellery or other possessions), the money they have in income, savings or investments and any expenditure. Attorneys and deputies can be appointed to make decisions about property and affairs on behalf of a person who lacks capacity.
Restraint	The use or threat of force to help do an act which the person resists, or the restriction of the person's liberty of movement, whether or not they resist. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.
SALT	Speech and Language Therapy.
Statutory principles	Are designed to emphasise the fundamental concepts and core values of the Act and to provide a benchmark to guide decision-makers, professionals and carers acting under the Act's provisions.

3.0 Duties

Person/Group	Duties
Medical Director	• The Medical Director must ensure that all medical staff are conversant with the Mental Capacity Act and are complying with the five Statutory Principles of the Act. (see 5.2)
Chief Nurse	• The Chief Nurse must ensure that all nurses are conversant with the Mental Capacity Act and are complying with the five Statutory Principles of the Act.(see 5.2)
Clinical Director, Therapies	• The Head of Allied Health must ensure that all Allied Health professionals working in the Acute Trust are conversant with the Mental Capacity Act and are complying with the Five Statutory Principles of the Act.(see 5.2)
Divisional Directors of Nursing and Quality (DDNQs)	• It is the duty of the DDNQs to identify and release key staff with the correct grade and skills to undertake the Mental Capacity Act training that is offered to equip staff with the requisite skills and knowledge.
Matron Safeguarding Adults	• It is the duty of the Matron for Safeguarding Adults to advise in complex cases with regard to Mental Capacity Assessments and Best Interest Decision Making processes. • It is their duty to ensure there is a training programme for Mental Capacity Assessments to reach all appropriate clinical staff and audit compliance.
Matrons	• It is the duty of the Matrons to have an overarching responsibility for safeguarding in their areas and support and provide advice to staff accordingly. They should ensure that they and their staff have received appropriate training and

Person/Group	Duties
	have the requisite skills and knowledge to perform their duties. For complex cases they should seek advice and support from the Matron Safeguarding Adults.
All clinical staff	• It is the duty of all staff to adhere to the five Statutory principles of the Mental Capacity Act 2005. • It is the duty of all staff to assess capacity in relation to each decision to be made and at the time this decision needs to be made, whether this is a simple or complex decision. • It is the duty of all staff assessing mental capacity to clearly evidence and document their findings and decisions and act in the person's best interests.

4.0 Training/competency requirements

- Mental Capacity Act (MCA) training is mandatory for all clinical staff.
- All staff that assess Mental Capacity for patients with regard to simple or complex decisions will require appropriate training.
  - Level 1 MCA Basic Awareness or Level 2 e-learning for Safeguarding Adults or Level 2 Safeguarding Adults Clinical Update.
- Advice and guidance is available from the Matron Safeguarding Adults and the Named Nurse Safeguarding Children (where a 16 or 17 year old is concerned).

5.0 Mental Capacity Act (MCA)

"A person must be assumed to have capacity unless it is established that he lacks capacity" (Principle 1, section 1 (2), Mental Capacity Act 2005).

Some people may require help to be able to make a decision or to communicate their decision. However, this does not necessarily mean that they cannot make that decision – unless there is proof that they do lack capacity to do so. **Anyone who believes that a person lacks capacity should be able to prove their case**.

"A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success" (Principle 2, section 1 (3), Mental Capacity Act 2005).

The support people might need to help them varies. It depends on personal circumstances, the kind of decision that has to be made and the time available to make the decision. It might include:

- Using a different form of communication.
- Providing information in a more accessible form.
- Treating a medical condition which may be affecting a person's capacity.
- Having a structured programme to improve a person's capacity to make particular decisions.

"Under the Mental Capacity Act 2005, capacity is decision-specific, and an individual is assumed to have capacity unless, on the balance of

probabilities, proven otherwise. The concept of capacity under the Mental Capacity Act 2005 is relevant to many decisions including care, support and treatment, financial matters and day-to-day living". (NICE Guideline: Decision-making and mental capacity (NG108). October 2018).

The Mental Capacity Act 2005 **does not** generally apply to people under the age of 16. Most of the Act applies for young people aged between 16 and 17 years, who may lack capacity within section 2(1) to make specific decisions. There are three exceptions:

1. Only people aged 18 and over can make a Lasting Power of Attorney (LPA)
2. Only people aged 18 and over can make an advance decision to refuse medical treatment
3. The Court of Protection may only make a statutory will for a person aged 18 and over.

An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not on their ability to make decisions in general.
Section 2(2) of the Act states that the impairment or disturbance does not have to be permanent. A person can lack capacity to make a decision at the time it needs to be made even if:

- The loss of capacity is partial
- The loss of capacity is temporary
- Their capacity changes over time

A person may also lack the capacity to make a decision about one issue but not about others.

An assessment that a person lacks capacity to make a decision must never be based simply on:

- Their age
- Their appearance
- Assumptions about their condition
- Any aspect of their behaviour

"Appearance", covers all aspects of the way people look i.e. physical characteristics of certain conditions (e.g. scars, features linked to Down's syndrome or cerebral palsy) as well as aspects of appearance such as skin colour, tattoos and body piercings, or the way people dress.

"Condition" includes physical disabilities, learning difficulties and disabilities, illness related to age, temporary conditions (e.g. drunkenness or unconsciousness).

Aspects of behaviour might include extrovert (shouting or gesticulating) and withdrawn behaviour (talking to yourself or avoiding eye contact).

Anybody who claims that an individual lacks capacity should be able to provide proof. They need to be able to show, *on the balance of probabilities,* that the individual lacks capacity to make a particular decision, at the time it needs to be made (section 2(4)). This means

being able to show that it is more likely than not that the person lacks capacity to make the decision in question.

5.1 The test of capacity

The Code of practice includes an important **'two-stage test of capacity':**

Stage 1. Does the person have impairment of, or disturbance in the mind or brain?

If the person does not have such an impairment or disturbance, they will **not** lack capacity under the Act.

Examples of an impairment or disturbance include:

- Conditions associated with some forms of mental illness
- Dementia
- Significant learning disabilities
- The long-term effects of brain damage
- Physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- Delirium
- Concussion following a head injury
- The symptoms of alcohol or drug use

Stage 2. Does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

People must be given all practicable and appropriate support to help them make the decision for themselves. Stage 2 can only apply if all support has failed.

A person lacks capacity to make a particular decision if they cannot either:

- **Understand** information relevant to the decision (Relevant information includes: the nature of the decision; the reason why the decision is needed and the likely effects of deciding one way or another, or making no decision at all), or
- **Retain** that information in their mind long enough to make the decision (People who can only retain information for a short while must not automatically be assumed to lack the capacity to decide – it depends on what is necessary for the decision in question), or
- **Weigh up** that information as part of the decision-making process (Sometimes people can understand information but an impairment or disturbance stops them using it. In other cases, the impairment or disturbance leads to a person making a specific decision without understanding or using the information they have been given), or
- **Communicate** their decision – by using verbal or non-verbal means. Refer to SALT if full assessment or assistive devices required.

(Sometimes there is no way for a person to communicate, before deciding that someone falls into this category, it is important to make all practical and appropriate efforts to help them communicate. This might include involvement of speech and language therapists, specialists in non-verbal communication or other professionals. Communication by simple muscle movements can show that somebody can communicate and may have capacity to make a decision.)

People with fluctuating or temporary capacity

- Some people have fluctuating capacity, some factors which may indicate that person may regain or develop capacity in the future are:
  - The cause of the lack of capacity can be treated, either by medication or some other form of treatment or therapy.
  - The lack of capacity is likely to decrease in time (e.g. when it is caused by the effects of medication or alcohol, or following a sudden shock.)
  - A person with learning disabilities may learn new skills or be subject to new experiences which increase their understanding and ability to make certain decisions.
  - The person may have a condition which causes capacity to come and go at various times, so it may be possible to arrange for the decision to be made during a time when they do have capacity.
  - A person previously unable to communicate may learn a new form of communication.
- As in any other situation, an assessment must only examine a person's capacity to make a particular decision when it needs to be made. It may be possible to put off the decision until the person has the capacity to make it.

5.2 Conducting an assessment of capacity

The Code of practice does not require care services and workers to undertake formal, recorded assessments for minor day-to-day decisions about giving routine care.

Normal assessment and planning arrangements for care, treatment and support should already be providing staff with full information on a person's capacities, needs and abilities.

All assessments relating to capacity, whether formal or informal, must be undertaken under the five principles of the Act:

1. **A person must be assumed to have capacity unless it is established that they lack capacity.**
2. **A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.**
3. **A person is not to be treated as unable to make a decision merely because they make an unwise decision.**

4. **An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.**
5. **Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.**

Assessors should have sufficient knowledge of the person being assessed (except in emergencies or where services have had no previous contact with the person) to be able to:

- Recognise the best time to make the decision.
- Provide tailored information, including information about the consequences of making the decision or of not making the decision.
- Know whether the person would be likely to attach particular importance to any key considerations relating to the decision.

The person who assesses an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision needs to be made. This means that different people will be involved is assessing someone's capacity to make different decisions at different times.

If a doctor or healthcare professional proposes treatment or an examination, they must assess the person's capacity to consent.

5.2.1 Preparing for an assessment

In preparing for an assessment, the assessor should be clear about:

- The decision to be made.
- Whether any ability to make a decision is caused by any impairment of or disturbance in the functioning of the mind or brain in that person.
- The options available to the person in relation to the decision.
- What information the person needs in order to be able to explore their options and make a decision, and in a format which is accessible for them.
- What the person needs in order to understand, retain, weigh up and use relevant information in relation to this decision, including the use of communication aids.
- How to allow enough time for the assessment, giving people with communication needs more time if needed.
- How to introduce the assessment and conduct it in a way that is respectful, collaborative, and non-judgemental and preserves the person's dignity.
- How to make reasonable adjustments including, for example, delaying the assessment until a time when the person feels less anxious or distressed and more able to make the decision.

- How to ensure that the assessment takes place at a location and in an environment and through a means of communication with which the person is comfortable.
- How to identify the steps a person is unable to carry out even with all practicable support.
- Whether involving people with whom the person has a trusted relationship would help the assessment.

Where consent has been provided, health and social care practitioners should identify people who could be spoken with in order to inform the capacity assessment. For example, this may include the individual's family or friends.

Health and social care practitioners should take a structured, person-centred, empowering and proportionate approach to assessing a person's capacity to make decisions, including everyday decisions.

Use of single tools (such as the Mini-Mental State Examination) that are not designed to assess capacity may yield information that is relevant to the assessment, but practitioners should be aware that these **should not be used as the basis for assessing capacity.**

If a person refuses to engage in some or all aspects of the capacity assessment, the assessor should try to establish the reasons for this and identify what can be done to help them participate fully.

Practitioners should understand that the person has to retain the information only for the purposes of making the specific decision in question, and for the period of time necessary to make the decision and for it to be put into effect.

Practitioners should be aware that a person may have decision-making capacity even if they are described as lacking 'insight' into their condition. Capacity and insight are two distinct concepts. If a practitioner believes a person's insight/lack of insight is relevant to their assessment of the person's capacity, they must clearly record what they mean and how they believe it affects/does not affect the person's capacity.

5.2.2 Recording the assessment

If, following the assessment of capacity, the practitioner finds no evidence to displace the assumption of capacity; this should be documented in the healthcare records.

If the outcome of the assessment is that the person lacks capacity, the practitioner should clearly document the reasons for this in the patient's healthcare record **(Appendix 4).**
Records of assessment and decisions must show:

- Details of the two-stage assessments of capacity.
- What impairment/disturbance of the mind or brain has been identified, the reasons why the person is unable to make the decisions and the fact that the person's inability to make the decision is a direct consequence of the impairment or disturbance identified.

- The practicable steps that have been taken to help the person make the relevant decision for themselves and any steps taken by other parties involved.
- How much the person is able to understand information that is relevant to the decision.
- Whether the person can remember relevant information long enough to make the decision.
- How well the person can weigh up relevant pros and cons when making the decision.
- How the person can let other people know what their decisions are, and how well they can do this.
- If the person is assessed as lacking capacity, why the practitioner considers this to be an incapacitous decision as opposed to an unwise decision.
- All assessments of mental capacity must be recorded at an appropriate level to the complexity of the specific decision being made at a particular time.

5.2.3 When to be involved

Health and social care practitioners and/or other relevant professionals and experts must be involved when an assessment and/or decision has particularly significant consequences. These include when:

- There are disagreements with the person, their family or others about their capacity to make a decision.
- The person's capacity may be challenged by someone.
- The decision is about life sustaining or other particularly significant medical treatment.
- Where a decision not to resuscitate someone is being considered.
- Reporting abuse or crime.
- Other people may be at risk.
- Considering whether the person should move to new accommodation or receive care, treatment or support at home.
- The decision has legal complications or consequences, such as for liability.
- There are significant financial or property issues.

5.2.4 Challenging a finding of lack of capacity

There are likely to be occasions when someone may wish to challenge the results of an assessment of capacity. The first step is to raise the matter with the person who carried out the assessment. Ask the assessor to:

- Give reasons why they believe the person lacks capacity to make the decision, and
- Provide objective evidence to support their belief.

The assessor must show they have applied the principles of the Mental Capacity Act.

Where there is disagreement about the initial capacity assessment a second opinion should be sought from an independent practitioner or another expert in assessing capacity.

If a disagreement cannot be resolved, the person who is challenging the assessment may be able to apply to the Court of Protection. The Court of Protection can rule on whether a person has capacity to make the decision covered by the assessment.

6.0 Best Interest decision making

One of the principles of the Act is that any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person's *best interests.*

There are exceptions to this, including circumstances where a person has made an advance directive to refuse treatment.

This principle covers all aspects of financial, personal welfare and health care decision-making actions. It applies to anyone making decisions or acting under the provisions of the Act, including:

- Family carers, other carers and care workers
- Healthcare and social care staff
- Attorneys appointed under a Lasting Power of Attorney or registered Enduring Power of Attorney
- Deputies appointed by the court to make decisions on behalf of someone who lacks capacity, and
- The Court of Protection

When working out what is in the best interests of the person who lacks capacity to make a decision or act for themselves, decision makers must take into account all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do if they were the person who lacked capacity.

6.1 Who can be a decision maker?

Under the Act, many different people may be required to make decisions or act on behalf of someone who lacks capacity to make decisions for themselves. It is the decision-maker's responsibility to work out what would be in the best interests of the person who lacks capacity.

- For most day-to-day actions or decisions, the decision-maker will be the carer most directly involved with the person at the time.
- Where the decision involves the provision of medical treatment, the doctor or other member of healthcare staff responsible for carrying out the particular treatment or procedure is the decision-maker.
- Where nursing or paid care is provided, the nurse or paid carer is the decision-maker.

- If a Lasting Power of Attorney (or Enduring Power of Attorney) has been made and registered, or a deputy has been appointed under a court order, the attorney or deputy will be the decision maker, for decisions within the scope of their authority.

In some cases, the same person may make different types of decision for someone who lacks capacity.

There are also times when a joint decision might be made by a number of people.

6.2 What must be taken into account?

Because every case – and every decision – is different, the law cannot set out all the factors that will need to be taken into account. Some common factors that must always be considered include:

- Working out what is in someone's best interests cannot be based simply on someone's age, appearance, condition or behaviour.
  ("Appearance", covers all aspects of the way people look, i.e. physical characteristics of certain conditions (e.g. scars, features linked to Down's syndrome or cerebral palsy) as well as aspects of appearance such as skin colour, tattoos and body piercings, or the way people dress.
  "Condition" includes physical disabilities, learning difficulties and disabilities, illness related to age, temporary conditions (e.g. drunkenness or unconsciousness).
  Aspects of behaviour might include extrovert (shouting or gesticulating) and withdrawn behaviour (talking to yourself or avoiding eye contact).
- All relevant circumstances should be considered.
- Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision.
- If there is a chance that the person will regain capacity to make a particular decision, then it may be possible to put off the decision until later if it is not urgent. Special considerations apply to decisions about life-sustaining treatment.
- The person's past and present wishes and feelings, beliefs and values should be taken into account.
- The views of other people who are close to the person who lacks capacity should be considered, as well as the views of an attorney or deputy.

What is in the person's best interests may change over time. This means that even when similar actions need to be taken repeatedly in connection with the person's care and treatment, the person's best interests should be regularly reviewed.

Any staff involved in the care of a person who lacks capacity should make sure a record is kept of the process of working out the best interests for each relevant decision, setting out:

- How the decision about the person's best interests was reached
- What the reasons for reaching the decision were

- Who was consulted to help work out best interests, and
- What particular factors were taken into account

6.2.1 Other factors to consider

Section 4(6) (c) of the Act requires decision-makers to consider any other factors the person who lacks capacity would consider if they were able to do so. This might include the effect of the decision on other people, obligations to dependents or the duties of a responsible citizen.

The Act allows actions that benefit other people, as long as they are in the best interests of the person who lacks capacity to make the decision. 'Best interests' goes beyond the person's medical interests. If it is likely that the person who lacks capacity would have considered these factors themselves, they can be seen as part of the person's best interests.

6.3 How should the person who lacks capacity be involved?

Wherever possible, the person who lacks capacity should be involved in the decision-making process. Even if they lack capacity to make the decision, they may have views on matters affecting the decision, and on what outcome would be preferred.

Consulting the person who lacks capacity will involve taking time to explain what is happening and why a decision needs to be made.

A number of practical steps to assist and enable decision-making include:

- Using simple language and/or illustrations or photographs to help the person understand the options.
- Asking them about the decision at a time and location where the person feels most relaxed and at ease.
- Breaking the information down into easy-to-understand points.
- Using specialist interpreters or signers to communicate with the person. (refer to SALT for formal assessment).

6.3.1 Who should be consulted?

The Act places a duty on the decision-maker to consult other people close to a person, where practical and appropriate. The decision maker has a duty to take into account the views of the following people:

- Anyone the person has previously named as someone they want to be consulted.
- Anyone involved in caring for the person.
- Anyone interested in their welfare.
- An attorney appointed by the person under a Lasting Power of Attorney, and
- A deputy appointed for that person by the Court of Protection.

If there is no-one to speak to about the person's best interests, the person may qualify for an Independent Mental Capacity Advocate (IMCA).

6.4 Recording a Best Interest decision

This should include:

- A clear explanation of the decision to be made.
- The steps that have been taken to help the person make the decision themselves.
- A current assessment concluding that the person lacks the capacity to make this decision, evidencing each element of the assessment.
- A clear record of the person's wishes, feelings, cultural preferences, values and beliefs, including any advance decision.
- The choices that have been put to the person.
- The details the person needs to understand.
- The best interest's decision made, with reasons.

When making best interest decisions, staff should explore whether there are less restrictive options that will meet the person's needs. This should take into account:

- What the person would prefer, including their past and present wishes and feelings, based on past conversations, actions, choices, values or known beliefs.
- What decision the person who lacks capacity would have made if they were able to do so.
- All the different options. The restrictions and freedoms associated with each option.
- The likely risks associated with each option.

Appendix 5 should be used to record the Best Interest Meeting.

6.5 How should someone's best interests be worked out when making decisions about life-sustaining treatment?

The fundamental rule is that anyone who is deciding whether or not life-sustaining treatment is in the best interests of someone who lacks capacity to consent to or refuse treatment must not be motivated by a desire to bring about the person's death.

Whether a treatment is 'life-sustaining' depends not only on the type of treatment, but also on the particular circumstances in which it may be prescribed. It is up to the doctor or healthcare professional providing treatment to assess whether the treatment is life-sustaining in each particular situation.

As with all decisions, before deciding to withdraw or withhold life-sustaining treatment, the decision-maker must consider the range of treatment options available to work out what would be in the person's best interests. All factors should be considered, and in particular, the decision-maker should consider any statements that the person has previously made about their wishes and feelings about life-sustaining treatment.

Doctors are not under an obligation to provide, or to continue to provide, life-sustaining treatment where that treatment is not in the best interests of the person, even where the person's death is

foreseen. Doctors must apply the best interest's principles and use their professional skills.

If the doctor's assessment is disputed, and there is no other way of resolving the dispute, ultimately the Court of Protection may be asked to decide.

Where a person has made a written statement in advance that requests particular medical treatments, these requests should be taken into account by the treating doctor. Like anyone else involved in making this decision, the doctor must weigh written statements alongside all relevant factors to decide whether it is in the best interests of the patient to provide or continue life-sustaining treatment.

If someone has made an advance decision to refuse life-sustaining treatment, specific rules apply (see section 10)

Where there is any doubt about the patient's best interests an application should be made to the Court of Protection for a decision (in such circumstances, staff should contact Legal Services and the Safeguarding Matron).

7.0 Using restraint

Section 6 (4) of the Act states that someone is using restraint if they:

- Use force – or threaten to use force – to make someone do something that they are resisting, or
- Restrict a person's freedom of movement, whether they are resisting or not.

Any action intended to restrain a person who lacks capacity will not attract protection from liability unless the following two conditions are met:

- The person taking action must reasonably believe that restraint is *necessary* to prevent *harm* to the person who lacks capacity, and
- The amount or type of restraint used and the amount of time it lasts must be a *proportionate response* to the likelihood and seriousness of harm.

In addition to the requirements of the Act, the common law imposes a duty of care on healthcare and social care staff in respect of all people to whom they provide services. Therefore if a person who lacks capacity to consent has challenging behaviour, or is in the acute stages of illness causing them to act in a way which may cause harm to others, staff may, under common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else.

Anyone considering using restraint must have objective reasons to justify that restraint is necessary. They must be able to show that the person being cared for is likely to suffer harm unless proportionate restraint is used.

A carer or professional must not use restraint just so that they can do something more easily. If restraint is necessary to prevent harm to the

person who lacks capacity, it must be the minimum amount of force for the shortest time possible.

Carers and healthcare and social care staff should consider less restrictive options before using restraint. Please refer to the MTW Restraint Policy and Procedure for further guidance. (RWF-OPPPCS-C-NUR4)

8.0 Lasting Power of Attorney (LPA)

Only adults aged 18 or over can make an LPA, and they can only make an LPA if they have capacity to do so.

Section 10 (4) of the Act allows the donor to appoint two or more attorneys and to specify whether they should act 'jointly', 'jointly and severally', or 'jointly in respect of some matters and jointly and severally in respect of others'.

- Joint attorneys must always act together. All attorneys must agree decisions and sign relevant documents.
- Joint and several attorneys can act together but may also act independently if they wish. Any action taken by an attorney alone is as valid as if they were the only attorney.

If a donor who has appointed two or more attorneys does not specify how they should act, they must always act jointly.

An LPA must be registered with the Office of the Public Guardian (OPG) before it can be used. An unregistered LPA will not give the attorney any legal powers to make a decision for the donor.

If an LPA is unregistered, attorneys must register it before making any decisions under the LPA.

Healthcare staff must ask to see the LPA to ensure that it has been registered and can be used. A copy of this should be placed in the healthcare records.

8.1 Personal Welfare LPAs

A personal welfare LPA allows attorneys to make decisions to accept or refuse healthcare or treatment unless the donor has stated clearly in the LPA that they do not want the attorney to make these decisions.

Even where the LPA includes healthcare decisions, attorneys do not have the right to consent to or refuse treatment in situations where:

- **The donor has capacity to make that particular healthcare decision.**
  An attorney has no decision-making power if the donor can make their own treatment decisions.
- **The donor has made an advance decision to refuse the proposed treatment.**

An attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment.
If the donor made an LPA after the advance decision, and gave the attorney the right to consent to or refuse the treatment, the attorney can choose not to follow the advance decision.

- **A decision relates to life-sustaining treatment.**
  An attorney has no power to consent or refuse life-sustaining treatment, unless the LPA document expressly authorises this.
- **The donor is detained under the Mental Health Act (section 28)**
  An attorney cannot consent or refuse treatment for a mental disorder for a patient detained under the Mental Health Act 1983.

Attorneys must always follow the Mental Capacity Act's principles and make decisions in the donor's best interests. If healthcare staff disagree with the attorney's assessment of best interests, they should discuss the case with other medical experts and /or get a formal second opinion. Then discuss the matter further with the attorney. If they cannot settle the disagreement, they can apply to the Court of Protection.

9.0 What is the role of the Court of Protection and court-appointed deputies?

The Court of Protection has powers to:

- Decide whether a person has capacity to make a particular decision for themselves.
- Make declarations, decisions or orders on financial or welfare matters affecting people who lack capacity to make such decisions.
- Appoint deputies to make decisions for people lacking capacity to make those decisions.
- Decide whether an LPA is valid, and
- Remove deputies or attorneys who fail to carry out their duties.

10.0 Advance decisions

It is a general principle of law and medical practice that people have a right to consent or refuse treatment. The courts have recognised that adults have the right to say in advance that they want to refuse treatment if they lose capacity in the future – even if this results in their death. This has been a fundamental principle of the common law for many years and it is now set out in the Act when a person can make an advance decision to refuse treatment. This applies if:

- The person is 18 or older, and
- They have the capacity to make an advance decision about treatment.

A valid and applicable advance decision to refuse treatment is as effective as a refusal made when a person has capacity. Therefore, an advance decision overrules:

- The decision of any personal welfare LPA made before the advance decision was made.
- The decision of any court-appointed deputy.
- The provisions of section 5 of the Act, which would otherwise allow healthcare professionals to give treatment that they believe is in a person's best interests.

Healthcare professionals must follow an advance decision if it is valid and applies to the particular circumstances. Where an advance decision is being followed, the best interest's principle does not apply. Healthcare professionals must follow a valid and applicable advance decision, even if they think it goes against a person's best interests.

People can only make advance decisions to *refuse* treatment. Nobody has the legal right to demand specific treatment, either at the time or in advance. But people can make a request or state their wishes and preferences in advance. Healthcare professionals should then consider the request when deciding what is in a patient's best interests if they lack capacity.

The Court of Protection may make declarations as to the existence, validity and applicability of an advance decision, but it has no power to overrule a valid and applicable advance decision to refuse treatment.

10.1 What should be included in an advance decision?

There are no particular formalities about the format of an advance decision. It can be written or verbal, unless it deals with life-sustaining treatment, in which case it must be written and specific rules apply.

An advance decision to refuse treatment:

- Must state precisely what treatment is to be refused – a statement giving a general desire not to be treated is not enough.
- May set out the circumstances when the refusal should apply.
- Will only apply at a time when a person lacks capacity to consent or refuse the specific treatment.

Specific rules apply to life-sustaining treatment:

- It must be in writing.
- Be signed by the person.
- Be signed in the presence of a witness, the witness must then sign the document in the presence of the person making the advance decision.
- Include a clear, specific written statement from the person making the advance decision that the advance decision is to apply to the specific treatment even if life is at risk.

An advance decision cannot refuse actions that are needed to keep a person comfortable (sometimes called basic or essential care). Examples include warmth, shelter, actions to keep a person clean and the offer of food and water by mouth. Section 5 of the Act

allows healthcare professionals to carry out these actions in the best interests of a person who lacks capacity to consent. An advance decision **can refuse artificial nutrition and hydration.**

10.2 Changes to an advance decision

Section 24 (3) allows people to cancel or alter an advance decision at any time while they have the capacity to do so. There are no formal processes to follow. People can cancel their decision verbally or in writing, and they can destroy any original written document.

Healthcare professionals should record a verbal cancellation in healthcare records. This then forms a written record for future reference.

People can make changes to an advance decision verbally or in writing whether or not an advance decision was made in writing, but if a person wants to change an advance decision to include a refusal of life-sustaining treatment, they must follow the procedure above.

10.3 Deciding if an advance decision is invalid or not applicable.

Events that would make an advance decision invalid include those where:

- The person withdrew the decision while they still had capacity to do so.
- After making the advance decision, the person made an LPA giving an attorney authority to make treatment decisions that are the same as those covered by the advance decision.
- The person has done something that clearly goes against the advance decision which suggests that they have changed their mind.

The advance decision is not applicable to the treatment in question if:

- The proposed treatment is not the treatment specified in the advance decision.
- The circumstances are different from those that may have been set out in the advance decision, or
- There are reasonable grounds for believing that there have been changes in circumstance, which would have affected the decision if the person had known about them at the time they made the advance decision.

11.0 Independent Mental Capacity Advocate (IMCA)

The aim of the IMCA service is to provide independent safeguards for people who lack capacity to make certain important decisions and, at the time such decisions need to be made, have no-one else (other than paid staff) to support or represent them or be consulted.
The IMCA service provides safeguards for people who:

- Lack capacity to make a specified decision at the time it needs to be made.
- Are facing a decision on a long-term move or about serious medical treatment and
- Have nobody else who is willing and able to represent them or be consulted in the process of working out their best interests.

If a person who lacks capacity has nobody to represent them or no-one that it is appropriate to consult, an IMCA must be instructed in prescribed circumstances. The prescribed circumstances are:

- Providing, withholding or stopping serious medical treatment.
- Moving a person into long-term care in hospital (for more than 28 days) or a care home (for more than eight weeks), or
- Moving the person to a different hospital or care home.

The IMCA will:

- Be independent of the person making the decision.
- Provide support for the person who lacks capacity.
- Represent the person without capacity in discussions to work out whether the proposed decision is in the person's best interests.
- Provide information to help work out what is in the person's best interests, and
- Raise questions or challenge decisions which appear not to be in the best interests of the person.

IMCAs have a different role from many other advocates. They:

- Provide statutory advocacy.
- Are instructed to support and represent people who lack capacity to make decisions on specific issues.
- Have a right to meet in private the person they are supporting.
- Are allowed access to relevant healthcare records and social care records.
- Provide support and representation specifically while the decision is being made, and
- Act quickly so their report can form part of decision-making.

If an IMCA is required it is important that they are involved as soon as possible. Delay can hold up medical treatment, discharge from hospital or placement in a care home. See **Appendix 6** IMCA referral form. Please note that you will need to add the word "[secure]" in the subject line of a message (with the inclusion of the square brackets).

12.0 What is the relationship between the Mental Capacity Act and the Mental Health Act 1983?

Professionals may need to think about using the Mental Health Act (MHA) to detain and treat somebody who lacks capacity to consent to treatment (rather than use of the MCA), if:

- It is not possible to give the person the care or treatment they need without doing something that might deprive them of their liberty.

- The person needs treatment that cannot be given under the MCA (for example, because the person has made a valid and applicable advance decision to refuse an essential part of treatment).
- The person may need to be restrained in a way that is not allowed under the MCA.
- It is not possible to assess or treat the person safely or effectively without treatment being compulsory (perhaps because the person is expected to regain capacity to consent, but might then refuse to give consent).
- The person lacks capacity to decide on some elements of the treatment but has capacity to refuse a vital part of it – and they have done so, or
- There is some other reason why the person might not get treatment, and they or somebody else might suffer harm as a result.

Before making an application under the MHA, decision-makers should consider whether they could achieve their aims safely and effectively by using the MCA instead.

Compulsory treatment under the MHA is not an option if:

- The patient's mental disorder does not justify detention in hospital, or
- The patient needs treatment only for a physical illness or disability.

The MCA applies to people subject to the MHA in the same way as it applies to anyone else, with four exceptions:

- If someone is detained under the MHA, decision-makers cannot normally rely on the MCA to give treatment for mental disorder or make decisions about that treatment on that person's behalf.
- If somebody can be treated for their mental disorder without their consent because they are detained under the MHA, healthcare staff can treat them even if it goes against an advance decision to refuse that treatment.
- If a person is subject to guardianship, the guardian has the exclusive right to take certain decisions, including where the person is to live, and
- IMCAs do not have to be involved in decisions about serious medical treatment or accommodation, if those decisions are made under the MHA.

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

- Annual audit of compliance with Mental Capacity Assessments and Best Interest Decision making processes will be undertaken, to monitor the frequency and quality of formal recording of steps taken to support decision-making. Findings of the audit will be reported to the Safeguarding Adults Committee with any appropriate action plans, by the Matron for Safeguarding Adults.
- A quarterly report in relation to IMCA referrals with their outcomes will be reported to the Safeguarding Adults Committee by the Matron for Safeguarding Adults.
- Quarterly training updates will be presented to the Safeguarding Adults Committee by Learning and Development, to identify areas of compliance and where improvements are required.

3.0 Review

This policy and procedure and all its appendices will be reviewed at a minimum of once every 4 years or sooner if changes in legislation or practice occur.

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: Mental Capacity Act Policy and Procedure

Consultation process – Use this form to ensure your consultation has been adequate for the purpose.

Please return comments to: Lead Nurse Dementia Care

By date: 31st December 2018

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	11/12/18	20/12/18	Y	Y
Counter Fraud Specialist Manager (tiaa)	11/12/18	11/12/18	N	N
Energy and Sustainability Manager	11/12/18			
Chief Pharmacist and Formulary Pharmacist	11/12/18			
Formulary Pharmacist	11/12/18			
Staff-Side Chair	11/12/18			
Complaints & PALS Manager	11/12/18			
Emergency Planning Team	11/12/18	13/12/18	N	N
Head of Staff Engagement and Equality	11/12/18			
Head of Clinical Information Systems and Healthcare Records Services	11/12/18	24/12/18	Y	Y
All individuals listed on the front page				
The relevant lead for the local Q-Pulse database				
All members of the approving committee (Safeguarding Adults Committee).	11/12/18	12/12/18	Y	Y
Other individuals the author believes should be consulted				
Ethics Committee	11/12/18			
Chief Nurse / Medical Director	11/12/18			
ADNSs	11/12/18			
Matrons	11/12/18			
Corporate Nursing Team	11/12/18	2/1/19	N	N
Dementia Strategy Group	11/12/18			
SALT	11/12/18	2/1/19	Y	Y
The following staff have given consent for their names to be included in this policy and its appendices:				

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	Mental Capacity Act Policy and Procedure
What are the aims of the policy?	To ensure all staff adhere to the principles of the Mental Capacity Act 2005.
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	Yes by law only applies to those aged 16 and over – refer to Safeguarding Children's Policy and Procedure.
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	Yes – if mental capacity is affected, refer to policy.
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?	Yes
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	Mental Capacity Assessment	RWF-OWP-APP65	This policy
5	Best Interest Decision Making Meeting	RWF-OWP-APP67	This policy
6	IMCA Referral	RWF-OWP-APP68	This policy

FAMILY NAME:	
Given name:	
Preferred name:	
Title:	Gender:
NHS number:	
Hospital number:	
Date of birth:	_ _ / _ _ / _ _ _ _
Complete above in full or affix patient label	
Location:	

NHS Maidstone and Tunbridge Wells NHS Trust

Mental Capacity Assessment

NB the Mental Capacity Act's first principle is that a person must be assumed to have capacity unless it is established that they lack capacity

The assessment must be about a particular decision that has to be made at the time the decision needs to be made.

1. Decision requiring assessment of mental capacity (provide details):

2. Two- stage test of mental capacity a. Does the person have impairment of, or disturbance in the mind or brain? (It doesn't matter whether the impairment of disturbance is temporary or permanent) Provide evidence:	
b. Does that impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made:	Yes ☐ No ☐
3. Practical steps taken to help the person make the relevant decision for themselves (provide details):	
Can the person:	
a. **Understand** the information relevant to the decision?	Yes ☐ No ☐
b. **Retain** that information?	Yes ☐ No ☐
c. Use or **weigh up** that information as part of the process of making the decision?	Yes ☐ No ☐
d. Communicate their decision (whether by talking or any other means)?	Yes ☐ No ☐
Provide evidence in respect of the person's ability in relation to each of these four elements of the test: **NB: if a person cannot do one or more of these four things, they are unable to make the decision**	

Patient's full name: ……..…… NHS no.: ……..……..……..

4. Outcome of Mental Capacity Assessment	
On the balance of probabilities, there is a reasonable belief that:	
The person **has** capacity to make this particular decision at this time:	Yes ☐ No ☐
The person **does not have** capacity to make this particular decision at this time:	Yes ☐ No ☐
5. Details of assessor	
Full name:	
Signature:	
Designation:	
Date and time:	