Independent Investigation Action Plan for Ms G and Mr Q

STEIS Ref No: 2018/15587 & 2018/16852

Report published: November 2022

Rec No.	Organisation	Recommendation	Actions to achieve recommendation	Implementation Lead	Implementation by when	Evidence of Completion	Monitoring & evaluation arrangements
1	Oxleas NHS FT	**The Trust** must improve ICMP care planning so that care plans are written and updated in line with Trust policy and include longer term goals, and adopt a biopsychosocial approach, incorporating the wider needs of the service user, beyond immediate day to day living.	We have rolled out DIALOG+ to all community mental health teams. This is part of wider plans to make care planning more person centred and places the service user and their support network more central to the care planning process. DIALOG is a scale of 11 questions. People rate their satisfaction with eight life domains and three treatment aspects on a 7-point scale. DIALOG provides a score for subjective quality of life and a score for treatment satisfaction. The scale is part of the DIALOG+ intervention but can also be used on its own. DIALOG+ is a full therapeutic intervention. It incorporates the DIALOG scale but goes far beyond administering a scale. DIALOG + is the first approach that has been specifically developed to make routine patient-clinician meetings therapeutically effective. It is based on quality of life research, concepts of patient-centred communication, IT developments and components of solution-focused therapy. Clinicians now use DIALOG+ as a tool to help ensure that goals are based on service users own defined goals and there time frame for achievement.	Service Director Community Mental Health	Completed October 2021	Dialog+ protocol, Example of a competed Dialog+, Care Plan Audits, Directorate Quality Group minutes, Qi ICMP measurements	Performance and Quality Assurance Committee (sub-committee of the Trust Board). Meets monthly.
2	Oxleas NHS FT	**The Trust** must review its assurance and monitoring programme for risk assessment and management plans to include clear quality indicators against the Trust policy and expected standards using learning from this investigation.	Ifox digital clinician task lists now provide an immediate real time view of compliance against risk plan completion for clinicians and managers. The quality of risk assessments are monitored through supervision. There is currently a review of the clinical risk assessment and management policy by the Associate Director for Nursing. Policy updated and ratified in July 2022. Two seminars to launch policy - first one 26 Oct, then 2 Nov.	Service Director Community Mental Health	Completed October 2022	Screenshot of clinicians task list, Risk Management Policy.	Performance and Quality Assurance Committee (sub-committee of the Trust Board). Meets monthly.
3	Oxleas NHS FT	**The Trust** should update its Zoning Policy to reflect the immediate interventions staff should take in response to a service user changing zones. This should include the timeliness of key interventions, which staff should be involved in, and details of ongoing monitoring including frequency and leads for escalations or reporting any issues found in practice.	Since this incident we have moved to an electronic zoning system that is more objective and means that zoning is now consistently recorded on RIO. We have added an escalation process to the Zoning Guidance. The Guidance has been thoroughly reviewed by clinicians and we are assure that there is sufficient direction regarding interventions and frequency of monitoring. We will disestablish the zoning guidance form the Community Mental Health Team Operational Policy and identify a named individual for being responsible for establishing it as a formal guidance / policy and discussing it with clinicans at the Community Mental Health Forum to establish if any additional principles are needed to be added. This will then be ratified through our governance structures (Patient Safety Group). To ensure that new staff understand the Zoning guidance / policy we will incorporate the practice requirements from it into the rolling community mental health team induction programme with updates at regular intervals where staff need to demonstrate that they are aware of it and how they use it in their practice.The guidance has been reviewed and a summary of best practice taken to the CHMT forum in August 2022. Discussions held around a new tool but decided to initiate a Qi project to understand the issues with the current tool. It is one of the Trust's Quality Priorities for 22/23.	Service Director Community Mental Health	Due for completion May 2023	Electronic Zoning tool screenshot. Community Mental Heath Forum Minutes. Zoning guideline. Heads Together Induction Programme.	Performance and Quality Assurance Committee (sub-committee of the Trust Board). Meets monthly.
4	Oxleas NHS FT	**The Trust** must support regular monitoring and assurance of mental capacity assessments in multidisciplinary teams. In instances where mental capacity is questioned, there must be a record of the final decision whether to undertake a capacity assessment and the underpinning rationale for this in keeping with best practice guidance. A regular audit programme to support this should be established.	The Trust has a Mental Capacity Act 2005 Policy (reviewed and ratified April 2022). It provides clear guidelines and processes for staff working within the Trust highlighting the key sections of the Mental Capacity Act and Code of Practice. The Trust has a full time designated clinical post: Lead for the Mental Capacity Act, appointed in 2021. The MCA lead undertakes regular deep dives of capacity assessments and provides support to individual clinicians. A Mental Capacity Act e-learning course is provided and required to be completed for all staff working in clinical settings. Face to Face one day workshop training delivered by the Lead for the Mental Capacity Act s provided monthly, augmented by a resource pack. The Trust has forms for recording capacity assessments and best interest decisions and entries are recorded in the clinical progress notes signposting to these. The Trust has a monthly Mental Capacity Act audit which is to be carried out in all clinical teams within the Trust. That audit identifies if the Mental Capacity Act 5 principles (presumption of capacity, support to make a decision, ability to make unwise decisions, best interest and least restrictive) are well understood and applied appropriately in practise. The audits are reviewed and reported at the Mental Capacity Act Steering Group, which meets bimonthly and in turn reports to the Mental Health Legislation Oversight Group, which meets bimonthly and is chaired by a Non-Executive Director and reports to the Board Performance and Quality Assurance sub-committee, chaired by a Non-Executive Director. When gaps in knowledge are identified then relevant training is provided by the Lead for Mental Capacity Act. The MCA lead undertakes regular deep dives of capacity assessments and provides support to individual clinicians.	Service Director Community Mental Health and Mental Capacity Act Lead	Completed October 2021 and ongoing	Mental Capacity Act Policy, Job Description Lead for Mental Capacity Act, Mental Capacity Act Training resources, Mental Capacity Act Audits, Mental Capacity Act Steering Group minutes, Mental Health Legislation Oversight Group Minutes, Deep Dives.	Mental Capacity Act Steering Group. Meets bi-monthly.
5	Oxleas NHS FT	**The Trust** must ensure there are clear standards and criteria within relevant policies to guide staff on the routine monitoring of patient property when the person lacks mental capacity.	We have CPA Policy, reviewed September 2020 which is underpinned by the Mental Capacity Act. The policy clearly states that the care coordinator will undertake a comprehensive assessment of the service-users physical and mental health needs and social care needs. It states that any safeguarding issues must be considered. The Safeguarding Adults Guidance, reviewed May 2021, includes reference to self-neglect. We will add to the CPA Policy guidance that it is the care coordinators responsibility to ensure that where there are concerns about the cleanliness or the upkeep of a service-user's living environment, and where a service user is reluctant to engage or are assessed as not having the capacity to make a decision in respect of the cleanliness or condition of their property, that they put a plant in place with partners to support addressing the concerns and that there is an agreement of who will monitor, this, how and when and where it will be documented.	Service Director Community Mental Health	Completed in September 2022	CPA policy, examples of CPA reviews, minutes of meetings showing changes in policy discussed with teams.	Performance and Quality Assurance Committee (sub-committee of the Trust Board). Meets monthly.
6	Oxleas NHS FT	**The Trust** must develop a system to identify service users who live in shared accommodation. Underpinning this should be an ongoing process for sharing proportionate risk information amongst internal and external services involved.	There is now an information sharing protocol, implemented in 2020 between Oxleas and the three main providers of supported housing. There is a system in place to ensure advance notification of Care Programme Approach (CPA) meetings to enable all providers to contribute to the discussion. We have completed audits against our compliance.	Service Director Community Mental Health	Completed 2020	Copy of information sharing protocol, audits of CPA involvement	Performance and Quality Assurance Committee (sub-committee of the Trust Board). Meets monthly.
7	Oxleas NHS FT	**The Trust** should review its management of repeat safeguarding referrals and concerns. This should include a review of policy and training materials to ensure repeat referrals and allegations are incorporated into Trust policy and guidance.	The corporate Safeguarding Adult Team (SGA) review all data for safeguarding adult concerns raised in the Trust quarterly. Through this process we identify repeat SGA concerns and contact teams to advise and support them in regards to completing a safeguarding enquiry if appropriate or to escalate the case to the local authority if they have responsibility for safeguarding. Complex cases can be brought to the trust safeguarding adults hubs active monthly in all 3 boroughs, so staff can be supported in how to manage difficult safeguarding cases by senior trust staff expeienced in safeguarding adults. Trust SGA guidance is being updated to include information to staff where multiple Merlins with relevance to safeguarding concerns or safeguarding referrals from other partners or where mental health teams have raised several safeguarding concerns for a client that they should review the case, arrange a professionals meeting and where necessary proceed to raising a safeguarding concern and completing an enquiry so that a plan is in place. The SGA guidnace has been reviewed and updated and will be ratified at the November SGA Committee.	Trust Lead Safeguarding Adults	Complete by November 2022	Trust SGA guidance, Greenwich SGA hub details. Case studies showing actions taken by teams in respect of repeated concerns.	Performance and Quality Assurance Committee (sub-committee of the Trust Board). Meets monthly.
8	RBG SAB	**The Royal Borough Greenwich Safeguarding Adult Board (RBG SAB)** should facilitate a peer review of adult safeguarding practice at the Trust, which includes quality assurance audits of randomly selected cases and a programme of planned audits going forward.	Oxleas staff have been involved in an external audit facilitated by a consultant commissioned by RBG which included 10 Oxleas safeguarding adult enquiries from mental health teams in Greenwich borough. Trust staff have attended feedback sessions on the audit and we are working with RBG on a joint action plan to quality assure Oxleas safeguarding adult work. An agreed action plan has been profuced as a result of the audits findings which will be monitored by a steering group to provide assurance that good practice is embedded future adult safeguarding.	Trust Lead Safeguarding Adults	Complete by January 2023	Safeguarding practice audit evaluation, list of staff who attended post audit workshop. Action plan following audit	Safeguarding Committee. Meets quarterly

9	Oxleas NHS FT	**The Trust** must provide assurance that involvement of service user's families is considered when planning care. This should include documenting any contact, and recording instances when the decision has been taken not to involve a family, or they have declined to engage.	The Trust has a Care Planning Policy dated January 2022, which is held and monitored via the clinical effectiveness quality stream. The policy mandates that "The Trust requires active engagement with carers and the family/social support networks for all service users. All clinicians are therefore required to identify the service user's carer/ family/support network, build relationships with those identified and include them as far as is possible in all aspects of the service user's care plan. Clinicians should seek the consent of the service user to do this." (Policy point 3.6). In addition, Appendix 1 has the positive practice poster for care planning which states that it is the responsibility of clinical staff that they must "Identify family/support networks and include them in care planning if consent is given from the service user" Appendix 6 defines Care planning standards for CMHTs and states that "Family members, the support network … should be engaged to contribute to the care plan." Our Quality Account 2021-22 has executive sign off in June 2022, and showed the Care Planning Audit 5,805 audits of RIO electronic clinical record in 2021-22. A care planning action group was established to review standards, revise the policy audit target was 95% "All eligible teams will audit five clinical records using "SNAP" survey software, monthly. The result was that average for two years up to May 22 was 88% We have a "Carers and Confidentiality" policy (dated November 2021, owned by patient safety group) which defines the parameters for including families, the process of obtaining consent from the service user and sharing information for use by clinicians. Our carers and support network Strategy 2019 – 2023 is monitored through the patient experience quality stream. This states that all service users and their support networks (including families) are offered the opportunity to be involved and engaged including care planning (domain II, aspiration 1). It also states that the trusts measures will accurately reflect this engagement (aspiration 6). We monitor involvement of family support network through our support network engagement tool (SNET) with a target of 80% within Mental health services. - completion rates average 82% Nov 2020 – April 2022 minutes June 2022 Performance and Quality Assurance Committee 15th June 2022 A Carers and support network lead was appointed in May 2022	Director of Therapies	Completed October 2021 and ongoing	Support Network engagement tool. Audit of CPA. Carers and support network strategy, Carers and confidentiality policy. Job description for carer and support network lead. Anonymised progress notes showing family involvement or documenting reason for not involving.	Performance and Quality Assurance Committee (sub-committee of the Trust Board). Meets monthly.
10	Oxleas NHS FT	**The Trust** must ensure any engagement with families during its internal investigation process is documented. This should include instances when the family declines to be involved and whether the final report has been shared.	The Trust Serious Incident Investigation template has been updated in order to provide more assurance that family members have been contacted at key points thought out the investigation. Staff now have to include the date the duty of candour letter was sent, the date of the initial telephone call and a summary of the conversation. The specific questions raised by the family are now documented. Investigators are required to make contact at the mid point of the investigation and provide information on the initial findings. The date of the final contact and summary of conversation which must include how the report will be shared with the family.	Head of Patient Experience and Patient Safety	Completed October 2021 and ongoing	Serious Incident Report Template, Completed Serious Incident Reports.	Patient Safety Group (sub-committee of the Trust Board Performance and Quality Assurance Committee). Meets monthly.
11	Oxleas NHS FT	**The Trust** needs to review the ICMP caseload with a view to evaluating the care pathway of service users whose treatment is based on long-term medication requirements (e.g., depot), to ensure service users are on the appropriate care pathway.	We have a number of initiatives ongoing including developing shared care protocols with primary care for stable patients on Depot to be transferred back to GP. Care Team Approach which is a new way of increasing contact for ICMP patients by introducing new Associate Mental health Worker roles, developing a physical health strategy to include monitoring for issues with long term medication and introducing Pharmacy technicians to support our review of depot medication. The biggest issue for ICMP is not being able to discharge stable service users back to primary care for their depots causing high caseloads. We are working with one borough (Bromley) on a protocol for primary care to take back a very small number (50) subject to the Local Medical Committee agreement. Bexley and Bromley have not agreed to this yet so discharges are not able to progress.	Service Director Community Mental Health	This action is longer term and links with our Community Mental Health transformation work. We have developed the shared care protocol for testing in Bromley before implementing in Bexley and Greenwich, the timeframes will be dictated by primary care but is hoped that by Summer 2023 will be in place in all three boroughs. Care Team approach launches in September 2022, Physical Health strategy is complete, Pharmacy technicians are currently being recruited with an expected start of October 2022.	Shared care protocol, Care Team approach operation policy	Performance and Quality Assurance Committee (sub-committee of the Trust Board). Meets monthly.
12	Oxleas NHS FT	**The Trust** should assure itself that it has fulfilled the requirements of the Mr Q and Ms G action plans from the internal investigations, with a view to providing commissioners and the families involved with evidence-based, completed action plans within three months of receipt of this report.	A review of the actions and initiatives to embed and sustain the improvements has been conducted by Head of Nursing. Assurances have been collated in respect of care planning, roles and responsibilities, supervision and monitoring of care plans, risk assessment and management practices, zoning and clinical discussions, safeguarding adults practice and training. A report is scheduled for the Patient Safety Group by the Head of Nursing and the Executive Committee and Performance Management and Quality Assurance Committee (attended by Commissioners) in September 2022 by the Service Director. A copy of the report will be made available to the families should they wish to receive it.Report went to the Trust Patient Safety Group in August 2022.	Service Director Community Mental Health and Head of Nursing	Completed September 2022	Minutes of Performance and Quality Assurance Committee.	Performance and Quality Assurance Committee (sub-committee of the Trust Board). Meets monthly.
13	MPS	**The Metropolitan Police Service (MPS)** should review the learning from this investigation to update its programme of safeguarding awareness and policy within 6 months of receiving this report.	The revised Safeguarding Adults policy has just been reviewed and updated to reflect the recommendations of this report. This is due to be implemented by Winter 2022.	Commander Head of public protection	To be completed in 01/12/2022	Published on the MPS intranet	Policy reviewed annually and monitored by the tactical policy advisor
14	MPS	**The Metropolitan Police Service (MPS)** and partner agencies should undertake a system review of how MERLIN Adult Come to Notice (ACN) reports are managed and responded to. The MPS should undertake a programme of regular review of MERLIN ACN reports to ensure they are being completed in line with MPS policy.	The Multi Agency Safeguarding Review (MASH) review has commenced. This has a separate Adults Task and Finish Group that will specifically look at thresholds in conjunction with partners. These will be realigned to ensure there is an agreed multi agency process for dealing with all incidents of adult vulnerability in a timely manner in line with processes and legislation. In May 2023 the MPs will move to a new IT system called Connect, this will encompass all vulnerability reports.	Commander Head of public protection	To be completed in 01/10/2023	Connect IT system, implemented in May 2023 Task and finish group for MASH are ongoing.	The four task and finish groups reports into the strategic MASH Board.
15	RBG SAB	**The RBG Safeguarding Adult Board (SAB)** should recommend that partner agencies expand the local children's safeguarding MASH to include adult referrals. Mental health specialism should be part of this MASH. Partner agencies should report back to the Safeguarding Adult Board within three months of receipt of this report.	This action has been scheduled to be discussed at Board meetings in December 2022 and March 2023 and will also be discussed at the Safeguarding Executive partnership Group (SEPG) which consists of chairs and directors of Adults and children's board, social care, health and Police.	RBG SAB	To be completed in 01/03/2023	RBG SAB Minutes and action/ SEPG action plan/ assurance reports	RBG SAB
16	LAS	**The London Ambulance Service (LAS)** must evidence an assurance programme that takes into consideration: • when to make a safeguarding referral • how LAS works with other agencies in relation to safeguarding • monitoring of safeguarding practice • embedding of recent changes (e.g., structure, increased training and supervision).	All non-operational staff receive Level 2 safeguarding training and all operation staff receive Level 3 in line with the NHS intercollegiate document for both adults and children. This training covers the core competencies, knowledge, skills, attitudes and values. • The LAS has a robust safeguarding referral pathway where referrals are submitted to the Local Authority for them to take forward. The LAS also has an escalation process. • The LAS engages with statutory requests for information and attends statutory meetings where appropriate. • The safeguarding team have a Safeguarding Governance and training support lead who carries out audits to monitor safeguarding practice. This role as well as supporting the training agenda they have a key role in creating and developing further governance and assurance systems for the team. They have introduced our learning database where we log and track all learning identified and ensure we have implemented to change/learning from the recommendations. • Any recent changes are received by staff via emails, internal social media, newsletters, bulletins and supervision.	Head of Safeguarding and Prevent & Deputy Head of Safeguarding and Corporate MCA Lead	All currently in place, implemented and underway	Level 3 and 2 Child and Adult at Risk Safeguarding e-learning and powerpoint packages. T019 Adult at Risk Policy and Procedure. LAS safeguarding referral and escalation flow chart. Learning log - excel spreadsheet. Various audits that can be provided on request. Various internal Safeguarding Team newsletters with updates and case studies.	Level 3/2 reviewed yearly and updated when required. New package every three years with learning from experience cases updated. Policies reviewed yearly, any relevant updates are added as and when required. Flow charts reviewed yearly and any relevant updates added as and when required. Learning log updated as weekly based on cases and outcomes. Number audits and general themes are agreed in the yearly work plan which is updated at the start of the financial year. Newsletter every quarter.
17	GP practice	**The Vanbrugh Group Practice,** within six months of this report, should provide assurance that any existing patients with long-term prescription of benzodiazepines have been reviewed and documented in line with NICE guidance. This should include introducing a method for future identification and review of new patients.	Vanbrugh Group Practice have a dedicated Medicine Management team who perform regular audits of certain medication groups such as Benzodiazepines, with the aim of highlighting their use & speaking to such patients to try to reduce their use. Many such patients are under mental health services and have not raised any objections to their use and indeed, the use of such medications in such patients is likely to be beneficial with respect to their mental health symptomatology. The audit is repeated every six months to pick up new users of Benzodiazepines to allow the practice to repeat the process with these patients.	Lead GP for Adult Safeguarding Vanbrugh Group Practice	Completed and ongoing	Example of audit	Audit repeated 6 monthly

18	GP practice	**The Vanbrugh Group Practice** should provide assurance that it has taken steps to support staff in understanding and applying its policies in relation to assessing mental capacity and adult safeguarding, and introduce a regular monitoring approach to make sure staff are consistently applying the principles of the policies.	Vanbrugh Group Practice have an adult safeguarding lead who is heavily involved in safeguarding issues; she keeps us abreast of recent changes and often discusses challenging cases with learning points. We additionally have child & adult safeguarding as separate standing agenda items at our weekly clinical meeting - we are all encouraged to share concerns or safeguarding issues not only to discuss specific issues but also to alert other HCPs who may come across these patients to these issues. On 21.06.2022 the local learning disability & adult safeguarding team attended to host a talk about capacity & safeguarding issues - we spoke at length about these complex issues & how we can contact them if needed. The talk was well attended by many HCPs so all would have received useful instruction & learning from this event. In addition, the Greenwich ICS safeguarding team are in the process of adapting a mental capacity act policy specifically for GP practices based on a policy originally developed in Lewisham. This will be launched at the next GP adult safeguarding forum in November	Lead GP for Adult Safeguarding Vanbrugh Group Practice	Complete Greenwich ICS expected completion date is November 2022.	GP Mental Capacity Act policy	
19	South East London Integrated Care Board (SEL ICB)	**The Clinical Commissioning Group** should clearly set out in a policy or procedure the expectations for GP practices in taking a proactive approach in triggering, requesting and/or engaging in multi-agency reviews in instances where there is clear evidence that service users are behaving erratically, over attending practices, excessively using services, or engaging several agencies.	Liaise with the Named GP for Adult Safeguarding regarding the development of a "trigger" policy or procedure which includes this requirement. This policy/procedure would aim to give GPs guidance on when to take further action, which might include requesting a multi-agency review. We would also ensure that the learning from this review is incorporated in future primary care training opportunities and presented as a case study at the primary care safeguarding adults forum (to which all primary care safeguarding leads are invited) - the next forum is in November.	Designated Nurse and Named GP for Adult Safeguarding	Completed in 01/10/2022	Policy/procedure developed Notes/minutes of primary care safeguarding adults forum Examples of revised training materials/case study	Safeguarding Adult Board scrutiny SEL ICS Safeguarding Committee Greenwich borough safeguarding assurance
20	RBG	**The Royal Borough of Greenwich (RBG)** Finance Protection and Appointee (FPA) Team should clarify and agree a process for identifying, managing and resolving safeguarding concerns brought to its attention by partner agencies. The policy should be updated to reflect this.	The FPAT team management and staffing has changed considerably. As part of team development work, we will arrange a series of group learning and development sessions specifically addressing the learning from the SAR, and clarifying officers' responsibilities under the RBG Safeguarding Policy and procedures.	Service Manager, Commissioning & Business Support	To be completed in 01/12/2022	We will use feedback forms from team learning and development sessions on safeguarding to evidence both attendance and engagement with this from the team.	
21	RBG	**The Royal Borough of Greenwich (RBG)** sheltered housing services must develop a system and set out expectations for staff to formally communicate and document the outcome of housing assessments and agree next steps with partner agencies. This should include regular monitoring to support implementation and improvements.	Discussion held with Assessment Officers and agreed that they will follow-up regularly (monthly) on pending assessments. Sheltered housing assessment outcomes to be noted on Mosaic and all parties informed of the decision. Cases to be discussed at panel meetings.	Sheltered Housing and Extra Care Manager	Completed in 01/07/2022	Upload onto Mosaic and TRIM	Fortnightly Extra Care Sheltered Housing panel meetings and Sheltered Housing Case Review Panel meetings. Individual supervision with sheltered housing Assessment Officer.
22	RBG	**The Royal Borough of Greenwich (RBG),** within six months, should lead a full review of how safeguarding and welfare referrals are received and managed to assure itself of the effectiveness of adult safeguarding activity carried out on its behalf. This should include consideration of referrals from external agencies, and the handover process between RBG and the Trust.	A quality assurance meeting is held between The Head of safeguarding adults' team and the Head of Mental Health social care every two months to look at cases that have been referred to Mental Health by the RBG front door team. Cases are identified via the Client database system ahead of this meeting with focus on people who have had multiple police referrals. Any quality assurance issues that arise are then fed back into the Safeguarding Mental Health hub. An further audit in November 2022 will be undertaken to look at safeguarding adults and welfare concerns receievd by RBG front door by external agencies. These cases will be scrutinised by an independnat consultant to identify future good practice and improve pathways with RBG and The Trust.	Head of Safeguarding	To be completed in 01/12/2022	Case audits ; All police referrals now raised as 'Adult Contact' by CAT on Mosaic, Performance reports; clear process map for merlin's; assurance /feedback from Oxleas about Merlin's being actioned; analysis of multiple Merlin's. Independnat audit.	Bi-Monthly Oxleas RBG Safeguarding Oversight meetings
23	All partner agencies	**All agencies** must use the findings from this investigation within safeguarding training for staff. All agencies must ensure staff are familiar with the requirements of, and their responsibilities under, the London Multi-Agency Adult Safeguarding Policy and Procedures.	All non-operational staff receive Level 2 safeguarding training and all operation staff receive Level 3 in line with the NHS intercollegiate document for both adults and children. This training covers the core competencies, knowledge, skills, attitudes and values.	Head of Safeguarding and Prevent & Deputy Head of Safegaurding and Corporate MCA Lead	Package currently in place	Level 3 and 2 Child and Adult at Risk packages, in line with the NHS Intercollegiate. Mix of 4 hour e-learning and 4 hour virtual (face to face) training.	Level 3/2 reviewed yearly and updated when required. New package every three years with learning from experience updated.