Safeguarding Vulnerable and At Risk Adults Policy

Category: Policy

Summary: This Policy and associated guidance sets out the principles to be adopted by all staff to safeguard vulnerable and at risk adults. It outlines the process for reporting suspected cases of abuse and the multi-agency approach to responding to reported cases.

Equality Analysis Undertaken: August 2015

Valid from: 10th February 2016

Date of Review: February 2019

Approved date/via: 4 June 2015 via Safeguarding Adults Steering Group
4 August 2015 via Clinical Policy Group

Distribution: OUH Intranet

Related documents: Consent to Examination or Treatment Policy
Raising Concerns at Work Policy
Managing Allegation if Harm Staff Policy
Incident reporting and Investigation policy

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This document replaces: OUH Safeguarding Vulnerable and At Risk Adults Policy Version 7.0

Lead Director: Chief Nurse

Issue Date: 10/02/2016
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Introduction

1. Oxford University Hospital NHS Foundation Trust will not condone any action or actions by any member of staff that might amount to, give rise to, or allow to continue unchecked the abuse, mistreatment or exploitation of patients of the organisation or indeed other vulnerable people.

2. The Oxford University Hospitals NHS Foundation Trust will take all reasonable actions necessary to promote the wellbeing, security and safety of vulnerable people consistent with their rights, capacity and personal responsibility, and prevent abuse occurring wherever possible.

3. The abuse of vulnerable adults is not uncommon. This has been exposed within the media and most notably in key Inquiries and reports Death by Indifference published by Mencap in 2007 and the The Mid Staffordshire NHS Foundation Trust Public Inquiry published in 2013. It is important to note that
   3.1. Abuse does not have to be deliberate, malicious or planned. It sometimes happens when people are trying to do their best but don’t really know what is the right thing to do.
   3.2. People who have a physical disability, learning disability, dementia, or who are older, are vulnerable and at an increased risk of abuse because they may not be able to defend themselves, and may find it challenging to communicate their worries.

4. The aims of the Oxfordshire Safeguarding Adults Board are to ensure that all incidents of suspected harm, abuse or neglect are reported and responded to proportionately to:
   - Enable people to maintain the maximum possible level of independence, choice and control.
   - Promote the wellbeing, security and safety of vulnerable people consistent with his or her rights, capacity and personal responsibility and to prevent abuse occurring wherever possible.
   - Ensure that people feel able to complain without fear of retribution.
   - Ensure that all professionals who have responsibilities relating to safeguarding adults have the skills and knowledge to carry out this function.
   - Ensure that safeguarding adults is integral to the development and delivery of services in Oxfordshire.

Source: Oxfordshire Safeguarding Adults Board website: Safe from Harm

Policy Statement

5. The Oxford University Hospitals NHS Foundation Trust, (hereafter referred to as the Trust), will cooperate fully with the police, the Care Quality Commission, Oxfordshire County Council Social Services other health care providers and partners of the Oxfordshire Safeguarding Adults Board to protect vulnerable adults from abuse, harm or distress, in accordance with the “Oxfordshire Codes of Practice for the Protection of Vulnerable Adults from Abuse Exploitation and Mistreatment”

6. All members of staff will at all times during the course of their employment act in such a way as to promote the wellbeing of patients. At no time during the course of their employment or at any other time act in any way that might amount to, give rise to, or allow to continue unchecked the abuse, mistreatment or exploitation of patients or other vulnerable people.
7. All members of staff will at all times during the course of their employment act in a way that is respectful to patients that promotes their dignity and at no time act in any way that causes harm or distress.

8. All concerns amounting to the possible abuse, mistreatment or exploitation of patients or other vulnerable people by a member of staff will be investigated in full accordance with the “Oxfordshire Codes of Practice for the Protection of Vulnerable Adults from Abuse Exploitation and Mistreatment”, any advisory documentation or guidance related to it and other relevant Trust Policies.

9. All members of staff will be aware of and have access to this policy and the following documents:
   9.1 “Oxfordshire Safeguarding Adults Procedures"
   9.2 “Oxfordshire Safeguarding Adults Guidance for All Staff”

10. It is the policy of the Trust to work actively to prevent abuse from occurring and to respond appropriately to allegations of abuse wherever they occur and to work proactively with patients to ensure that they are aware of how to raise concerns relating to abuse or neglect.

Scope

11. This policy applies to Adults. This means those aged 18 and above. The term adult includes patients and visitors. Safeguarding adults is described within the Care Act 2014 as ‘the need to protect people from abuse and neglect’.

12. This policy applies to all staff of Oxford University Hospital NHS Foundation Trust (including those managed by a third party), irrespective of grade, experience or role. The policy applies equally to contractual and temporary staff and does not differentiate or discriminate at any level.

Aim

13. This Policy and associated guidance sets out the principles to be adopted by all staff to protect and safeguard vulnerable and at risk adults. It outlines the process for dealing with allegations and disclosures of abuse, reporting suspected cases of abuse and the multi-agency approach to responding to reported cases.

Definitions

14. Abuse, which would include the following and may take the forms of:
   14.1 Physical abuse: This includes hitting, slapping, pushing, kicking, misuse of medication, and misuse of restraint, or inappropriate sanctions, unsafe practice including misuse of lifting and handling equipment, Female Genital Mutilation.
   14.2 Sexual abuse: This includes rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting.
   14.3 Psychological abuse: This includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal of services or supportive networks. Please note this includes vulnerable adults at risk of

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14.4. **Financial or material abuse:** This includes theft, fraud, rogue trading, exploitation, pressure in connection with wills property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

14.5. **Neglect and acts of omission:** This includes ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, pressure ulcers, the withholding of the necessities of life, such as medication, adequate nutrition and heating. It is especially important, following the conclusions of the Inquiry into the Mid Staffordshire NHS foundation Trust, that all staff understand the meaning of neglect in terms of vulnerable adults receiving health and social care. This is particularly relevant for people with dementia, delirium, learning disability, mental health problems and cognitive impairment.

14.6. **Discriminatory abuse:** This includes racist or sexist remarks or comments based on a person’s impairment, disability, age or illness and other forms of harassment, slurs or similar treatment. This may also include isolation or withdrawal from religious or cultural activity, services or supportive networks.

14.7. **Institutional abuse:** This involves the collective failure of an organisation to provide an appropriate and professional service to vulnerable people. It can be seen or detected in processes, attitudes and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping. It includes a failure to ensure the necessary safeguards are in place to protect vulnerable adults and maintain good standards of care in accordance with individual needs, including training of staff, supervision and management, record keeping and liaising with other providers of care.

14.8. **Domestic Abuse:** This is not a separate type of abuse. It is important to remember that domestic abuse may manifest as financial, psychological, physical, sexual or neglect. Domestic abuse can happen to anyone; regardless of their vulnerability.

15. **The Care Act 2014:** Chapter 14 outlines the responsibilities of the Local Authority and organisations in relation to adult safeguarding. The Government expects local authorities and others to help people with care and support needs, who may be at risk of abuse or neglect as a result of those needs, keep safe. This must not mean preventing them making their own choices and having control over their lives. Everyone in the community should understand the importance of safeguarding and help keep people safe. The local authority must provide information and advice on how to raise concerns about the safety or wellbeing of an adult who has needs for care and support and should support public knowledge and awareness of different types of abuse and neglect, how to keep yourself physically, sexually, financially and emotionally safe, and how to support people to keep safe. The information and advice provided must also cover who to tell when there are concerns about abuse or neglect and what will happen when such concerns are raised, including information on how the local Safeguarding Board works.

Source: The Care Act 2014

16. **The Care Act 2014.** No Secrets 2000 has been replaced the Care Act 2014. The Act was granted Royal Assent in May 2014 and became legally binding and mandatory practice on 1 April 2015. Chapters 14 and 15 have particular relevance for Safeguarding Adults. Chapter 14 includes:

- Adult safeguarding – what it is and why it matters;
Abuse and neglect:
Understanding what they are and spotting the signs;
Reporting and responding to abuse and neglect;
Carers and adult safeguarding;
Adult safeguarding procedures;
Local authority’s role and multi-agency working;
Criminal offences and adult safeguarding;
Safeguarding enquiries;
Safeguarding Adults Boards;
Safeguarding Adults Reviews;
Information sharing, confidentiality and record keeping;
Roles, responsibilities and training in local authorities, the NHS and other agencies.

17. **Principles of Safeguarding Adults**

17.1 – The following key principles: underpin Safeguarding Adults practice and make safeguarding personal

- **Empowerment**: Providing people with support, assistance and information, and enabling them to make choices and give informed consent
- **Protection**: Support and representation for those in greatest need
- **Prevention**: It is better to take action before harm occurs
- **Proportionality**: Proportionate and least intrusive response appropriate to the risk presented
- **Partnership**: Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability**: Accountability and transparency in delivering safeguarding

18. **Section 42 enquiry**: This is a request for an investigation by a local authority. Organisations are legally obliged to comply with this request. A section 42 enquiry is requested when:

18.1. A local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs)
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

18.2. The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult’s case (whether under this Part or otherwise) and, if so, what and by whom.

18.3. “Abuse” includes financial abuse; and for that purpose “financial abuse” includes:

- having money or other property stolen,
• being defrauded,
• being put under pressure in relation to money or other property, and
• having money or other property misused.

19. **Vulnerable adult** - A vulnerable adult is a person aged 18 years or over who may be unable to take care of themselves or protect themselves from being exploited or harmed. This may be because they have a mental health problem, a disability, a sensory impairment, are old and frail or have some form of illness.

**Responsibilities**

20. The **Chief Executive** has overall responsibility for ensuring processes are in place for the safeguarding of vulnerable and at risk people and has designated the **Chief Nurse** as the Trust Management Executive member with specific responsibilities in this area. This includes being responsible for ensuring appropriate arrangements are in place to make certain the aims and objectives of this Policy are being met and maintained.

21. The **Chief Nurse** is the nominated Board member charged with accountability for vulnerable adults and will ensure that necessary arrangements are in place to meet their safeguarding needs.

22. **The Head of Patient Experience** has lead responsibility for Adult Safeguarding throughout the Trust and reports to the Trust Board and Trust Management Executive through the Chief Nurse. Responsibilities include:

   22.1. Ensuring an investigation is undertaken where there is known non-compliance with the Policy. This may involve the Oxfordshire Adult Safeguarding Lead.

   22.2. Liaison with clinical governance teams to ensure that incidents, concerns and complaints that have the potential to be a safeguarding concern are effectively monitored and reviewed.

   22.3. Ensuring there is a regular review and update of the Safeguarding Vulnerable and At Risk Adults Policy, in response to Organisational risk assessments, current legislation and guidance and to subsequently establish, monitor and report on the process of adult safeguarding.

   22.4. Undertaking the role of Trust Lead for PREVENT.

23. The **Safeguarding Adult Lead Practitioner** has responsibility for reporting all safeguarding concerns and where Deprivation of Liberty Safeguard applications are required. The Safeguarding Adult Lead Practitioner should also be consulted when there may be concerns around the Mental Capacity Act, Modern Slavery and Human Trafficking. The lead will liaise with all internal and external agencies.

24. **Divisional Nurses, Divisional General Managers and Clinical Directors** are responsible for:

   24.1. Ensuring the policy is disseminated and implemented in their areas of responsibility.

   24.2. Providing the necessary resources in order to achieve the requirements of this policy.

   24.3. Ensuring that staff can be released for training in the safeguarding of vulnerable adults

25. **All Clinical staff** including nursing, medical, allied health professions, health care scientists, pharmacy staff and clinical support workers are responsible for

   25.1. Understanding and following this policy and its requirements.
25.2. Understanding the mechanisms for reporting suspected or actual cases of potential abuse of vulnerable adults.

26. **Non clinical staff** must be aware of the Adult Safeguarding Policy and how it affects their role and be aware of how to raise concerns with their line manager.

**Organisational arrangements**

27. The Oxford University Hospitals NHS Foundation Trust is a co-signatory to all of the policies and procedures of the multi-agency Oxfordshire Safeguarding Adults Board (OSAB).

28. The OSAB is responsible for creating the framework within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse. The OSAB is also responsible for a consistent and effective response to any circumstances giving ground for concern, formal complaints or expressions of anxiety.

29. The Chief Nurse is the Trust representative and member of the multi-agency Oxfordshire Safeguarding Adults Board. This can be delegated to the Trust’s Safeguarding Adults and Patient Services Manager and responsibilities include:

29.1. Ensuring that the Trust policies and reporting structures are consistent with the Oxfordshire Codes of Practice,

29.2. Training is available at the appropriate level to all staff and volunteers

29.3. A risk assessment and review of Trust protocols with regard to Safeguarding is undertaken annually. A report is provided to the Oxfordshire Safeguarding Adult Board to provide assurance that appropriate measures and processes are in place.

29.4. Ensuring that the Care Quality Commission is notified whenever a safeguarding alert is raised in relation to a patient receiving healthcare from the Trust.

30. Organisationally, the Trust will ensure that all employees working on Trust premises have had the relevant checks to protect the interests of all patients. The Trust’s process for carrying out appropriate checks is set out in the **Criminal Records and Barring Checks Policy**.

**Reporting concerns**

31. Please refer to the Reporting concerns algorithm in Appendix 2.

32. Where members of staff have concerns arising during the course of their employment or at any other time that a patient or other vulnerable person may have been or are the victim of abuse or is at risk of harm or distress. They must report this to their supervisor/manager. The supervisor must discuss with the Ward Manager/ Matron or lead clinician and make a safeguarding referral using the OSAB online Safeguarding Adults Alert (see link to OSAB website via Safeguarding intranet site in Appendix 2).

33. Reports or disclosures of abuse must also be reported on the Trust’s incident management system using the Trust’s Incident reporting and Investigation policy and use the Trust’s Safeguarding Adults Investigative Algorithm. Please refer to Appendix 3.

34. Where a complaint is received about patient care and this appears to indicate abuse i.e. abuse or neglect is mentioned, this should be investigated in accordance with the Trust’s Incident reporting and Investigation policy. A safeguarding alert should also be raised to the relevant Local Authority Safeguarding Team using the OSAB online Safeguarding Adults Form (see link in Appendix 2), and the Trust’s Safeguarding Adults Investigative Algorithm (Please refer to Appendix 3).
35. Staff will be offered initial support via their line manager and additional arrangements can be made in discussion with the Safeguarding Adults and Patient Services Manager. All staff will be given feedback around the outcomes of the concern raised, giving them a better understanding of the processes.

36. For instances where allegations of harm have been made against a member of staff, (be they permanent, temporary, students or volunteers), the **Managing Allegations of Harm (by) Staff Policy** should also be referred to.

37. Concerns that amount to a criminal act will be reported to Thames Valley Police in accordance with the **Disciplinary Procedure**. Any actions or investigation undertaken will be in accordance with agreed multiagency protocols.

38. Any member of staff who is the subject of such an investigation may be placed on Special Leave from any work involving a patient contact or subject to the outcome of the investigation. This action is taken to protect the staff member from further allegations, protect patients from risk of coercion, intimidation or abuse, colleagues from risk of coercion or intimidation and to facilitate the process of completing the investigation as quickly as possible.

39. Consideration will be given to referring an individual to the Disclosure and Barring Service (DBS) under the Vetting and Barring Scheme where this is indicated in the DBS checks: eligibility guidance.

40. Following an investigation and where the member of staff has been subject to a Performance and Conduct hearing and where they have been found at fault of misconduct which harmed or placed at risk of harm a vulnerable adult or vulnerable adults a referral to the relevant professional body will be made.

41. **PREVENT:** All staff with any concerns regarding a patient’s vulnerability of exposure to risk of being drawn into terrorism, has begun to express radical extremist views or may be vulnerable to grooming or exploitation by others should report this to their line manager. This should be then reported to the Safeguarding Adults Lead Practitioner who will be the primary point of contact to manage such enquiries with support from the Safeguarding Adults and Patient Service Manager and the Chief Nurse. Please refer to Appendix 6: NHS England Protocol for Prevent referrals).

### Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS)

42. All clinical staff must ensure that they are familiar with their responsibilities within the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and follow the respective codes of practice.

43. All clinical staff must ensure that patients who lack capacity are assessed using the Oxfordshire Mental Capacity Act and Deprivation of Liberty Safeguards Policy. This must be clearly and accurately documented in the patients’ healthcare records. Staff can use the Trust’s Mental Capacity Act form, but this is not obligatory. Staff are able to seek advice from the Safeguarding Adult Lead Practitioner to complete the form. The DOLS form can be found on the intranet [here](#).

44. All patients who do not have close friends or family must be referred to the Independent Mental Capacity Advocates (IMCA) in adult protection safeguarding adults’ cases.

45. Following the Supreme Court’s judgement in March 2014 known as ‘Cheshire West and other rulings’, staff must understand when a patient should be referred for a DOLS. In particular the Acid test. This refers to the three indicators which are essential for a DOLS application.

- The ‘Acid Test’
  - The patient is under continuous supervision
The patient is under continuous control

The patient is not free to leave

- The Trust is a ‘Managing Authority’. This means the Trust, if satisfied that the Acid Test is applicable, can grant an urgent DOLS which is valid for 7 days. The clinical team must complete and sign the urgent and standard DOLS application form.

- This must be sent to the safeguardingadults@OUH.nhs.uk email address for forwarding to the relevant DOLS Supervisory office. An urgent DOLS is legally valid when the relevant DOLS Supervisory Office have received the completed and signed form.

- A Clinical Team must apply for an extension to the urgent DOLS if the patient has not been assessed by a Best Interest Assessor and a Medical Assessor within 7 days.

- A Clinical Team must inform the safeguardingadults@OUH.nhs.uk email address when a DOLS is no longer applicable for the patient, the patient has been transferred to another hospital or been discharged.

**PREVENT**

46. Healthcare professionals have a key role in PREVENT. PREVENT focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist-related activity.

47. The role of health services require all healthcare workers to exercise a duty of care to patients and, where necessary, to take action for safeguarding and crime prevention purposes. Through PREVENT this includes taking preventive action and supporting those individuals who may be at risk of, or are being drawn into, terrorist-related activity.

47.1. In order to do this it is important that all staff attend any PREVENT training and awareness programmes provided by the Trust. This is incorporated into all of the Safeguarding training, which includes face to face, nursing assistant induction, EU training for nurses from the European Union and the Trust ELMS (Electronic Learning Management System)

48. Staff should be aware of professional responsibilities, particularly in relation to the safeguarding of vulnerable adults and children and familiar with the Trust's organisation’s protocols, policies and procedures.

49. Indicators that staff may observe or identify regarding individuals behaviour or actions may include 2,3:

- Graffiti symbols, writing or artwork promoting violent extremist messages or images.
- Patients/staff accessing violent extremist material online, including social networking sites.
- Family reports of changes in behaviour, friendships or action and requests for assistance.

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2 Building Partnerships, Staying Safe The health sector contribution to HM Government’s Prevent strategy: guidance for healthcare workers

3 Northamptonshire Healthcare NHS Foundation Trust
• Patients voicing opinions drawn from violent extremist ideologies and narratives.
• Use of extremist or hate terms to exclude others or incite violence.
• Harmful influences on vulnerable individuals from staff, colleagues, volunteers, parents, spouse, family members, friends, external groups of other patients.
• Inappropriate use of the internet on Trust premises.
• External groups using the Trust premises for meetings, distributing violent extremist material.

50. The Trust’s PREVENT lead is the Head of Patient Experience. Any concerns in relation to the following people (patients, relatives or visitors) should be first directed to as follows

• A child or young person aged under 18 years of age: Contact the Safeguarding Children Lead and Patient Experience
• An adult: Head of Patient Experience
• A member of staff: Deputy Director

51. A referral will then be made by the above person to the Multi-Agency Safeguarding Hub (MASH) or Thames Valley Police as appropriate.

Domestic Abuse

52. Domestic Abuse can be experienced by anyone. Staff must pay attention to the potential risk of vulnerable adults in relation to psychological or physical abuse arising from Domestic Abuse.

53. Staff should be familiar with the potential risks of domestic abuse for both children and adults and the role of the Oxfordshire Domestic Abuse Support Service and Thames Valley Police. This is of particular importance if children live at the patients address or are part of the family group. This information can be found on the Trust’s Safeguarding children and vulnerable adults’ intranet site.

Pressure Ulcers

54. Pressure ulcers can be an indication of physical abuse or neglect. Patients with physical disabilities and people who have limited communication. For example people with profound learning and multiple disabilities, long term and progressive conditions, stroke and dementia are at risk of pressure ulcers.

55. Please follow the Trust’s Pressure Ulcer Prevention Management Policy and procedure

56. If a patient is admitted or reviewed in an outpatient department with a category 3 or 4 pressure ulcer or multiple category 2 pressure ulcers, please seek advice from the Trust’s Tissue Viability Team. Please refer to the assessment protocol in Appendix 5.

Modern Slavery and Human Trafficking

57. Modern Slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation.

Source: Health Education England: e-lfh

58. Under the Modern Slavery Act 2015, frontline NHS healthcare workers have an important role to play in identifying and caring for trafficked people, referring them for further support and also supporting them to report to the appropriate authorities. This is done according to the procedures agreed by the Oxfordshire Safeguarding Adults Board.
59. Staff who suspect that a patient may have been trafficked can contact the safeguarding adults lead within working hours, or use the out of hours Oxfordshire Safeguarding Adults number for advice on referrals to the UK Human Trafficking Centre. Contact details available on the Safeguarding Children and Vulnerable Adults intranet site.

**Female Genital Mutilation (FGM)**

60. The World Health Organisation (WHO) defines female genital mutilation (FGM) as: "all procedures (not operations) which involve partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or other non-therapeutic reasons" (WHO, 1996).

61. In England, Wales and Northern Ireland all forms of FGM are illegal under the Female Genital Mutilation Act 2003 and in Scotland it is illegal under the Prohibition of FGM (Scotland) Act 2005.

62. Health professionals in GP surgeries, sexual health clinics and maternity services are the most likely to encounter a girl or woman who has been subjected to Female Genital Mutilation (FGM).

63. Health professionals encountering a girl or woman who has undergone FGM should be alert to the risk of FGM in relation to her:
   - Younger siblings
   - Daughters or daughters she may have in the future
   - Extended family members

64. All girls/women who have undergone FGM (and their boyfriends / partners or husbands) must be told that re-infibulation is against the law and will not be carried out under any circumstances. Each woman should be offered counselling.

65. If staff suspect are concerned that a child or woman are at risk of FGM they must report this to their line manager and seek immediate guidance from the Trust’s Children’s Safeguarding Lead.

Sources: Oxfordshire Safeguarding Children’s Board (OSCB) and the World Health Organisation

**Chaperoning and Intimate Care**

66. Any patient may need assistance with intimate care as a result of receiving healthcare or because of a disability, delirium, dementia or cognitive impairment.

67. All staff must be familiar with the Trust’s Chaperone and Intimate Care document to safeguard their patients’ safety and privacy and dignity.

68. This is particularly important in relation to patients who lack mental capacity. Please refer to the Trust’s Chaperoning and Intimate Care Guidelines for guidance and the Trust’s expected standards of practice.

**Incident reporting and investigation**

69. A safeguarding concern about a vulnerable patient must be recorded on the Trust’s incident management system and reported to the ward sister/charge nurse and patients consultant, however this does not classify as raising a safeguarding alert. An OSAB online Safeguarding Adults Alert form (link located in Appendix 2), should be completed and also the safeguarding adult lead should be informed via the safeguardingadults@ouh.nhs.uk email address.

70. If a safeguarding adult’s alert is raised about OUH services, this should be reported on Trust’s incident management system, care must be taken to restrict the number of
71. All safeguarding alerts in relation to adult patients should follow the Safeguarding Adults’ investigative Algorithm and investigated according to the Trusts’ Incident and Investigation Policy. (Please refer to Appendix 3).

72. An online Safeguarding Adults Alert form (link located in Appendix 2), should be completed. The Safeguarding Adults lead practitioner should also be informed.

73. Each clinical area will have a ‘Safeguarding Adults leader’ to provide expert safeguarding advice.

74. Safeguarding adults reviews (SARs):

- Safeguarding Adults Boards must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

- Safeguarding Adults Boards must also arrange a SAR if an adult in its area has not died, but the Safeguarding Adults Boards knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. Safeguarding Adults Boards are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

- The Safeguarding Adults Boards should be primarily concerned with weighing up what type of ‘review’ process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.

- SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

Source: Care Act 2014

75. Following the publication of the Serious Incident Requiring Investigation (SIRI) in April 2015. All SARs must be accompanied by a SIRI investigation4.

**Education and training**

76. All staff must complete and pass the Safeguarding Children Level 1 and Level 2 and Adults Safeguarding training. The Safeguarding Adults e-learning module can be accessed here, via Electronic Learning Management System (ELMS); [here](http://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf)

Classroom sessions can also be booked via ELMS.

77. WRAP3 Training enables senior staff to become facilitators of the PREVENT programme. This gives a greater understanding of the government’s strategy in preventing radicalisation.

78. Managers will provide initial information during induction on the Policy for Safeguarding Vulnerable and at Risk Adults. This will include being made aware of:

- Definitions of abuse
How to report concerns

Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

Links to the Domestic Abuse Care Pathway

Prevent

79. All safeguarding alerts in relation to adult patients should follow the Safeguarding Adults’ investigative Algorithm and investigated according to the Trusts’ Incident and Investigation Policy. (Please refer to Appendix 3)

80. Additional training will be provided to targeted staff groups by internal and external subject experts according to the priorities identified by the audit of the Policy for Safeguarding Vulnerable and at Risk Adults and in line with requirements identified in the trust Statutory and Mandatory and Essential Training Plan.

Further guidance

81. Please refer to the appendices and Oxfordshire Safeguarding Adults Board attachments to this policy:

Monitoring and review

82. The Safeguarding Adults and Patient Services Manager will ensure monitoring and updating of this policy annually or in response to substantial changes in the nature of Operations, changes in legislation or developing best practice.

83. The Clinical Governance Committee will assess this policy annually to determine its effectiveness and appropriateness.

84. Implementation of policies and procedures will only be effective if adequate evaluation and monitoring systems ensure shortcomings in policy implementation are identified and managed. Managers within Divisions are responsible for initiating an on-going performance monitoring process within their areas of responsibility.

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<td>Matrons and Divisional Executive Teams</td>
<td>Annually</td>
<td>Divisional Executive meetings OUH Safeguarding Adult Steering Group Oxfordshire Safeguarding Adults Board</td>
</tr>
<tr>
<td>Compliance with the DH process for DOLS</td>
<td>Review of patients healthcare records where a DOLS has been either granted or declined</td>
<td>Safeguarding Adults and Patients Services Manager</td>
<td>Annually</td>
<td>Divisional Executive meetings OUH Safeguarding Adult Steering Group Oxfordshire</td>
</tr>
</tbody>
</table>
## Review

85. This policy will be reviewed in 3 years, as set out in the *Developing and Managing Policies and Procedural Documents Policy*.

## Risk assessment

86. An organisational self-assessment will be undertaken annually and the results will be risk assessed in accordance with the OUH Risk Management Strategy. This will be the responsibility of the Safeguarding Adults and Patient Services Manager.

## Equality Analysis

87. As part of its development, this policy and its impact on equality, diversity and human rights has been reviewed, an equality analysis undertaken (see appendix 1) and in order to minimize the potential to discriminate, the following adjustments have been identified:

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Reasonable adjustments required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability (all disability including dementia and learning disability)</td>
<td>The policy applies to all people who are vulnerable</td>
</tr>
<tr>
<td>Sex</td>
<td>The policy applies to all people who are vulnerable</td>
</tr>
<tr>
<td>Age</td>
<td>Document aimed at those aged 18 and above</td>
</tr>
<tr>
<td>Race</td>
<td>Adjustments may be required for language</td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>The policy applies to all people who are vulnerable</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>The policy applies to all people who are vulnerable</td>
</tr>
<tr>
<td>Religion or belief</td>
<td>The policy applies to all people who are vulnerable</td>
</tr>
<tr>
<td>Gender re-assignment</td>
<td>The policy applies to all people who are vulnerable</td>
</tr>
<tr>
<td>Marriage or civil partnerships</td>
<td>The policy applies to all people who are vulnerable</td>
</tr>
<tr>
<td>Carers</td>
<td>The Carers are clearly identified in the Care Act 2014</td>
</tr>
</tbody>
</table>
### How does this policy affect each characteristic?

**Protected Characteristic:**

<table>
<thead>
<tr>
<th>Safeguarding people who are vulnerable</th>
</tr>
</thead>
</table>

**Reasonable adjustments required**

The policy applies to all people who are vulnerable. Anyone who is deemed vulnerable and meeting the criteria as stated by the Care Act 2014 will be included in the policy. The areas that need particular care and attention are victims of Domestic Abuse, Female Genital Mutilation (FGM), Modern Slavery and PREVENT as people may not be defined as vulnerable but are made vulnerable by Domestic Abuse, FGM, Modern Slavery and PREVENT.

### References


Document history

This is the eighth edition of the Oxford University Hospitals Adult Safeguarding Policy.

<table>
<thead>
<tr>
<th>Date of revision</th>
<th>Version number</th>
<th>Reason for review or update</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2007</td>
<td>1.0 Adult Safeguarding Policy</td>
<td>New policy</td>
</tr>
<tr>
<td>March 2011</td>
<td>2.0 Policy for safeguarding vulnerable and at risk adults</td>
<td>Reviewed policy</td>
</tr>
<tr>
<td>October 2012</td>
<td>3.0 Policy for Safeguarding Vulnerable and at Risk Adults</td>
<td>Updated Policy with new Trust information</td>
</tr>
<tr>
<td>March 2013</td>
<td>4.0 Policy for Safeguarding Vulnerable and at Risk Adults</td>
<td>Updated Policy with new Trust information and new national information</td>
</tr>
<tr>
<td>August 2013</td>
<td>5.0 Policy for Safeguarding Vulnerable and at Risk Adults</td>
<td>Minor amendments following sign off from Clinical Governance Committee in June 2013</td>
</tr>
<tr>
<td>January 2014</td>
<td>6.0 Policy for Safeguarding Vulnerable and at Risk Adults</td>
<td>Amendments in line with changes in process and establishment of Safeguarding Adults Steering Group</td>
</tr>
<tr>
<td>October 2015</td>
<td>7.0 Policy for Safeguarding Vulnerable and at Risk Adults</td>
<td>Updated to include Safeguarding Adults investigative algorithm, safeguarding alert form, Cheshire West judgement, Female Genital Mutilation (FGM), PREVENT and Domestic Abuse, SIRI guidance and the Care Act 2014.</td>
</tr>
<tr>
<td>January 2016</td>
<td>8.0 Safeguarding Vulnerable and at Risk Adults Policy</td>
<td>Updated to include Human Trafficking and Modern Slavery, in addition to updating the process for raising concerns.</td>
</tr>
</tbody>
</table>
### Authors & Contributors

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Head of Patient Experience</td>
</tr>
<tr>
<td></td>
<td>Safeguarding Adult Lead Practitioner</td>
</tr>
</tbody>
</table>

### Stakeholders – Who has Been Consulted?

<table>
<thead>
<tr>
<th>Who? Individuals or Committees</th>
<th>Rationale and/or Method of Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUH FT Safeguarding Adults Steering Group</td>
<td>Expert Advice. Review of policy. Discussion in Group Meeting.</td>
</tr>
</tbody>
</table>
### Appendix 1: Equality Analysis

<table>
<thead>
<tr>
<th>Equality Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy for Safeguarding Vulnerable and At Risk Adults Version 7.0</strong></td>
</tr>
<tr>
<td><strong>Date of Policy</strong></td>
</tr>
<tr>
<td>October 2015</td>
</tr>
<tr>
<td><strong>Date due for review</strong></td>
</tr>
<tr>
<td>October 2018</td>
</tr>
<tr>
<td><strong>Lead person for policy and equality analysis</strong></td>
</tr>
<tr>
<td>Head of Patient Experience</td>
</tr>
<tr>
<td><strong>Does the policy /proposal relate to people? If yes please complete the whole form.</strong></td>
</tr>
<tr>
<td>The only policies and proposals not relevant to equality considerations are those not involving people at all. (E.g. Equipment such as fridge temperature)</td>
</tr>
</tbody>
</table>

1. **Identify the main aim and objectives and intended outcomes of the policy.**
   - Who will benefit from the policy?
   - How is the policy likely to affect the promotion of equality and minimize discrimination considering: age, disability, sex/gender, gender re-assignment, race, religion or belief, sexual orientation, pregnancy and maternity, marriage or civil partnerships or human rights?

   **Vulnerable adults at risk of any form of abuse or neglect**

   It will promote equality and minimise discrimination by highlighting the responsibilities of the Trust staff to safeguard all vulnerable adults regardless of age, disability, sex/gender, gender re-assignment, race, religion or belief, sexual orientation, pregnancy and maternity, marriage or civil partnership.

2. **Involvement of stakeholders.**
   List who has been involved in the policy/proposal development?

   - Tissue Viability Team
   - Psychological Medicine Service
   - DOLS Supervisory Office
   - Lead Clinician for FGM
   - Safeguarding Children’s and Patient Experience Lead
   - Oxford Health NHS Foundation Trust Prevent Lead
   - OUH Safeguarding Adults Steering Group
   - Oxfordshire Safeguarding Adults Board

3. **Evidence.**
Population information on [www.healthprofiles.info](http://www.healthprofiles.info) search for Oxfordshire.

Safeguarding Vulnerable Adults is increasingly important following the Public Enquiry into the Mid Staffordshire NHS Foundation Trust 2013, the Care Act 2014 and the expose of care at Winterbourne View 2011.

### Disability
Have you consulted with people who have a physical or sensory impairment? How will this policy affect people who have a disability?

No

### Disability: learning disability

### Sex
How will the policy affect people of different gender?

The policy is relevant and should be followed for people of different gender

### Age:
How will the policy affect people of different ages – the young and very old?

The policy is relevant for any patient or visitor over 18 years of age

### Race:
How will the policy affect people who have different racial heritage?

The policy is relevant and should be followed for people who have different racial heritage

### Sexual orientation:
How will the policy affect people of different sexual orientation - gay, straight, lesbian, bi-sexual?

The policy is relevant and should be followed for people of different sexual orientation - gay, straight, lesbian, bi-sexual

### Pregnancy and maternity:
How will the policy affect people who are pregnant or with maternity rights?

The policy is relevant and should be followed for people who are pregnant or with maternity rights

### Religion or belief.
How will the policy affect people of different religions or belief – or no faith?

The policy is relevant and should be followed for people of different religions or belief – or no faith

### Gender re-assignment.
How will the policy affect people who are going through transition or have transitioned?

The policy is relevant and should be followed for people who are going through gender reassignment transition or have transitioned

### Marriage or civil partnerships:
How will the policy affect people of different marital or partnership status?

The policy is relevant and should be followed for people of different marital or partnership status

### Carers
Remember to ensure carers are fully involved, informed, supported and they can express their concerns. Consider the need for flexible working. How will carers be affected by the policy?

The policy is relevant and should be followed for carers
**Safeguarding people who are vulnerable:** How has this policy plan or proposal ensured that the organisation is safeguarding vulnerable people? (E.g. by providing communication aids or assistance in any other way.)

This is the Safeguarding adults policy

**Other potential impacts e.g. culture, human rights, socio economic e.g. homeless people**

<table>
<thead>
<tr>
<th>Section 4  Summary of Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the evidence show any potential to discriminate? If your answer is no – you need to give the evidence for this decision.</td>
</tr>
<tr>
<td>This policy does not have the potential to discriminate as it written to ensure the Trust safeguards vulnerable adults.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How does the policy <strong>advance equality of opportunity?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>It promotes and advances equality of opportunity by embracing the safeguarding principles outlined in the Care Act 2014.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How does the policy <strong>promote good relations between groups?</strong> (Promoting understanding).</th>
</tr>
</thead>
<tbody>
<tr>
<td>It clarifies the role of practitioners in relation to safeguarding adults within the Trust and with external agencies</td>
</tr>
</tbody>
</table>
Appendix 2: Reporting Safeguarding concerns algorithm

Managing concerns for safeguarding vulnerable adults in hospital

Concern is identified by member of staff or public – this could be from disclosure of patient/relative or other member of staff, assessment of clinical condition, known risk for individual

ENSURE THE INDIVIDUAL’S SAFETY
Document all concerns

Discuss concern within clinical team and escalate to Ward Manager, and Safeguarding Adult Lead Practitioner

Has the Patient been harmed?

Yes

Ensure patient is safe

Record all concerns and any evidence of harm

Do you suspect abuse, risk of harm, injury or death?

Yes

Complete online Safeguarding Form linked direct to Social Services Safeguarding Team. Link located on Safeguarding intranet site here

Important Things You May Need to Act On:
- Are others at risk?
- Have concerns been clearly documented?
- Has mental capacity been assessed and documented? – is there a need for Independent Mental Capacity Advocate (IMCA)

- Discuss all concerns with the individual and keep them fully informed
- Safeguarding adults investigation may take precedence over other Trust actions
- Consider professional accountability and support of those involved
- Are all the right people involved?

No

Seek Advice from Safeguarding Leads
Raise concerns of risks to OUH social workers

No

SEEK ADVICE FROM AND DISCUSS CASE WITH: Clinical Team, Ward Manager/Co-ordinator, Safeguarding Adult Lead Practitioner

Continue with and contribute to multi-agency procedures for Safeguarding investigation/plans
Appendix 3: Safeguarding Adults Investigative Algorithm

Disclosure made by a patient, carer or member of staff

Safeguarding alert made by OCC Safeguarding Team.

OUH Safeguarding Adults and Patient Services Manager (SAPS) or nominated deputy informed.

Alert made to Health and Social care team immediately

Details of Safeguarding alert sent to Divisional Nurse, relevant matron, and copied to Clinical Governance and Risk Practitioner and Risk Management email address

- Log as a DATIX incident within 24 hours. OUH SAPS or nominated deputy will check with the Divisional Nurse that this has been completed
- Complete an-initial summary report (ISR). Completed within 48 hours/ 2 days
- Inform appropriate Local Authority Safeguarding Team immediately and advise of next steps.

ISR reviewed by Divisional Nurse, Safeguarding Adults and Patient Services Manager and Risk Management. One of the following actions will be decided by Risk Management, Safeguarding adults and Patients Services Manager, Divisional Nurse and relevant Executive Director

No further action

Internal Division/ Concise investigation report monitored by Clinical Governance Procedures

Serious incident requiring investigation (SIRI). Reported on STEIS

Divisional Nurse attaches ISR to the DATIX incident with outcome added

Further investigation carried out, concluded, monitored by Clinical Governance Procedures signed off by relevant Executive Director.

Copy of concise investigation report or SIRI sent to the appropriate Local Authority Safeguarding Team.

Copy of SIRI sent to Clinical Commissioning Group.

ISR sent to relevant Safeguarding Team by OUH Safeguarding Adults Team and confirmation that Safeguarding alert is closed
## Appendix 4: Mental Capacity Assessment Form

### Patient Details:

<table>
<thead>
<tr>
<th>Attach Patient Details Here</th>
<th>Consultant:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ward:</th>
<th>Details of treatment decision(s) or other specific issue(s) in relation to which capacity is being assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Assessors details

<table>
<thead>
<tr>
<th>Print name:</th>
<th>Role:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Contact Details: | |
|-----------------||

### Patient Mental Capacity Assessment

**Does the patient have a permanent or temporary impairment/disturbance of the functioning of the mind or brain?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**If yes, give a diagnosis or brief description**

### In relation to this decision/issue please answer the following questions:

Please note that if the service user fails the test at any point, they lack capacity in relation to the decision at the time of the assessment.

**Can your patient understand the information relevant to the decision?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Please write in the reason for your answer:**

**Can your patient retain the information long enough to make the decision?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Please write in the reason for your answer:**

**Weigh the information in the balance in order to make a decision?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Please write in the reason for your answer:**

**Can your patient communicate the decision by any means?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Please write in the reason for your answer:**

**Is your patient likely to recover capacity?**

If yes, the assessment of capacity should be repeated at a future point.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
Is This Emergency Treatment?
If so go to proposed action and reasons, complete, sign, date and place in your patient’s healthcare records.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Referral to IMCA**

Does your patient have any relatives or friends who can contribute to this assessment?
If no please refer your patient to an IMCA
IMCA contact details: [http://gettingheard.org/contractual-services/](http://gettingheard.org/contractual-services/)

Date of referral:

**Determination of Best Interests**
If the outcome of the assessment is that the service user lacks capacity, it may be possible to treat/act in their best interests. To help determine this please complete the following checklist

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Have the patient’s and present wishes and feelings been taken into account as far as possible?
Please write in the reason for your answer:

Has account been taken of the patient’s known beliefs and values?
Please write in the reason for your answer:

Have the patient’s relatives/friends been consulted?
Please write in the reason for your answer:

Is there any IMCA/other advocate. If yes, have their views been taken into account?
Please write in the reason for your answer:

If there is an advance decision/lasting Power of Attorney/deputy appointed by the Court of Protection?
Have they been consulted?
Please write in the reason for your answer:

Is the person subject to a DOLS authorisation?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Proposed course of action and reasons**

Completed by: Print name:  Position:  Date:   /   /   .

Sign:
Appendix 5: Raising A Safeguarding Alert In Relation To a Patient’s Pressure Ulcer

**STEP ONE**
- Clinical area reports all Acquired and Inherited Pressure Damage on Datix
- Tissue Viability Team – Follow up Category 3, 4 and Suspected Deep Tissue Injuries (SDTI) to ensure appropriate care has commenced and offer further support (this may be phone advice).

**STEP TWO**
- Clinical area to arrange photography of affected areas with appropriate consent. Arrange upload to Datix.
- Consider if there are any other concerns in relation to neglect or abuse.
- If unsure, contact the Safeguarding Lead for advice.

**STEP THREE**
- If a Safeguarding alert is appropriate please call 07825145546 or page 07623958647 and supply the following information.
  - Patient name:
  - DOB:
  - Address:
  - NHS number:
  - Details of health, social care, private or unpaid care input:
  - Details of specific concerns:
Appendix 6: NHS Protocol for Prevent Referrals

NHS ENGLAND

PROTOCOL FOR PREVENT REFERRALS


Adopted by NHS England and re-launched August 2013.


Target audience: NHS England

- E NHS PREVENT Leads;
- F Directors of Nursing and Executive Safeguarding Leads within Provider organisations;
- G Area Team Assistant Directors for Nursing and Patient Experience;
- H Clinical Commissioning Group Quality/Safeguarding Leads;
- I Safeguarding Boards;
- J Health and Wellbeing Boards

Partners

Police PREVENT Leads, CHANNEL Co-ordinators, other interested parties including PREVENT Leads with the private, voluntary and charitable sector.

This document is not intended for general circulation to front line healthcare workers.

Document classification: This document is NOT PROTECTIVELY MARKED, other than Appendix D – NHS England CHANNEL Referral Form on page 11 which is RESTRICTED WHEN COMPLETE.
NHS ENGLAND

PROTOCOL FOR PREVENT REFERRALS

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<tr>
<td>Appendices:</td>
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<tr>
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<tr>
<td>Appendix B: NHS PREVENT concern escalation process relating to a colleague</td>
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<tr>
<td>Appendix C: The CHANNEL process referral pathway</td>
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<tr>
<td>Appendix G: Information governance legislation and guidance</td>
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</tr>
</tbody>
</table>

NHS ENGLAND

PROTOCOL FOR PREVENT REFERRALS

A. Introduction

1.1 This protocol has been developed for implementation across NHS England.
1.2 The health sector’s contribution to PREVENT focuses on objectives 2 and 3 of the PREVENT Strategy, namely:
   (a) Preventing people from being drawn into terrorism and ensure that they are given appropriate advice and support;
   
   (b) Work with sectors and institutions where there are risks of radicalisation which we need to address.
1.3 This protocol describes the steps to be taken by PREVENT leads when a concern has been raised and is intended to help both those who are vulnerable and believed to be at risk of exploitation by radicalisers and those who are already engaged in terrorist related activity and could be radicalising others.

1.4 Reporting (1) to Regional PREVENT Co-ordinators and (2) to outside agencies for further risk assessment and support via the CHANNEL process are key.

1.5 Department of Health PREVENT guidance and toolkit Building Partnerships, Staying Safe for healthcare organisations⁵ and healthcare workers⁶ highlights the fundamental concept that patients, service users and staff who are at risk of radicalisation should be considered as vulnerable persons in the context of the existing safeguarding agenda. As such, radicalisation should be considered as a form of abuse in a similar way to exploitation, intimidation and coercion which are familiar terms to healthcare professionals involved in safeguarding adults and children.

1.6 We are committed to tackling discrimination of any kind, promoting equality and diversity, protecting and promoting human rights. We encourage an open, honest and immediate incident reporting system that is used to improve practice and reduce risk. Staff have a responsibility to report incidents.

1.7 PREVENT deals with the pre-criminal space. If you have an immediate concern about someone’s life or a property you should telephone 999 or the Anti-Terrorist Hotline on 0800 789 321. A Textphone facility for people who are deaf or who have hearing difficulties is available on 0800 0324 539. For all non-emergency enquiries or to report crime and other concerns call 101.

B. THE PROTOCOL

Reporting to Regional PREVENT Co-ordinators

2.1

--------


2.2 PREVENT Leads within the organisation should advise the Regional PREVENT Co-ordinators of the following:

- PREVENT cases referred to local multi-agency panels to determine an appropriate intervention, i.e. Multi-Agency Public Protection Arrangements (MAPPA), safeguarding panel or CHANNEL;

- The Number of PREVENT ‘Cause for Concern’ alerts that have been raised by staff that have not resulted in the case being taken forward. This will be provided at the end of each calendar month

- PREVENT cases where referrals from partner agencies into a local multi-agency panel result in a local NHS provider undertaking an intervention;

- All cases where an NHS staff member is referred to their line manager or Human Resources as a result of a PREVENT concern raised under internal policies;

- PREVENT cases where an initial risk-assessment of a patient, service user or staff by the NHS organisation safeguarding lead, following discussion with the local Police PREVENT lead, leads to information being disclosed regarding an on-going investigation or operation.

**Reporting by Regional PREVENT Co-ordinators (RPCs)**

2.3 **NHS England**: RPCs will ensure that the PREVENT/Safeguarding lead in the CCG and the Safeguarding Lead in the Area Team along with the Assistant Director for Patient Experience within the Area Team responsible for hosting the RPCs are kept abreast of PREVENT referrals which are accepted onto CHANNEL or other safeguarding/multi-agency panel.

2.4 **NHS England PREVENT Monthly Referrals Tracker**: Information on the number of referrals initiated by health, along with the number of cases where health input has been provided is held regionally. NHS PREVENT Leads should complete the Tracker on a monthly basis and send it to the RPCs for inclusion in their monthly report.

**Reporting to outside agencies for further risk assessment and support via the CHANNEL process**

**What is a CHANNEL process?**

2.5 CHANNEL is a supportive multi-agency process designed to safeguard those individuals who may be vulnerable to being drawn into any form of terrorism. It is a key part of PREVENT – the Government’s strategy to stop people becoming terrorists or supporting terrorism.\(^7\)

---

2.6 CHANNEL works by identifying individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist-related activity, assessing the nature and extent of the risk, and where necessary, providing an appropriate support package tailored to the individual's needs. A multi-agency meeting, called a CHANNEL panel, usually chaired by an appropriate safeguarding chair, decides on the most appropriate action to support the individual after considering their circumstances.

2.7 It is about early intervention to protect and divert people away from the risk they may face at an early opportunity. Partners already work with individuals vulnerable to being drawn into criminal activity such as drugs, knife or gang crime.

2.8 Partnership involvement ensures that those at risk have access to a wide range of support ranging from mainstream services such as health and education through to specialist mentoring or faith guidance and wider diversionary activities. Each support package is monitored closely and reviewed regularly by the multi-agency panel.

2.9 See Appendix C on page 10 for the CHANNEL Process Referral Pathway.

**What happens with the referral?**

2.10 Each referral is screened for suitability according to the vulnerability and risk factors. If the referral is not deemed appropriate for CHANNEL it will exit the process or be referred to those services which are more appropriate to the vulnerable individual's needs. It is vital that those organisations raising the concern are advised of the outcome of the referral i.e. whether their concern was unsubstantiated/substantiated.

2.11 Appropriate referrals will go through a preliminary assessment by the local CHANNEL Case Officer, co-ordinated by the Regional CHANNEL Co-ordinator and key statutory partners as appropriate.

2.12 Partners will be asked to check and report back to the local CHANNEL Case Officer if the vulnerable individual is known to their service and a Vulnerability Assessment Framework will be created to assist decision making at the CHANNEL multi-agency panel.

2.13 The CHANNEL panel will convene and be chaired by an appropriate safeguarding chair where the needs of the individual will be identified and a support plan will be put in place. See Appendix F on page 13: Responsibilities of NHS representatives attending CHANNEL panels.

2.14 Each case is monitored regularly on a case by case basis based on local agreement. In addition there will be a 6 and 12 monthly review meeting, once the referral has exited the process and where there is no current channel intervention.

2.15 Interventions are projects intended to divert those who are being drawn into terrorist activity and can include statutory, community or specialist interventions i.e. mentoring, counselling, theological support, encouraging civic engagement, development of support networks (family and peer structures) or providing mainstream services (education, employment, health, finance or housing).

**Will the vulnerable person be informed that they have been referred into the CHANNEL Process?**
2.16 PREVENT is based on the active engagement of the vulnerable individual and is at a pre-criminal stage, therefore appropriate consent should be obtained from the individual involved prior to a referral to CHANNEL intervention both to comply with the Code of Practice on Confidentiality (2003) and to establish an open relationship with the vulnerable individual at the start of the process. However, in exceptional circumstances, where seeking consent prior to referral would cause immediate significant harm to the vulnerable individual and/or where the vulnerable person lacks capacity to give consent, a referral may be made without consent in their best interests. Additionally agencies may share limited and proportionate information prior to consent in exceptional cases where this is immediately required to establish whether the case should be managed under PREVENT or as a Counter Terrorism case. See Appendix G on page 14: Information governance legislation and guidance.

2.17 When seeking consent, there should be consideration of the need to support the vulnerable individual in the giving of their consent and throughout the time a support plan is in place. This should include an offer and provision of appropriate advocacy to the vulnerable individual to assist them in becoming active participants in the planning to support them.

Escalating your concern

2.18 In the absence of any existing organisational arrangements for escalating PREVENT concerns, the flow charts provided in Appendix A on page 8 and Appendix B on page 9 may be helpful.

Referring to CHANNEL

2.19 Please complete Appendix D, the NHS England CHANNEL Referral Form on page 11 (noting that this is RESTRICTED WHEN COMPLETE) and use the secure email addresses contained within the relevant local area contact details in Appendix E on page 12.

2.20 Incidents which are likely to cause significant public concern and/or media interest either locally or nationally should be reported by NHS organisations. Therefore, upon completion of a CHANNEL Referral Form, consideration should be given as to whether to escalate to Directors within Trusts/CCGs for upward reporting and whether it qualifies as a Serious Incident Requiring Investigation (SIRI) for reporting under STEIS.
Appendix A - NHS PREVENT escalation process for a concern relating to a patient
To be used in the absence of any existing organisational arrangements.

Appendix B – NHS PREVENT escalation process for a concern relating to a colleague

To be used in the absence of any existing organisational arrangements.

Source: Building Partnerships, Staying Safe. The health sector contribution to HM Government’s PREVENT strategy: guidance for healthcare organisations. (Department of Health, November 2011)

Please note that the CHANNEL Process is also available for staff at risk of radicalisation

* Corporate policy will direct the involvement of LSMS as necessary.
‡ This is an advisory role and it will be at the discretion of healthcare practitioners and safeguarding leads to contact police Prevent lead for advice and support as necessary. Police Prevent leads can also assist safeguarding leads and Caldicott Guardians with advice on risk-assessment procedures.
Appendix C – The CHANNEL Process Referral Pathway

**Source:** HM Government. CHANNEL: Protecting vulnerable people from being drawn into terrorism. A guide for local partnerships (October 2012)

**THE CHANNEL PROCESS**

This diagram shows the different stages within the CHANNEL process.
### Appendix D - NHS England CHANNEL Referral Form

To submit use the secure email addresses as shown in Appendix E on page 12

**RESTRICTED when complete**

<table>
<thead>
<tr>
<th>DETAILS OF THE INDIVIDUAL BEING REFERRED INTO CHANNEL</th>
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<tbody>
<tr>
<td><strong>Name of the individual</strong></td>
</tr>
<tr>
<td>*</td>
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<td><strong>Date of birth</strong></td>
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<td><strong>Address</strong></td>
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<table>
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<tr>
<th>DETAILS OF THE REFERRING ORGANISATION</th>
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<tr>
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<tr>
<td><strong>Name of staff contact</strong></td>
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<td></td>
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<tr>
<td><strong>Secure email address (i.e. NHS net)</strong></td>
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</table>

<table>
<thead>
<tr>
<th>REFERRAL FACTORS</th>
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<tr>
<td><strong>SHORT DESCRIPTION</strong></td>
</tr>
<tr>
<td>ENGAGEMENT - Is there any information to indicate that this individual is showing any signs of becoming involved with a group, cause or ideology that justifies the use of violence and other illegal conduct in pursuit of its objectives?</td>
</tr>
<tr>
<td>INTENT - Is there any information supporting that this individual has indicated that they may be willing to use violence or other illegal means?</td>
</tr>
<tr>
<td>CAPABILITY - Is there any information supporting what this individual may be capable of doing?</td>
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- RPCs are to receive a redacted version of this CHANNEL Referral Form
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Appendix F – Responsibilities of NHS representatives attending CHANNEL panels

The purpose of this document is to provide advice to NHS staff who may be required to attend a multi-agency CHANNEL panel to support the effective delivery of the PREVENT Strategy. CHANNEL is an existing multi-agency programme which assesses how vulnerable an individual is to radicalisation and to ensure support is provided in a pre-criminal space before any offence related to an extremist ideology is committed. CHANNEL draws on the expertise of policing, local authorities, health, community organisations, probation, Youth Offender Services, UK Border Agency etc., and where necessary provides an appropriate support package tailored to an individual’s needs. Health professionals can make a significant contribution through sharing knowledge and expertise from a health perspective, thereby ensuring that a holistic programme of support is available. A multi-agency panel could be bespoke and tailored to the needs of the individual or an existing panel formed for other referral mechanisms i.e. safeguarding.

The following should be considered before attendance at a CHANNEL panel:

B      Attend a HealthWRAP (a Workshop to Raise Awareness of PREVENT).
C      Know the contact details of your NHS Trust’s PREVENT Lead and that they are aware of the case.
D      Collate in advance of the meeting all information from your organisation which is relevant to the case. In order to undertake a fully informed assessment of the person’s vulnerability, partners will need to share the relevant and necessary information with strict regard to confidentiality. A confidentiality agreement will need to be signed at the beginning of each CHANNEL panel meeting.
E      Follow information sharing principles to ensure this is proportionate to the request being made.
F      Ensure that you are clear at the end of the meeting about how information will be shared or used.
G      Ensure you have a good understanding of the services which are available from your organisation locally for people who require support.
H      Be familiar with the local initiatives in your area which support PREVENT.
I      If necessary, be prepared to challenge and advocate for the needs of the person being discussed.
J      Remember that as a health representative other agencies may assume you are representing all health agencies so be clear about your role and responsibilities.
K      If in doubt, or if you have concerns about the process or the case, contact your organisation’s PREVENT lead or Regional PREVENT Co-ordinator.

Thanks to NHS Midlands and East and Derbyshire Police for the original idea. Adapted for NHS England.
Appendix G : Information governance legislation and guidance

A The Care Record Guarantee: Our guarantee for NHS Care Records in England (NHS, 2011)
B Children Act 2004
C Common law duty of care
D Common law duty of confidentiality
F Crime and Disorder Act 1998
G Data Protection Act 1998
H Data Protection (Processing of Sensitive Personal Data) Order 2000
I Health and Social Care Act 2008
J Human Rights Act 1998
K Information Sharing: Guidance for practitioners and managers (HM Government, 2009)
L Mental Capacity Act 2005
M National Health Service Act 2006
N NHS Information Governance: Guidance on legal and professional obligations (Department of Health, 2007)
O No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (Department of Health, 2000)
P Professional codes of conduct (as relevant)
Q Public Interest Disclosure Act 1998
R Reference Guide to Consent for Examination or Treatment (Department of Health, 2nd edition, 2009)
## Appendix 7: Document Development Checklist

<table>
<thead>
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<th>Title of Document Being Reviewed:</th>
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</tr>
<tr>
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</tr>
<tr>
<td>Is the document correctly and consistently defined as a Policy, Procedure, Protocol, Guideline or Strategy?</td>
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<tr>
<td><strong>Rationale</strong></td>
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<tr>
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<tr>
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<tr>
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</tr>
<tr>
<td>Do all pages have appropriate branding and header and footer content?</td>
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<tr>
<td>Have contributors to the development of the document been identified?</td>
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</tr>
<tr>
<td>Is there evidence that relevant expertise has been used in developing the document?</td>
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</tr>
<tr>
<td>Have links to national guidance and/or CQC Standards been identified?</td>
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<tr>
<td>If the document relates to or has implications for medications, has advice and approval be sought from the relevant medicines committee?</td>
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<td>Have all references been cited?</td>
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<tr>
<td>Are links to other associated OUH procedural documents or information sources included?</td>
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<td><strong>Content</strong></td>
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<tr>
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<td>Have the relevant responsibilities been described?</td>
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<tr>
<td>Are there processes detailed for monitoring the implementation and effectiveness?</td>
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<td>Have any training needs been identified and planned for?</td>
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<tr>
<td>Is the review date considered appropriate?</td>
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**Approval & Responsibility**

| Does the document clearly state the author(s) by role/position and not name? | Yes |
| Does the document identify the relevant committee or group who will approve it? | Yes |
| Is the lead Director correctly identified? | Yes |

**Comments**

Delayed issue since Clinical Policy Group due to finalised formatting of some elements of content and key points for inclusion from subject experts.

**Clinical Policy Group or Delegated Group for Approval:**

If the Clinical Policy Group (CPG) or delegated group for approval is happy to recommend this document for ratification, enter group details below. The Document will then be forwarded to the relevant committee for final ratification prior to publication.

| Name of Committee: |
| Date of Meeting: |

**Final Committee Ratification**

| Name of Committee: **Clinical Policy Group** |
| Date of Meeting: **4 August 2015** |
Supported Discharge Pathway Operating Policy

V. 02
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**Introduction**

This operating policy outlines the common approach across the NHS and Social Care in Oxfordshire to managing timely and effective transfer of patients through the supported discharge pathway.

This underpins the agreed supported discharge policy for Oxfordshire through outlining shared behaviours, culture and practice to which all organisations who contribute to supported discharge have committed.

Patients who are delayed in the wrong care setting can be at higher risk of avoidable harm, and can experience delays in recovery and reablement. Delays in moving to the appropriate setting for the patient’s current needs can also negatively affect other patients who are awaiting access to services right along the supported discharge pathway.

As a system we are committed to improving patient experience and outcomes through improved timely flow through our supported discharge pathway. In turn this will ensure reduction in delayed transfers of care (DTOC) and support delivery of the 4 hour standard for A&E.

1. **Aim**

The aim of the operating policy is to define the shared standards, processes and set of behaviours for supported discharge that will ensure timely and effective discharge of patients along the supported discharge pathway.

2. **Measurement**

The Single System Indicator which we will use to monitor the success of our plan is the number of discharges from the 440 acute beds on which our action is targeted. This will be measured daily.

**The whole system target is 69 per day** (this total includes “simple” and “complex” discharges).

3. **Standards**

3.1 **Patient -centred**

- Discharge planning is individual to the patients and their needs.
- It is undertaken through the development of shared expectations of patients, carers and the multi-disciplinary team from prior to the point of admission onwards.
- Discharge planning is undertaken with patients (and their carer’s and relatives).
- It focuses on a managed balance of risk to enable timely and safe patient discharge or transfer to onward care.
- Basis of informed patient consent.
3.2 Safely Equalising Demand Pressure

It is recognised that when teams are under demand pressure then “tribal” behaviours can emerge, where protection of one’s own service overcomes the functioning of the whole pathway. This includes:

- Protecting a service from demand regardless of disproportionate pressures elsewhere on the pathway
- Blaming other services for ineffective operational practices
- Slowing discharge processes when demand drops

As a system, all organisations have committed to the standard of safely equalising demand pressure across the supported discharge pathway. This requires all teams to:

- Be aware of whole system demand pressures each day, especially significant demand pressure occurring during a 24 hour period.
- Maximise capacity through effective discharge planning and operational delivery
- Offer constructive feedback to improve pathway flow (see below)
- Action constructive feedback received (see below)

3.3 ‘You fix your bit and I’ll fix mine’

All organisations have areas for improvement to achieve consistent timely and effective patient discharge. All organisations are committed to working together to

- constructively to meet individual patient needs
- manage flow effectively
- safely equalise demand pressure
- learn through delivery
- embed good discharge planning across the supported discharge pathway

3.4 Escalation

All organisations have committed to escalation within 30 minutes for any issues that are impeding timely discharge / transfer.

This requires all teams to:

- proactively manage discharge planning
- monitor progress against discharge actions
- be aware of their points of escalation
- utilise these within the 30 minute escalation standard

3.5 Learning Approach

All organisations have committed to running a shared issues log to ensure learning is applied across the pathway. This is to support us in achieving a “learn once, fix once” approach, rather than frontline staff having to re-address chronic issues over a period of time.
The shared issues log will be maintained by representatives from

- OUH Discharge Liaison Team
- Single Point of Access (SPA)
- OCC acute social workers
- Reablement Service (ORS)
- Supported Hospital Discharge Service (SHDs)
- CHC Team
- Purchasing Team (OCC)
- Transport
- Other providers as required in terms of expertise.

The issues log will comprise of

- The issue
- What was the solution to rectify the issue immediately
- What learning or wider action is suggested

Issues need to be reported in a way that is constructive and seeks continuous learning and improvement.

Review of issues will take place on Thursday’s weekly DTOC meetings at the JR.

Actions will be reviewed monthly by the Discharge Steering Group, and formal close-down of issues will be approved by this group.

A summary of issues, actions and outcomes will be reviewed by the weekly Whole System Urgent Care Working Group.

1.6 Application of Patient Choice

Patient choice must be proactively managed in accordance with the system’s Choice Policy. However, patient choice does not legally apply in the transfer from one NHS bed to another NHS bed. Therefore, patient choice does not apply in the transfer from an acute bed to a community hospital bed.

Patients who are requested to transfer to a community hospital which is not their local / preferred will be offered

- Repatriation to their nearest appropriate community hospital when a bed becomes available.
- Relatives who would struggle to visit a patient placed in a distant community hospital may be offered discretionary one-off financial support via a personal budget. This will be managed by OCC and a process is provided for circulation at ward level and for display in appendix 6
All OHFT and OUH staff must escalate to the OUH Discharge Liaison Team within 30 minutes of a patient refusing to transfer to an appropriate available community hospital bed. This 30 minute escalation will only be expected in the agreed areas of:

- All JR wards
- All Horton Wards
- All Churchill Wards
- OCE – Nuffield

Nuffield escalation should be referred to Matron / Ward Sister or senior member of team.

If this refusal cannot be resolved within the OUH escalation process, the CCG will be notified, and a senior CCG manager will attend same day to broker an agreement with the patient / family.

All other areas not listed in policy will follow their organisation escalation process if discharge destination cannot be agreed.

4. The Supported Discharge Pathway

The wholes system agreement and standards for the Support Discharge Pathway is that:

The discharge planning process should start before, or no later than 36 hours after admission for all patients

EDD is set within 36 hours of admission

A Section 2 and Section 5 is the agreed documentation to notify services of a requirement for onward services and a medically fit date

A section 5 should be sent when:

A. The decision is made by the lead clinician responsible for their care that the patient is ready for transfer
   And
B. The multi-disciplinary team that has responsibility for their care has made the decision that they are ready for transfer
   And
C. The patient is safe to discharge / transfer

The following Diagram is a high-level visual representation of expectations within the pathway. This is also provided in appendix 2 for display in ward and administration areas for all staff.
5. Standard Operating Procedures

5.1: Acute Board Round:

**Aim**
To provide a meeting point 7 days a week where OUH and Social Care Staff can meet twice daily (or virtually) and feedback on patients which require onward service.

**Purpose**
Ward staff and Social Care Staff will meet to agree discharge plans for all patients on ward and update the board with confirmed plans:

- Between 09:15 and 9:30 in the morning by prior agreement
- At 15:00 as agreed by ward teams
- At weekends by prior agreement as required by teams.

The Board will be a “single source of truth” and will support the production of the R4 List by the Discharge Liaison team. It is expected that when an answer is required in regard to the patient, all ward staff will use the Ready Board to update stakeholders with discharge plans.

**Roles & Responsibilities**
Attendees to the Acute Board Round will be:

- Senior Nurse
- Doctor (am meeting, pm if required by prior agreement
- OCC Social Worker
• Therapist
• Other providers as required in terms of expertise.
• Single Point of Access (SPA), Clinical Coordinator, ad hoc attendance as agreed by lead.

This list of attendees may vary at weekends and evenings

Acute Board ward list will have OUH agreed standard patient information with the addition of:

1. **EDD** which is timely and realistic.
2. Date **Section 2** complete.
3. Date **Section 5** complete and therefore added to the Ready For List.
4. **Ready For or Complex** column – i.e. is the patient ready for discharge in 48 hours or is the patient requiring a complex MDT to discharge.
5. **CHC status**
6. **TTOs** completed
7. Patient **transport** arranged.

The attendees to the Acute Board Meeting will agree:

1. Patients who need to be moved to the complex discharge list
2. A date for this patients escalated MDT
3. Notify all relevant stakeholders who need to attend within 30 minutes of decision

The meeting is expected to be an “on the feet” meeting which discusses plans and any discharge concerns. It should take **no longer than 30 minutes in the morning or 15 minutes in the afternoon**. Patients discussed should be those added since last board meeting and an updated discussion on those which were previously discussed.

CHC screening should be undertaken at this point and a collective agreement on whether the patient is appropriate for CHC and therefore if a full checklist needs to be created. The screening checklist is available on the OUH Intranet, under the discharge page here on the OUH website:

5.2: “Ready For” List (R4):

**Aim**
The R4 list will provide a list of patients ready for discharge to onward services in next 48 hours from the acute ward daily. Sites currently undertaking this process are:

- John Radcliffe
- Churchill
- Horton

NOC referrals are managed by the SPA team via their electronic mailbox, social work referrals are managed via the OCC mailbox.

The R4 will also include a breakdown of:

**Social Work referrals**
To allow all stakeholders to track referrals requiring social work input.

Referrals Out of Area
To allow OUH to track referrals which are Out of County.

Discharges
To allow all stakeholders to see discharges and therefore ensure all systems are updated in a timely manner

Waiting
Patients who have a section 2 but are not medically fit and those which have had a withdrawal of a section 5, for Care at home and Community Beds only.

Purpose
The R4 List is a **single source of truth** which all partners can use to identify patients ready for discharge for onward services. The information will be held on a spreadsheet and provide patient discharge plans, EDD and medically fit date. This will identify the pathway and be split into:

1. Non-complex discharge and ready in 48 hours

2. Complex discharge needs, identified as:
   a) Bariatric
   b) Mental health needs / best interests
   c) Non weight bearing
   d) Needs specialist equipment / dressings / clinical competencies
   e) Unstable fit / not fit
   f) Housing needs, including adaptations
   g) Family dynamics
   h) No fixed abode
   i) Shared care protocols need to be in place to enable discharge
   j) Safeguarding concerns
   k) Complex moving and handling needs
   l) Patients who reside out of county and wish to access an Oxfordshire Community Bed.

If solutions are not in place the MDT team will still add to the R4 list but **highlight as Complex** and immediately notify the onward service to progress discharge plans. The Complex Discharge process will then be followed on page 11.

Roles & Responsibilities
R4 list will be updated daily by the Discharge Liaison Team in the OUH. The R4 list is updated by OUH staff for all stakeholders and therefore the list held in the OUH network is the **single source of truth**.

R4 list will contain the following information provided by the acute:

1. Ability to filter information on:
   - Ready
   - Complex
2. Site
3. Ward
4. NHS number
5. Patient Surname and Initials
6. Gender
7. Postcode
8. Town
9. EDD
10. Reason for Referral
11. Section 2 Date
12. Section 5 date
13. TTOs Completed: Yes / No
14. Own Transport
15. Infection Control Status
16. Equipment
17. Provision for Aiming Home (heating, food)
18. Discharge Destination
19. Comments Box: free text

This list is not exhaustive and will provide only the information which pertains to that patients discharge.

SHDS (OUH), OCC and OHFT will send updated comments back to Discharge Liaison Team in the acute to update the R4 list as appropriate to support discharges.

5.3: Escalation procedures:
Concerns with discharge plans which will result in a delay in discharge should be escalated 30 minutes from decision to Discharge Liaison Team or another senior member of the ward team. Escalation processes should then be followed for each organisation as shown in appendix 1.

5.4: Complex MDT Case Review:
Aim
Those patients which are identified as complex, i.e. those patients:

- Where a clear destination cannot be agreed
- Where there are issues around choice
- Patients which have had a longer length of stay of more than 21 days

Require an escalated MDT in order to be reviewed as early in the discharge planning as is possible to expedite discharge arrangements.

Purpose
The Acute Board meeting will identify complex patients and agree when an MDT case review needs to take place with the relevant stakeholders within 30 minutes of decision.

Patients who are complex are identified as:
1) Bariatric
2) Mental health needs / best interests
3) Non weight bearing
4) Needs specialist equipment / dressings / clinical competencies
5) Unstable fit / not fit
6) Housing needs, including adaptations
7) Family dynamics
8) No fixed abode
9) Shared care protocols need to be in place to enable discharge
10) Safeguarding concerns
11) Complex moving and handling needs
12) Patients who reside out of county and wish to access an Oxfordshire Community Bed

If the MDT agree complex needs can be resolved with relevant stakeholders within 48 hours of discharge the process for the For R4 list will be followed on page 8. If complex needs cannot be resolved then a date to arrange a case review will be agreed same day or as soon as MDT agree discharge plans can progress at the daily board meeting.

**Roles & Responsibilities**
The complex patients will be added to the R4 List and highlighted as complex by the Discharge Liaison Team. The section 2 and 5 will be sent to onward services to notify of potential discharge, EDD and medically fit date as any other patient.

The Complex MDT will require attendance of OUH staff and the following list depending on discharge route:

- Single Point of Access (SPA)
- OCC acute social workers
- Reablement Service (ORS)
- Supported Hospital Discharge Service (SHDs)
- Continuing Health Care Team
- Specialist practitioner / agencies

**Escalation procedures:**
Concerns with discharge plans which will result in a delay in discharge should be escalated 30 minutes from decision to Discharge Liaison Team to update the R4 List and escalation processes for each organisation will be followed as shown in appendix 1.
5.5: Continuing Healthcare Pathway (CHC)

Aims
All patients are entitled to a continuing health care screening if there has been a change in an individual's assessed needs as a result of this acute episode. To aid discharge planning the whole system has agreed a screening process which will support the full completion of the CHC checklist.

Purpose
The Acute Board Meeting will identify those patients which need to be considered for CHC funding. The ward will use the prompt sheet screening tool, (see appendix 8), to support decision making and will consider if the patients’ needs have change since admission. If the MDT agree the patient should be considered for CHC funding they will complete the Checklist referral. This referral needs to be sent within **24 hours of decision making** and the patient board updated to confirm date and time sent. The CHC team need to respond with a decision **48 hours from receipt** to confirm if the individual is eligible for a full CHC care assessment.

Roles and Responsibilities
MDT Acute Board Group will consider if patient requires CHC screening using the prompt sheet in appendix 8.

If the prompt sheet guides the group to complete a full checklist the MDT acute board group will designate a member of the group to complete and send within **24 hours of decision**

The ward will issue a CHC Discharge Pathway Letter in appendix 9 to the patient or identified carer / family member.

If the checklist is incomplete a fax will be sent by the CHC team to advise what information is required and a phone call will be made to advise the fax has been sent. If no response is received from the ward sending the checklist by 16:30 it will be escalated following the escalation process in appendix 1.

The CHC team will respond to the decision within **48 hours of receipt**. If the person is eligible for a full assessment the designated member of the MDT will provide the family / carers / patient with the following:
- CHC Information Letter to advise:
- On Interim funding arrangements.
- The Process for discharge and placement for the full assessment.

A full documented process for CHC is attached in appendix 5 with a high level pathway map.
5.6: Weekly Delays Review

The weekly OUH Delays Review is held on a Thursday at the
- JR at 10:30 in the Social Care Conference Room
- HGH Medical Seminar Room at 09:45
- CH at 8:45 at Operational Room, Upper GI Ward
- NOC at Operational Room 09:30

The process and terms of reference for this meeting is shown in appendix 3a with a matrix of Oxfordshire DTOC coding, which can be mapped to the DOH guidelines.

The weekly OHFT Delays Review is held on a Friday at Corporate Services and is chaired by the Head of Community Hospitals. TOR for this group is in appendix 3b.

5.7: Issues Log and Review Process:

Aim
All organisations have committed to running a shared issues log to ensure learning is applied across the pathway.

A double loop learning approach in discharge planning, aims to provide a feedback loop which is constructive and evidences gaps in the process of discharge planning, seeks solutions to modify behaviour in light of experience and ensures learning to increase effectiveness.

The log will be disseminated amongst all providers to provide learning and education via the OUH Drive:

Purpose
The issues log will be accessed and shared by all partners. It will aid a weekly teleconference and be discussed at the weekly delays meeting, seeking solutions and agreed responsibilities to resolve issues.

Roles & Responsibilities
The shared issues log will hold feedback and learning from representatives as suggested below:
- OUH Discharge Liaison Team
- Single Point of Access (SPA)
- OCC acute social workers
- Reablement Service (ORS)
- Supported Hospital Discharge Service (SHDs)
- Continuing Health Care Team
- Other providers as suggested for education and learning.

The Issues log will be held in the OHFT network and maintained by the SPA Leads who will circulate to representatives before each teleconference / meeting weekly.
The issues log will comprise of

- The issue
- What was done to rectify the issue immediately
- What learning or wider action is suggested
- Date learning shared within the Discharge Pathway Steering Group.

Issues need to be reported in a way that is constructive and seeks continuous learning and improvement.

Review of issues will take place every Thursday afternoon at the JR Delays meeting

Actions will be reviewed monthly by the Discharge Steering Group, and formal close-down of issues will be approved by this group. Via this group if solutions are not agreed it will be escalated to the Urgent Care Summit for resolution.

The teleconference will be facilitated the Chair of the Delays meeting on Thursday. A copy of the issues log will be held in the OUH shared drive so all partners are able to view and forward to individuals within their own organisation where appropriate. The OUH shared drive is here:
6. Glossary

<table>
<thead>
<tr>
<th>Supported Discharge Pathway</th>
<th>Patients requiring onward services</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDT</td>
<td>Multi-disciplinary Team consisting of all partnership organisation supporting discharge plans</td>
</tr>
<tr>
<td>Double Loop Learning</td>
<td>Aids learning by reflection on issues, agreeing on actions to modify behaviour in light of learning and then actioning change, continuously learning from experience.</td>
</tr>
<tr>
<td>OHFT</td>
<td>Oxford Health Foundation Trust</td>
</tr>
<tr>
<td>OUH</td>
<td>Oxford University Hospital</td>
</tr>
<tr>
<td>OCC</td>
<td>Oxfordshire County Council</td>
</tr>
<tr>
<td>SPA</td>
<td>Single Point of Access</td>
</tr>
<tr>
<td>R4</td>
<td>Ready for list</td>
</tr>
<tr>
<td>SHDS</td>
<td>Supported Hospital Discharge Service</td>
</tr>
<tr>
<td>TTOs</td>
<td>To Take out</td>
</tr>
<tr>
<td>EDD</td>
<td>Estimated Discharge Date</td>
</tr>
<tr>
<td>DTOC</td>
<td>Delayed Transfer of care – those patients who are medically fit for onward services in a hospital bed.</td>
</tr>
<tr>
<td>CHC</td>
<td>Continuing Health Care</td>
</tr>
<tr>
<td>TOC</td>
<td>Transfer Of Care</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Admissions and Emergency</td>
</tr>
<tr>
<td>Whole System</td>
<td>Whole system refers to all providers within Oxfordshire</td>
</tr>
<tr>
<td>ORS</td>
<td>Oxford Reablement Service</td>
</tr>
<tr>
<td>JR</td>
<td>John Radcliffe</td>
</tr>
<tr>
<td>HGH</td>
<td>Horton</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>Section 2</td>
<td>Notification of requirement for onward service</td>
</tr>
<tr>
<td>Section 5</td>
<td>Notification of medically fit date</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
</tbody>
</table>
Appendix 1:

1A: Escalation Process OHFT

![Diagram showing the escalation process with roles and titles including Chief Operating Officer, Divisional Director, Clinical Director, Head of Service, Head of Urgent Care, Head of Community Hospitals, Head of Countywide Services, SPA Clinical Lead / Modern Matron, Community Hospitals Unit Managers, Reablement (ORS), Service Manager, and Operating Manager. The diagram arrows point upwards indicating escalation.]

Page 17 of 50
<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>29th September 2014</td>
<td>5th October 2014</td>
</tr>
<tr>
<td>6th October 2014</td>
<td>12th October 2014</td>
</tr>
<tr>
<td>13th October 2014</td>
<td>19th October 2014</td>
</tr>
<tr>
<td>20th October 2014</td>
<td>26th October 2014</td>
</tr>
<tr>
<td>27th October 2014</td>
<td>2nd November 2014</td>
</tr>
<tr>
<td>3rd November 2014</td>
<td>9th November 2014</td>
</tr>
<tr>
<td>10th November 2014</td>
<td>16th November 2014</td>
</tr>
<tr>
<td>17th November 2014</td>
<td>23rd November 2014</td>
</tr>
<tr>
<td>24th November 2014</td>
<td>30th November 2014</td>
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<tr>
<td>1st December 2014</td>
<td>7th December 2014</td>
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<td>8th December 2014</td>
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<tr>
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</tr>
<tr>
<td>29th December 2014</td>
<td>4th January 2015</td>
</tr>
<tr>
<td>5th January 2015</td>
<td>11th January 2015</td>
</tr>
<tr>
<td>12th January 2015</td>
<td>18th January 2015</td>
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<tr>
<td>19th January 2015</td>
<td>25th January 2015</td>
</tr>
<tr>
<td>26th January 2015</td>
<td>1st February 2015</td>
</tr>
<tr>
<td>2nd February 2015</td>
<td>8th February 2015</td>
</tr>
<tr>
<td>9th February 2015</td>
<td>15th February 2015</td>
</tr>
</tbody>
</table>
Appendix 3a Terms of Reference Delays Meeting

Terms of Reference

Inpatient Patient Flow Meeting for the John Radcliffe, Churchill and Horton Hospitals Site

Purpose
The group will meet to provide clinical and operational review of:

- Inpatient flow
- Management of Delayed Transfer of Care (DTOC)
- Monitoring of Length of Stay (LOS)

The group will identify and escalate potential individual risks to patient flow, as well as to devise whole system solutions.

Frequency
The group will meet every Thursday between 10:30-12:00 in the Social Care Conference Room. Any cancellations / rescheduling of meetings must be agreed by the Chair and will be communicated via email to all representatives.

Membership

<table>
<thead>
<tr>
<th>Chair</th>
<th>Discharge Liaison Nurse Team Leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deputy Chair</td>
<td>Acute Medicine Matron / Discharge Team Member</td>
</tr>
<tr>
<td>Invitees</td>
<td>OUH Ward Manager / Deputies</td>
</tr>
<tr>
<td></td>
<td>Lead Social Worker</td>
</tr>
<tr>
<td></td>
<td>Oxford Health representative</td>
</tr>
<tr>
<td></td>
<td>Therapy Team Leaders</td>
</tr>
<tr>
<td></td>
<td>Any other clinical representative as required</td>
</tr>
</tbody>
</table>

Non-attendance will be monitored and reported to Operational Service Managers

Objectives of each meeting

1. To ensure the proactive and early commencement of discharge planning, sign posting to other services as appropriate and communication with partners to support patient flow and best practice.

2. To undertake a weekly review of patients to identify blocks to patient flow and reasons for delays with a view to resolving, providing challenge and / or escalating as required.

3. To ensure the weekly review, agreement and sign off of DTOC within the John Radcliffe & Churchill Hospitals with the purpose of reporting to the DOH.
4. To provide learning and education across clinical areas in instigating, developing and carrying out measures to ensure the effective and timely management of activity and actions required to maximise patient flow and clinical outcomes.

5. To maintain records on planned actions / solutions and hold all partners to account for implementation.

6. To provide leadership for the Trust on the Discharge process

**Format of meeting**
The following format will be followed in the meeting in order to minimise Ward Managers need to be away from clinical areas:

<table>
<thead>
<tr>
<th>Clinical Area</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Churchill Wards</td>
<td>10:30-11:00</td>
</tr>
<tr>
<td>Surgical Wards – Trauma, SSIP, Neuro, SEU &amp; Vascular Cardiac</td>
<td></td>
</tr>
<tr>
<td>Adams &amp; Bedford Wards (Geratology) + Stroke &amp; L5A</td>
<td>11:00-11:15</td>
</tr>
<tr>
<td>L7A/B</td>
<td>11:15-11:30</td>
</tr>
<tr>
<td>L7C/D</td>
<td>11:30-11:45</td>
</tr>
<tr>
<td>Post-Acute Ward</td>
<td>11:45-12:00</td>
</tr>
</tbody>
</table>

All times are estimates and may fluctuate according to number of patient

Each team will review cases based on longest – shortest admission time.

Meeting will:
- Ensure appropriate discharge planning has been undertaken
- Highlight actions for all partners to expedite discharge
- Flag potential impediments to discharge and develop plan to mediate

**Administrative Support**
This will be provided by the SPARC team and will:
- Provide reports prior to weekly meeting organised with RAG rating:
  - Days between admission and current date
  - Days between contact assessment and current date
  - Days between section 5 and current date
  - Days between first medical fit date and current date
  - Days since delay start date
- Provide support to update patient sheet with agreed actions
- Record the coding of patients in accordance the DOH guidance
- Provide a final report to the Oxfordshire DTOC group
- Update and distribute weekly Friday reports monitoring reports
Appendix 3B Terms of Reference OHFT Delays Meeting (CHIP)

Terms of Reference

Community Hospital Information and Performance Meeting (CHIP)

Purpose

The Community Hospital Information and Performance Meeting (CHIP) ensures the clinical, operational scrutiny and overview of:

- Inpatient Flow
- Management of Delayed Transfer of Care (DTOC)
- Pathway Management
- Performance Management

This is aligned with the requirements of the community services contract and whole system DTOC taskforce. The group will identify risks and exception to DTOC, ensure resolution and escalation with agreed timely actions, monitored weekly.

Frequency and Membership

The group will meet every Friday at 11am. Exceptions to this rule will be agreed with the Head of Community Hospitals OHFT, communicated via email to all representatives.

The meeting will be chaired by the Head of Community Hospitals, who will agree a deputy in their absence. Representatives are required from all areas:-

- Head of Community Hospitals – Karen Campbell
- Unit Managers all sites or nominated Ward Manager
- Service Manager Hospitals and Out of County Social Work Team – Joan Norris

If there is consistent under performance in one area additional representation will be requested as necessary until resolved.

Objectives

7. Ensure consistent, timely, accurate data recording on the Length of Stay database and RiO. Clinical records should be kept up to date at all times in accordance with the Information Governance Policy.

8. Ensure compliance with contractual and regulatory performance requirements (KPI, CQUIN and Activity) underpinned by the consistent communication across all sites for performance
requirements and the implications (clinical, whole system, contractual and financial) of underperformance. Performance status to be an integral part of Multi-disciplinary (MDT) ward level forums for discussion and action if required.

9. To ensure the proactive and early commencement of discharge planning, sign posting to other services as appropriate and communication with partners to support patient flow and best practice.

10. To undertake a weekly review of patients to identify blocks to patient flow and reasons for delays with a view to resolving, providing challenge and/or escalating as required.

11. To ensure the weekly review, agreement and sign off of DTOC in Community and Mental Health Hospitals for the purposes of reporting to the DOH.

12. To ensure co-operation across the service in instigating, developing and carrying out measures to ensure the effective and timely management of activity and actions required to maximise patient flow and clinical outcomes.

13. To ensure adherence to the DOH DTOC guidance for reporting purposes.

Functions / Tasks to Guarantee Service Delivery

1. Weekly review of LOS at CHIP and Mental Health spreadsheet with timely response to identified data and quality issues by Unit Managers.

2. Monthly comparison of RiO and LOS activity to ensure consistent and accurate reporting. Identified inconsistencies to be resolved within 1 week of identification.

3. Monthly review of KPI, CQUIN and Activity performance and agreement of actions to address areas of underperformance.

4. Weekly review of inpatients to:
   i. Identify inappropriate admissions and agree on-going management in whole system.
   ii. Ensure discharge planning has commenced and establish responsibilities in pathways.
   iii. Signpost patients to other community services if and as appropriate.
   iv. Establish reasons for delay and seek to resolve or escalate blocks.
   v. To provide an appropriate level of challenge across the whole system.

5. Provide predicated discharges to Single Point of Access to ensure advanced capacity planning in the whole system.
6. Ensure partnership agreement to the final DTOC number and reasons for delays for DOH reporting purposes.

7. Representatives are to ensure full preparation for the meeting and be equipped with the relevant information to address and queries / actions relating to the area they are representing.

8. The Service Manager for Hospitals and Out of County Social Work team will be sent a secure copy of the CHIP database and Mental Health spreadsheet 24 hours before the meeting to allow time to gather information for the meeting. This will be sent to a deputy in their absence.

9. Representatives will be required to make decision on behalf of the organisation they represent and ensure effective and timely communication of discussion and required actions.

**Frequency and Membership**

The group will meet every Friday at 11am. Exceptions to this rule will be agreed with the Head of Community Hospitals.

The meeting will be chaired by the Head of Community Hospitals, who will agree delegation in their absence. Representatives are required from all areas:

- Head of Community Hospitals –
- Unit Managers all sites or nominated Ward Manager.
- Service Manager Hospitals and Out of County Social Work Team –
- Mental Health Ward Representatives and / or Deputies.

If there is consistent under performance in one area additional representation will be requested as necessary until resolved.
## Appendix 4: DTOC coding Grid – agreed for Oxfordshire

<table>
<thead>
<tr>
<th>Code</th>
<th>NHS</th>
<th>Social Care</th>
<th>Both</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>completion of assessment</td>
<td>CONTINUING CARE ASSESSMENT Other NHS assessments</td>
<td>Social Work Assessment</td>
</tr>
<tr>
<td>B</td>
<td>public funding</td>
<td>none</td>
<td>none</td>
</tr>
<tr>
<td>C1</td>
<td>further non acute NHS care</td>
<td>COMMUNITY HOSPITAL BED</td>
<td>N/A</td>
</tr>
<tr>
<td>C2</td>
<td>further non acute NHS care</td>
<td>intermediate care bed</td>
<td>ASSESSMENT BED restart of placement New long term placement but only by exception</td>
</tr>
<tr>
<td>D1</td>
<td>residential care home</td>
<td>Restart of NHS placement New long term NHS placement</td>
<td>ASSESSMENT BED restart of placement New long term placement but only by exception</td>
</tr>
<tr>
<td>D2</td>
<td>EMI residential care home</td>
<td>Restart of NHS placement New long term NHS placement</td>
<td>ASSESSMENT BED restart of placement New long term placement but only by exception</td>
</tr>
<tr>
<td>D3</td>
<td>Nursing care home</td>
<td>Restart of NHS placement New long term NHS placement</td>
<td>ASSESSMENT BED restart of placement New long term placement but only by exception</td>
</tr>
</tbody>
</table>
| D4     | EMI Nursing care home | Restart of NHS placement
New long term NHS placement | ASSESSMENT BED restart of placement
New long term placement but only by exception | restart of joint funded placement
long term joint funded placement |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>E1</td>
<td>Community based care package - SHDS Hospital at home District Nurse Bed Based Service Delay Provision/restart of Health funded dom care (by CHC eg meds only visits)</td>
<td>DISCHARGE TO ASSESS With Social Services Restart of care package</td>
<td></td>
<td>REABLEMENT funded care</td>
</tr>
<tr>
<td>E2</td>
<td>Community based care package</td>
<td></td>
<td></td>
<td>Patient requiring Dom Care &amp; Health Tasks which require additional training</td>
</tr>
<tr>
<td>E3</td>
<td>Community based care package</td>
<td></td>
<td></td>
<td>Patient delayed due to joint responsibility of NHS and Social Care</td>
</tr>
<tr>
<td>F</td>
<td>Equipment/Adaptions</td>
<td>Equipment (if care ready)</td>
<td>Equipment (if care ready)</td>
<td>Equipment (if care ready)</td>
</tr>
<tr>
<td>G1</td>
<td>Patient or family choice</td>
<td>Private / Self Funder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G2</td>
<td>Patient or family refusal of bed</td>
<td>CHC funded delayed due to choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G3</td>
<td>Patient or family refusal of bed</td>
<td>OCC funded delayed due to choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----</td>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>Disputes</td>
<td>none</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>Housing</td>
<td>HOMELESS PERSON</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Housing association issues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 5: CHC Full Process

Wholec system Referral Process for consideration of NHS Continuing Healthcare (CHC) Funding for long term care provision.

Patient in hospital bed- decision to discharge confirmed:

<table>
<thead>
<tr>
<th>STEP</th>
<th>ACTION</th>
<th>ACTION</th>
</tr>
</thead>
</table>
| 1.   | MDT to consider whether appropriate for continuing healthcare CHECKLIST referral. If YES go to step 2 | If NO discharge plans continue and ward document in patient record as “not appropriate for CHC”.
<p>| 2.   | Appropriate MDT member to complete CHC referral with appropriate CONSENT within 24 hours of decision to discharge |
| 3.   | Fax or email completed forms to email: |
| 4.   | Referral received by CHC front door administrator- checked for appropriately completed consent and sufficient information to make a decision. | IF REFERRAL incomplete- either incorrect consent and or insufficient information on assessed need to support the level of need indicated in referral: Front door administrator will contact referrer by: a) sending a fax requesting omissions and corrections followed by b) a telephone call (this has been found to be most successful approach). ESCALATION- if no response received from |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 5. | Forwarded to duty Healthcare Manager (HCM) for screening. | referrer by the end of the working day (16.30), the case will be escalated to the following email address for the acute:  
Or to the Unit Manager (UM) for community hospitals. |
|   |   | The duty HCM may need to contact the referrer directly by telephone for clarification. As for incomplete referral above follow the ESCALATION process. |
| 6. | Outcome decision confirmed at management check. |   |
| 7. | Referrer contacted by telephone and informed of outcome decision. This will be followed up in writing.  
STEPS 4, 5, 6 & 7 to be completed by CHC team within 48 hours or 2 working days.  
If eligible for full assessment go to step 8 below: | If not eligible for full assessment ward staff continue discharge plans and document in patient record “not eligible for a full assessment”.  
CHC Administrator sends Not eligible letter to NOK and Ward. |
| 8. | For cases where the individuals is found eligible for a full CHC assessment in Oxfordshire and requiring a Nursing Home placement, there are Interim Funding arrangements in place in Oxfordshire:  
1. CHC check OSJ bed is available, if yes: (contacts CSPO for availability).  
   a) CHC CSPO contacts ward to inform family of where OSJ home is available.  
   b) CHC CSPO contacts OSJ home to request assessment within 48 hours or 2 working days.  
   c) CHC CSPO telephones ward to inform of date and time of assessment. (Nursing home to liaise with ward regarding time of assessment.  
   d) Care home assess and confirm discharge date with ward.  
2. If no OSJ home available:  
   a) Checklist information and screening management checklist is sent to password protected or sent via OCC egress system which is also a secure route. Email to include area and any specialist requirements. | If family refuse offer of OSJ home or CSPO home that is offered hospital will follow Choice Policy and escalation procedures |
| b) CSPO source placement. CSPO provide regular updates on process until placement sourced.  
| c) Once placement sourced confirmed with CHC and return to process 1c. above.  
If patient is found eligible for a full assessment and package of care at home is requested follow step 9.  
|  
9. For cases where the individual is found eligible for a full assessment and a package of care at home is requested:  
1. For individuals who have been found eligible for Fast Track funding - the funding stream for health has been determined and the Fast Track team make all the arrangements for ongoing care provision.  
2. For cases determined by the MDT as complex, discuss with CHC team and request full CHC assessment to take place prior to discharge.  
3. MDT to arrange all discharge requirements such as, equipment, contacting community nursing team and any carer training.  

**CHC to coordinate arrangements for package of care:**  
1. CHC email completed Checklist information to HSPO team. **Email to include the level of care required.**  
2. HSPO will identify provider and liaise with ward to make arrangements for domiciliary agency to assess patient on ward. OCC to check previous care provider on swift and if a direct payment is in place.  
3. HSPO will confirm discharge date with ward. HSPO to send cost’s to CHC. CHC to request authorisation from JC/NC  
4. Ward to confirm to CHC final discharge date and commencement of package of care  

Please note: The Checklist decision will only remain valid for 2 weeks from the date of decision of eligibility for a full assessment. Please inform the CHC duty HCM of any change, either an improvement or deterioration in an individual’s condition.  

- Service Manager, Continuing Care. 21 January 2014.
CONTINUING HEALTH CARE PROCESS

Acute Board Round Meeting

Does patient: need CHC screening tool?

Complete checklist within 24 hours of decision

Document it has been considered in patient notes

Follow Supported Discharge Pathway process

CHC High Level Map

ALL PATIENTS ARE ENTITLED TO A CHC CHECKLIST SCREENING

Champions available in each area for support

Fax to CHC within 24 hours of decision

Is checklist complete?

Send to ward via Fax and confirm by phone requirements

Escalate following organisational procedures

Agreed

Declined

Eligible for full assessment

Not eligible for full assessment

Interim funding arrangements place

TOC letter issued to support discharge

Add to complex discharge list and follow Supported Discharge Pathway Process

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V.02 Supported Discharge Pathway Operating Policy - July 2014
Appendix 6: Process to Access Funds to Support Choice Delays

It is recognised that in some cases people will need to move to a short term bed in a Community Hospital or Intermediate Care Bed which is not in their local area. There are times when this is initially refused as relatives cannot afford to visit. In such cases of hardship it may be possible to make discretionary payments or find suitable support services to facilitate agreement to the proposed transfer. In such cases please follow this procedure:

- Contact Lead Social Worker on site to discuss
- Lead Social Worker will review specific circumstances & ensure sources of transport eg volunteers, Community transport are advised/agree payment amount if not
- Lead Social Worker to confirm arrangements to ward staff & the amount agreed can be paid by Cash or cheque to patient or relative from Avoiding Delays budget.
- Response will be same day
**Appendix 8: CHC Prompt Checklist to support decision making.**

**Continuing Healthcare Checklist completion Prompt Sheet**

**January 2014**

Key prompts have been placed in each domain to assist the referrer to include the key information required in support of a level A, B or C in the Checklist referral.

### Behaviour
- Any verbal or physical challenging behaviour which affects the care provision?
- Can the care be delivered with appropriate care plan in place?
- Describe challenging behaviour. Physical – Hitting, Kicking, Biting, throwing objects? Verbal- shouting, calling out, screaming?
- Does any behaviour put patient or others at risk of harm? Eg Absconding, Invasion of patients/ visitors personal space.
- Known triggers of behaviour?
- How often does the challenging behaviour occur?
- How is the behaviour managed? What approach do you use and what medications are required?
- CPN/CMHT Involvement?

### Cognition
- Has mental capacity been determined in relation to discharge destination?
- Have you completed a MMSE score or equivalent.
- Is patient orientated to time and place?
- Does patient recognise family/ friends/ staff?
- Can patient make basic choices? Eg What to eat.
- Is patient able to assess any basic risks?

### Psychological and Emotional Needs
- Does patient display any anxiety or agitation?
- Known triggers?
- Can patient be reassured in a timely fashion?
  - If not how long does it take to reassure them?
  - How is this managed?
- Is there a history of low mood or depression?
- How is this managed? Is there a specific care plan in place?
- What medication is prescribed and is there a need for PRN medication?
Communication
- Can the patient speak clearly and meaningfully?
- Is it in context?
- Can the patient hear? Hearing aid?
- Does the patient have any sight difficulties?
- Are there any word finding difficulties? Please explain.
- Are non-verbal gestures used? Eg pointing to pain, facial expressions.
- Any communication aids used? Eg Picture boards, IT, Ipad.

Mobility
- Can the patient weight bear?
- How does the patient transfer? Eg standing frame
- Can the patient assist with transfers?
- Is the patient unsteady?
- Balanced when sitting?
- Can the patient reposition him/herself in bed?
- Does the patient use walking aids/1-2 carers?
- Does the patient suffer with pain/ contractures/ spasms.
- Is there a record of falls occurring or a history of falls.
- Incidents reports of falls?
- Has a falls risk assessment been complete and/or a referral to the falls team?
- Any involvement from the Physio, OT etc.

Nutrition
- Does the patient take adequate nutrition?
- MUST score / BMI- percentage of any weight loss noted?
- Special diet/soft/liquidised?
- Fortified drinks/food supplements?
- Does the patient need prompting with food/drinks?
- Does the patient eat and drink independently?
- Does the patient need supervision with meals?
- Does the patient need assistance with eating and drinking? Does this take longer than 30 minutes?
- Is the patient reluctant to eat and drink? How is this managed?
- Are there any problems with swallowing/coughing/choking? SALT referral?
- Has/Is a dietician been involved?

**Continence**
- Is the patient continent?
- Is the patient doubly incontinent?
- How often?
- How is this managed? Eg prompts, pads, toileting?
- Is there a specific toileting programme in place?
- Are night changes required?
- Is a catheter in situ? Have there been any recorded blockages and what action is taken?
- Does this person have a Stoma?
- UTI’s? How often do they occur? Please note any specific management plan.
- Constipation? How is this managed?
- Would you consider continence is problematic to manage? Are timely and skilled interventions are required?

**Skin**
- Which pressure prevention score or tool do you use? Please provide scores. Walsall? Waterlow? PSPS?
- Is the patient’s skin intact?
- Is there a skin condition that requires daily/weekly reassessment?
- Are there any cuts/Wounds? How deep?
- Are there any rashes/scabies/eczema?
- Is a specialised dressing required?
- Are wounds responding to treatment?
- Is there Tissue Viability involvement?
- What is the risk of skin breakdown?
- Does the patient require repositioning? How often/ how long/ how many carers?

**Breathing**

- Is there a history of respiratory disease?
- Does the patient suffer from wheezy or coughing?
- Does the patient suffer from shortness of breath on exertion?
- Is there any specialist Nurse involvement? Eg respiratory or heart failure nurse.
- Does the patient require the use of inhalers/nebulisers? How often and is this effective in managing the need?
- Does the patient require Oxygen therapy?
- Does the patient suffer from chest infections? Does this respond to treatment? How often do they occur?
- Medication? Preventative, maintenance or cure?
- How often are carers monitoring/ observing to ensure welfare? How is this monitored?
- Physiotherapy/ chest drainage?

**Medication**

- Is the patient compliant with prescribed medication?
- Is it given covertly?
- Does the patient require supervision or prompting with medication administration?
- Pain – Mild/moderate?
- Has medication been changed recently? Medication review and / or evidence of titration?
- Are regular blood tests required? Eg Anticoagulation.
- Medication charts – Please provide a copy?
- Does the patient require PRN medications?

**ASC**

- Does the patient suffer from loss of consciousness?
- Faints?
• CVA/TIA’s/absences? History?
• Fits/seizures?
• Log of incidents? How many in a day/week/month? How long do they last and describe the actual risk?
• How long to recover?
• Triggers?
• Is a prompt and/or skilled response required?
• Does the patient require close/ongoing monitoring?
• Is rescue medication required or ever been used?
For information

The discharge pathway for people eligible for a full Continuing Healthcare assessment.

DATE

Re: DOB:

It has been identified as part of the discharge plan that XXXXX requires a Checklist referral for consideration for NHS Continuing Healthcare funding. This process is to determine whether someone is eligible for NHS continuing healthcare or NHS-funded nursing care.

If the Checklist referral demonstrates that XXXX is eligible for a full continuing care assessment, the NHS remains responsible for funding the care provision during the assessment process.

In Oxfordshire Interim Funding arrangements are put in place, this means that XXXXX/you will be cared for in a nursing home until a decision is made on eligibility for continued NHS funding.
This process is expected to take up to eight weeks and allows sufficient time for that person/you to settle into the home and for the care staff to understand your/his/her care needs prior to the assessment being completed.

If the full assessment shows that XXXXX/you has/have needs eligible for Continuing Care funding the NHS will continue to pay for XXXXX/your healthcare provision and will support any appropriate and necessary transfers to alternative placements.

If the outcome of the full assessment is that XXXXX/you does/do not have needs eligible for Continuing Care funding XXXXX/you will be required to make alternative arrangements for the care provision from the date of the decision for eligibility.

If the decision is that you do not have needs eligible for NHS Continuing Healthcare funding, in addition to the national Funded Nursing Care contribution, XXXXX/you may be eligible for some support from social services. If XXXXX/you is/are assessed as being eligible under their criteria, XXXXX/you would be expected to complete a financial assessment to determine whether they would financially support any part of XXXXX/your care costs. The financial services team are alerted to the discharge date and will send the forms to you directly.

Oxfordshire Continuing Care Service