MEETING DATE:	11 April 2013	NHS North Lincolnshire Clinical Commissioning Group **REPORT TO THE** **CLINICAL COMMISSIONING GROUP** **GOVERNING BODY**
AGENDA ITEM NUMBER:	Item 7.8	
AUTHOR: **JOB TITLE:** **DEPARTMENT:**	Karen Rhodes Senior Officer Quality & Assurance CCG	

SAFEGUARDING ADULTS AIDE MEMOIRE FOR CCGS

PURPOSE/ACTION REQUIRED:	**To receive and note**
CONSULTATION AND/OR INVOLVEMENT PROCESS:	NL CCG Quality Group
FREEDOM OF INFORMATION:	*Is this document releasable under FOI at this time? Yes* Public

1. PURPOSE OF THE REPORT:

The purpose of the Safeguarding Adults Aide Memoire for Clinical Commissioning Groups is to provide guidance in relation to commissioners' duties to safeguard adults in all aspects of their commissioning.

2. STRATEGIC OBJECTIVES SUPPORTED BY THIS REPORT:

Continue to improve the quality of services	**X**
Reduce unwarranted variations in services	**X**
Deliver the best outcomes for every patient	**X**
Improve patient experience	**X**
Reduce the inequalities gap in North Lincolnshire	

3. IMPACT ON RISK ASSURANCE FRAMEWORK:

Yes		**No**	**X**

4. IMPACT ON THE ENVIRONMENT – SUSTAINABILITY:

Yes		**No**	**X**

5. LEGAL IMPLICATIONS:	**Yes**		**No**	**X**
6. RESOURCE IMPLICATIONS:	**Yes**		**No**	**X**
7. EQUALITY IMPACT ASSESSMENT:	**Yes**		**No**	**X**
8. PROPOSED PUBLIC & PATIENT INVOLVEMENT AND COMMUNICATIONS:	**Yes**		**No**	**X**
9. RECOMMENDATIONS:				
The CCG is asked to: - • To receive and note				

Item 18a

Safeguarding Adults:
An Aide Memoire for Clinical Commissioning Groups

All adults have the right to live lives free from abuse and neglect. Clinical Commissioning Groups have particular responsibilities to safeguard patients who may be unable to protect themselves from abuse and neglect

'Patients must be the first priority in all of what the NHS does by ensuring that, within available resources, they receive effective care from caring, compassionate and committed staff, working within a common culture and protected from avoidable harm and any deprivation or their basic rights'.

Francis Report 2013

March 2013

Contents

1. Purpose and scope

Purpose

The purpose of the Safeguarding Adults Aide Memoire for Clinical Commissioning Groups is to provide guidance in relation to commissioners' duties to safeguard adults in all aspects of their commissioning.

The document sits alongside a sister document 'Safeguarding and Protecting the Welfare of Children and Child Protection: Aide Memoire for Clinical Commissioning Groups' [1]

Scope

The aide memoire sets out how Clinical Commissioning Groups (CCGs) discharge their duties in accordance with the legislation, guidance and policy relating to Safeguarding Adults.

Safeguarding Adults incorporates measures to reduce the likelihood of abuse and neglect occurring as well as 'adult protection' i.e. making effective responses to protect 'adults at risk' where abuse and neglect has occurred or is suspected to have occurred.

Safeguarding our patients should always include consideration of children and young people. 'Think Family' entails a cross generational approach to safeguarding, recognising that adults may be parents or carers, cared for by children or young people or represent a danger to children.

The aide memoire seeks to help CCGs understand the context of safeguarding adults, their roles and responsibilities and the measures they can take to deliver effective safeguarding on behalf of their patients.

Each section contains a 'Quick Summary' and tables to highlight information.

A glossary, reference and resource list is provided for further guidance on specific areas outlined within the aide memoire.

Acknowledgements

The work of North East London Cluster is acknowledged in creating the safeguarding children aide memoire for CCGs.

Information has also been drawn from the Pan – London Multi Agency procedures and SCIE multi agency procedures for the West Midlands

[1] NHS London: Safeguarding and Protecting the Welfare of Children and Child Protection: Aide Memoire for Clinical Commissioning Groups: Nov 2012

2. Definitions and Principles

QUICK SUMMARY:

'Safeguarding adults' relates to how individuals, services and agencies work together to support people who are unable to protect themselves from neglect and abuse. This includes:

- measures to reduce the risk of neglect and abuse occurring
- 'adult protection' responses under multi-agency procedures where neglect or abuse has occurred or is suspected to have occurred.

Neglect and abuse may occur in any setting. It may occur within a person's home and community. Neglect and abuse may also occur through care provided by regulated services.

Principles that support good safeguarding practice are:

***Empowerment**: presumption of person led decisions and consent*

***Protection:** support and protection for those in greatest need*

***Prevention:** reducing risks of neglect and abuse*

***Proportionality**: least intrusive response appropriate to the risk presented*

***Partnerships:** solutions through services working together*

***Accountability:** accountability and transparency in delivering safeguarding*

2.1. Definitions

All adults have the right to live a life free from abuse and neglect. Our communities and the people within them, should expect services to work together to safeguard them where they are unable uphold this right for themselves.

Neglect and abuse may occur within individual's homes and communities. Neglect and abuse may also occur through care provided by regulated health and social care services.

'Adult at Risk'

No Secrets[2] sets out the multi-agency arrangements to safeguard and protect 'vulnerable adults'. Later policy[3] has directly replaced the term 'vulnerable adult' with 'adult at risk'. This recognises that vulnerability does not lie with the individual but lies in a complex interconnection between the

[2] Dept. Health (2000) No Secrets; guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse, London, DH

[3] Protecting Adults at Risk: London Multi –Agency Policy and Procedures to Safeguard Adults from Abuse; SCIE: Adult Services report 60; Safeguarding Adults; multi agency policy and procedures for the West Midlands

individual's personal qualities, their situation or environment and the social factors that may protect them or increase their risk.

An 'adult at risk' is

'a person aged 18 or over who is in receipt or who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.'

No Secrets: DH 2000

An adult at risk may be a person who:

- is frail due to age, ill health, physical disability or cognitive impairment, or a combination of these
- has a learning disability
- has a physical disability and/or a sensory impairment
- has mental health needs including dementia or a personality disorder
- has a long-term illness/condition
- misuses substances or alcohol
- is a carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse
- is unable to demonstrate the capacity to make a decision and is in need of care and support..

The list is not exhaustive and nor does it indicate that a person who may fall within this description, is inevitably 'at risk'.

Factors that impact on vulnerability

Personal characteristics of the adult at risk that increase vulnerability may include	**Personal characteristics of the adult at risk that decrease vulnerability may include**
Not having mental capacity to make decisions about their own safety including fluctuating mental capacity associated with mental illness and other conditions • Communication difficulties • Physical dependency – being dependent on others for personal care and activities of daily life • Low self-esteem • Experience of abuse • Childhood experience of abuse	Having mental capacity to make decisions about their own safety • Good physical and mental health • Having no communication difficulties or if so, having the right equipment/support • No physical dependency or, if needing help, able to self-direct care • Positive former life experiences • Self-confidence and high self-esteem
Social/situational factors that increase the risk of abuse may include	**Social/situational factors that decrease the risk of abuse may include**
Being cared for in a care setting, i.e. more or less dependent on others • Not receiving the right amount or the right kind of care • Isolation and social exclusion • Stigma and discrimination • Lack of access to information and support • Being the focus of anti-social behaviour	Good family relationships • Active social life and a circle of friends • Able to participate in the wider community • Good knowledge and access to a range of community facilities • Remaining independent and active • Access to sources of relevant information

Reference: Protecting Adults at Risk: London Multi –Agency Policy and Procedures to Safeguard Adults from Abuse; Published 2011

2.2. Principles

Adults have the right to be protected from abuse and neglect but must maintain choice and control over the decisions that affect their lives and to be involved to the extent that they are able. The Government made a statement of policy[4] on safeguarding adults and set out the principles that should be applied in operational and strategic responses in safeguarding adults.

Safeguarding Adults Principles		Application within Health Commissioning
Principle 1	Empowerment – presumption of person led decisions and consent	Patients need to be in control of their care and involved in all aspects to the extent they are able. This includes involving people in how services related to safeguarding adults are designed and delivered as well as involvement in their own care planning.
Principle 2	Protection- Support and representation for those in greatest need	Positive obligation to take additional measures for patients who may be 'adults at risk' who may not have their voice heard or be unable to protect themselves.
Principle 3	Prevention	Planning and procuring services that deliver personalised care that reduces the likelihood of neglect and abuse occurring.
Principle 4	Proportionality. Proportionality and least intrusive response appropriate to the risk presented	Efficient and proportionate responses to risks whether this relates to individual patient care or whole service provision.
Principle 5	Partnerships. Local solutions through services working with their communities	Integrated and cohesive partnerships at all levels of the organisation focused at improving outcomes for patients in the most vulnerable situations, for example: Health and Wellbeing Boards; Local Safeguarding Adults & Children's Boards; Community Safety Partnerships; Quality Surveillance Groups
Principle 6	Accountability. Accountability and transparency in delivering safeguarding	Require openness and transparency to patients in how concerns are managed in line with 'Being Open' Managing allegations of abuse and neglect in services (including those identified as serious incidents) through inter-agency procedures Providing assurance on the effectiveness of safeguarding arrangements to patients; public and Local Safeguarding Adults Board

[4] Dept. Health 2011; Statement of Policy on Safeguarding: DH Gateway 126748

Local and regional multi-agency procedures[5] include the following principles and values:

Adults at risk

- The services provided must be appropriate to the adult at risk and not discriminate because of disability, age, gender, sexual orientation, race, religion, culture or lifestyle.
- The primary focus/point of decision-making must be as close as possible to the adult at risk, and individuals must be supported to make their own choices. Adults at risk must be offered support services as appropriate to their needs.
- There is a presumption that adults have the mental capacity to make informed decisions about their lives. If someone has been assessed as not having mental capacity to make safeguarding decisions, those decisions will be made in their best interests as set out in the MCA 2005 and the MCA *Code of practice.*2.
- Adults at risk should be given information, advice and support in a form that they can understand and have their views included in all forums that are making decisions about their lives.
- All decisions taken by professionals about a person's life should be timely, reasonable, justified, proportionate, ethical and fully recorded.

Organisations working with adults at risk

- Staff have a duty to report promptly any concerns or suspicions that an adult at risk is being, or is at risk of being, abused.
- Actions to protect the adult from abuse should always be given high priority by all organisations involved. Concerns or allegations should be reported without delay.
- Organisations working to safeguard adults at risk should make the dignity, safety and wellbeing of the individual a priority in their actions.
- As far as possible organisations must respect the rights of the person causing, or alleged to be causing, harm. If the person alleged to have caused harm is also an adult at risk they must receive support and their needs must be addressed. Staff should fully understand their role and responsibilities in regard to the policy and procedures.
- Every effort must be made to ensure that adults at risk are afforded appropriate protection under the law.
- Organisations will have their own internal operational procedures which relate and adhere to the policy and procedures, including complaints by service users and by staff who raise concerns ('whistle blowers'), always in compliance with the Public Interest Disclosure Act (PIDA) 1998.
- Organisations will ensure that all staff and volunteers are familiar with policies relating to Safeguarding Adults, that they know how to recognise abuse and how to report and respond to it.
- Organisations will ensure that staff and volunteers have access to training that is appropriate to their level of responsibility and will receive clinical and/or management supervision that allows them to reflect on their practice and the impact of their actions on others.

[5] SCIE: Adult Services report 60; Safeguarding Adults; multi agency policy and procedures for the West Midlands

Organisations working together

- Partner organisations will contribute to effective inter-agency working, multi-disciplinary assessments and joint working partnerships in order to provide the most effective means of Safeguarding Adults. Action taken under these procedures does not affect the obligations on partner organisations to comply with their statutory responsibilities, such as notification to regulatory authorities under the Health and Social Care Act (HSCA) 2008, employment legislation or other regulatory requirements.
- Organisations continue to have a duty of care to adults who purchase their own care through personal budgets (PBs) (including direct payments), and/or who fund their own care. Organisations are required to ensure that reasonable care is taken to avoid acts or omissions that are likely to cause harm to the adult at risk.
- Partner organisations will have information about individuals who may be at risk from abuse and may be asked to share this where appropriate, with due regard to confidentiality and information sharing protocols.

3. NHS responsibilities for Safeguarding Adults

QUICK SUMMARY:

Neglect and abuse has a profound impact on the person's emotional, physical and mental health and well- being. Neglect and abuse also has a high financial cost due to the care and treatment arising from the abuse.

Lessons from high profile failures in care such as Winterbourne View and Mid Staffordshire NHS Trust highlight the importance of safeguarding adults in all commissioned services.

The legislation surrounding safeguarding adults is complex and is set to be clarified through the Care and Support Bill.

The legislative framework includes:

NHS Community Care Act 1990

Human Rights Act 1998

Mental Capacity Act 2005

Deprivation of Liberty Safeguards 2007

Equality Act 2010

Health and Social Care Act 2008

Health and Social Care Act 2012

The NHS Constitution through the Health and Social Care Act 2012, provides a statutory duty to continually seek to improve the quality of care to patients and to treat individuals with dignity and respect in accordance with their Human Rights.

3.1. Safeguarding Adults and Quality Innovation Productivity and Prevention (QIPP)

The NHS should be proud of the care it provides to patients every day, and of the expertise and commitment of the vast majority of staff that work within NHS and the independent services it commissions care from. However, we also know from patient's stories and high profile inquiries, of the shocking circumstances of abuse and neglect by services and the failures of commissioners to act.

Abuse and neglect has a profound impact on individuals, their independence and their physical, mental and psychological well-being. Abuse and neglect also has a high financial impact on the NHS

due to the cost incurred from care and treatment and the increased levels of dependency that a person may have as a direct consequence of the abuse and neglect.[6]

Winterbourne View

'Despite the high cost of places at Winterbourne View (on average £3,500 per week) ***commissioners*** *do not seem to have focused much on quality, or on monitoring how the hospital was providing services in line with its registered purpose – i.e. assessing the needs of individuals and promoting their rehabilitation back home. The lack of any substantial evidence that people had meaningful activity to do in the day, the way in which access by outsiders to wards was restricted, reports of safeguarding alerts (where these were shared with commissioners) should have been followed up rigorously, but were not.* ***This amounts to a serious failure of commissioning****.'*

Transforming Care: A national response to Winterbourne View Hospital; Department of health Review: Final Report

Sadly, the findings from the Francis report into failings in Mid-Staffordshire NHS Foundation Trust identified that quality and prevention had been sacrificed for productivity and cost savings – ultimately neither was achieved.

Mid Staffordshire NHS Foundation Trust

'The first inquiry heard harrowing personal stories from patients and patient's families about the appalling care received at the Trust. On many occasions, the accounts received related to basic elements of care and the quality of the patient experience. These included cases where:

- *Patients were left in excrement in soiled bed clothes for lengthy periods.*
- *Assistance was not provided with feeding for patients who could not eat without help*
- *Water was left out of reach*
- *In spite of persistent requests for help, patients were not assisted in their toileting*
- *Wards and toilets were left in a filthy condition*
- *Privacy and dignity, even in death, were denied*
- *Triage in A&E was undertaken by untrained staff*
- *Staff treated patients and those close to them with what appeared to be callous indifference'*

Robert Francis QC; Report of Mid Staffordshire NHS Foundation Trust, Public Inquiry; Feb 2013

[6] Example: The cost of pressure care is estimated to comprise 4% of NHS expenditure; NHS Institute for Innovation and Improvement 2012

3.2. Legislation relevant to safeguarding adults

The legislation surrounding Safeguarding Adults is complex. Unlike Safeguarding Children, the law is not contained in specific legislation but derives from a range of related statute.

Care and Support Bill

The Care and Support Bill is set to provide clearer legislation specifically relating to safeguarding adults and the duties of cooperation by other agencies. The Bill was in response to a Law Commission review of Adult Social Care that reported in May 2011.[7] The key provisions of the draft Bill are:

- A duty of inquiry on the Local Authority where an adult in need of care and support is at risk. The Local Authority must make a decision on what action may be required and by whom
- Establishing a Local Safeguarding Adults Board (LSAB) to help and protect adults in its area, co-ordinating and ensuring the effectiveness of its members.
- Arranging a review where an adult was experiencing abuse or neglect (or was suspected to be) and the adult dies or there is concern about how the LSAB or member responded.
- Abolition of section 47 of the National Assistance Act 1948 - a Local Authority power to remove persons in need of care.

The Social Care Institute for Excellence has published a comprehensive legal guide for practitioners.[8] Key relevant legislation relating to safeguarding adults includes:

NHS and Community Care Act 1990

Under section 47 of the NHS and Community care Act, Local Authorities have a duty to assess people who may be in need of community care services. It is through this provision that assessments to safeguard adults are carried out. The Local Authority must consult the person being assessed and take all reasonable steps in order to reach agreement about the provision of services.

Human Rights Act 1998

Since coming into force in 2000, the Human Rights Act 1998 has made the European Convention of Human Rights enforceable in UK courts.

As public authorities, NHS and Health Trusts have a 'positive obligation' to take proactive steps to protect human rights. Particular articles of the convention that are relevant to safeguarding adults are:

[7] The Law Commission: Adult Social Care; Presented to Parliament May 2011.
[8] SCIE report 50: Safeguarding adults at risk of harm; A legal guide for practitioners; Dec 2011

Mental Capacity Act 2005

The Mental Capacity Act is relevant to ***all*** patients aged 16 and over and their care and treatment.

The Act and Code of Practice[9], provides a legal framework for acting or making decisions on behalf of individuals who lack mental capacity to make particular decisions for themselves. Lack of mental capacity may be a temporary, fluctuating or permanent condition and relates to the ability to make a specific decision at a specific time.

The Act is of central importance in delivering health care. It is the statute that sets out patients' rights to make decisions about their care and treatment, balancing this with the right to be protected from harm, and requiring others to act in the patient's 'best interests' where they lack capacity for a particular decision.

The Act also provides protections to staff in relation to consent to treatment; use of restriction and restraint; duty of care where a person with capacity refuses care and treatment.

The Act introduces rights for individuals to make decisions about future treatment at a point where they may lose mental capacity.

- The person's wishes and preferences must be taken into account as part of 'best interest decision' where they lack capacity for that decision.
- A person with capacity may make an Advance Decisions to refuse treatment.
- Attorneys or deputies may make decisions on the incapacitated person's behalf relating to their personal welfare; property and affairs.

As such, it provides an important means of empowering patients to manage their future care for example, patients newly diagnosed with dementia; planning contingencies with people with mental health needs; end of life care planning.

[9] Department for Constitutional Affairs (2007) Mental Capacity Act 2005; Code of Practice, London: DH

Mental Capacity Act: Five Statutory Principles	
Principle 1: Presumption of Capacity	A person must be assumed to have capacity unless it is established that they lack capacity
Principle 2: Individuals supported to make their own decisions	A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
Principle 3: Unwise decisions	A person is not to be treated as unable to make a decision merely because he makes an unwise decision
Principle 4: Acting in best interests	An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
Principle 5: Least restrictive option	Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action

The Mental Capacity Act is central to safeguarding adults

- The ability of adults to make informed decisions about the way they live their lives and the risks they want to take
- The ability and rights to give consent to any actions taken on their behalf that are designed to protect them from harm.
- Duties on services to intervene where a person lacks capacity to make a decision about their care, and to act according to their 'best interest.'

Deprivation of Liberty Safeguards 2007

The Deprivation of Liberty Safeguards are an amendment to the Mental Capacity Act 2005. The Mental Capacity Act (section 6(4)) permits restraint and restrictions to be used where it is necessary and proportionate and to prevent harm to the person who lacks capacity. However, extra safeguards are needed if the restrictions and restraint are so extensive as to deprive the person of their liberty. These are called the Deprivation of Liberty Safeguards. These safeguards do not apply to patients detained under the Mental Health Act 1983.

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

Care homes or hospitals must ask the Local Authority[10] if they can deprive a person of their liberty. This is called requesting a standard authorisation. The Local Authority[11] must then carry out six, legally prescribed assessments to determine whether an authorisation can be given.

Where an assessment identifies the person *is* being deprived of their liberty but it is *not* in their best interests, revised care must immediately be put in place. Consideration should also be given about whether a referral under local Safeguarding Adults procedures is required.

CCGs must ensure that commissioned services comply with the provisions of the Mental Capacity Act and Deprivation of Liberty Safeguards and that use of restriction and restraint is the least restrictive to meet the needs of the patient and that there is no unlawful deprivation of liberty.

Equality Act 2010

The Equality Act 2010 combines almost all the UK's previous anti-discrimination laws in one single law. The Equality Act 2010 applies to all organisations that provide a service to the public or a section of the public[12]. The Act provides protection from direct or indirect discrimination; harassment and victimisation for people with a 'protected characteristic' that relate to:

- Disability.
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion belief or non-belief
- Sex, Sexual orientation
- Age

Safeguarding adults disproportionality impacts upon people with protected characteristics, in particular, characteristics related to disability and age. It may also impact on those who may be subject to discrimination by association, for example carers of people with disabilities.

Safeguarding adults also impacts upon other people with a protected characteristic due to factors giving rise to dual discrimination, for example, the over representation of Black Minority Ethnic groups within mental health secure settings.

The Equality Act 2010 sets out 3 general aims of the equality duty**.**

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
2. Advance equality of opportunity between people who share a protected characteristic and those who do not.
3. Foster good relations between people who share a protected characteristic and those who do not

[10] Note: Duties of PCTs to act as Supervisory Body passed to the Local Authority on 1st April 2013. www.**scie**.org.uk/publications/reports/report62

[11] The Local Authority is determined by 'ordinary residence' Directors of Adult Social Services (ADASS) *National Protocol on Ordinary Residence Arrangements for People Moving Between Local Authority Areas* October 2010.

[12] http://www.equalityhumanrights.com/advice-and-guidance/new-equality-act-guidance/equality-act-guidance-downloads/

Duties to advance equality	Relevance in safeguarding adults: - Examples
Removing or minimising disadvantages suffered by people due to their protected characteristics.	• Taking additional steps to enable and empower people to manage their care • Protecting rights and protecting individuals from harm where they are unable to protect themselves
Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.	• Making 'reasonable adjustments' in care and treatment
Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low	• Involvement in service design delivery and review • Multi-agency safeguarding and community safety initiatives promoting inclusion and social cohesion

Health and Social Care Act 2008 (regulated activities) regulations 2009

These regulations describe the Essential Standards of Quality and Safety that people who use Health and Social Care services have the right to expect.[13]

Outcome 7: 'Safeguarding people who use services from abuse' is specifically about safeguarding but all standards are relevant in delivering quality care to patients and reducing risks of abuse and neglect.

[13] Care Quality Commission (2009): Guidance about compliance; Essential Standards of Quality and Safety

3.2. Policy relevant to safeguarding adults

'Safeguarding adults' involves:

1. **Protecting adults at risk:** where abuse or neglect has occurred or is suspected and agencies work together to investigate and put a protection plan in place.

'No Secrets'

'No Secrets,'[14] is the policy guidance on multi- agency adult protection. 'No Secrets' is statutory guidance for Local Authorities, made under section 7 of the Local Authority Social Services Act 1970. Every area will have local multi- agency procedures[15] for adult protection in line with the No Secrets guidance and ratified by partner agencies of the Local Safeguarding Adults Board.

2. **Prevention:** the wider context of safeguarding adults through providing effective, high quality care; and personalised care planning that supports 'adults at risk' to reduce or manage risks within their lives.

Consequently policy & guidance related to personalised care; carers support; risk assessment and risk enablement; dignity and privacy; patient safety; improving quality; early warning systems; best practice guidance in disabilities; dementia; substance misuse; mental health – all are relevant to promoting effective preventative measures in safeguarding adults

The Department of Health published a series of guides[16] on safeguarding adults for Health managers, commissioners and practitioners along with a self-assessment and assurance framework.

Two high profile inquiries have had a major impact on learning and government policy and are fundamental to safeguarding adults.

Winterbourne View

Winterbourne View was an independent hospital operated by Castlebeck Care that was commissioned to provide care to people with learning disability and autism.

In May 2011, BBC Panorama reported the findings from an undercover investigation that revealed shocking levels of sustained and widespread abuse to the patients of Winterbourne View. Subsequent criminal investigations led to 11 individuals being prosecuted and sentenced, 6 were imprisoned.

The Department of Health review[17] of Winterbourne View was published in Dec 2012 and drew on learning from earlier reviews including:

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[14] Dept. Health 2000; No Secrets: Guidance on Developing and Implementing Multi Agency Policies and Procedures to Protect Vulnerable Adults from Abuse

[15] Examples: Protecting Adults at Risk: London Multi –Agency Policy and Procedures to Safeguard Adults from Abuse;
SCIE: Adult Services report 60; Safeguarding Adults; multi agency policy and procedures for the West Midlands

[16] Dept. health 2011; Safeguarding Adults: the role of Health services; DH gateway reference 15738
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882

- A review by the Care Quality Commission of all services operated by Castlebeck Care, and a programme of inspections of 150 learning disability hospitals and homes
- A review carried out by NHS South of England of serious untoward incident reports and commissioning of places at Winterbourne View
- An independent Serious Case Review commissioned by the South Gloucestershire Safeguarding Adults Board, published August 2012 containing 39 recommendations.
- A Department of Health interim report published June 2012

The review also drew on the finding of the criminal investigations and the experiences and views of people with learning disabilities or autism and mental health conditions or behaviours described as challenging, their families and carers, care staff, commissioners and care providers.

The findings of the review has had a profound impact in challenging how care is commissioned and provided for people with learning disabilities and/or autism. The learning is equally applicable to other groups of people who may be in vulnerable situations due to their high levels of dependency on others. This includes those in restrictive or closed environments who are unable to protect themselves from those who are meant to be caring for them – for example, patients with mental health needs; people with dementia and children and young people in secure environments.

Commissioners should familiarise themselves with the detail of the Winterbourne View reviews. The key themes are:

1. **How care is commissioned for and with people with learning disabilities and their families.**
   Care needs to be person centred and close to home. There are too many people in in-patient services for assessment and treatment and they are staying there for too long. This model of care has no place in the 21st century.
2. **The involvement of people with learning disabilities and their families.**
   People with learning disabilities and their families need to have choice and control over their care and mechanisms, including advocacy, to ensure full involvement in care planning and their voice is heard and responded to in relation to complaints.
3. **The quality of care provided**.
   In too many services there is evidence of poor quality of care, poor care planning, lack of meaningful activities to do in the day, and too much reliance on restraining people. Commissioners need to assure themselves about the quality of care being delivered, use of restriction and restraint is necessary and proportionate, and have robust contracts and monitoring of those contracts
4. **How services work together**
   All parts of the system– commissioners, providers, workforce, regulators and government – must play their part in driving up standards of care and demonstrating zero tolerance of abuse. This includes having mechanisms to share information about poor care and acting immediately where poor practice or sub-standard care is suspected. There is a need to clarify roles and responsibilities across the system and support better integration between health and care.

There themes are considered further in section 4.3 below

[17] Dept. Health 2012; Transforming care: A national response to Winterbourne View Hospital; Department of Health Review: Final report; DH

The Department of Health has set out a programme of action to transform services and strengthen CQC inspections and regulations of hospitals and care homes for people with learning disability and autism. This learning is equally applicable for commissioning services for other groups where similar vulnerabilities may exist for example, dementia care; mental health; secure provision for children and young people.

Francis Report

A Public Inquiry was called into the serious failings at Mid-Staffordshire NHS Foundation Trust between 2005 and 2008. Building on the report of the first inquiry, the report[18] tells of the appalling suffering of many patients primarily caused by a serious failure on the part of the provider Trust Board.

The Trust failed to listen to patients and staff concerns about the care provided. The Trust failed to tackle a culture that accepted poor standards and a disengagement from management and leadership responsibilities. The inquiry highlighted that this was in part due to a focus on targets, finance and achieving foundation status, to the cost and disregard of the care of the quality of care provided to patients. The Trust was seen to have a closed culture that ascribed more weight to positive information and sought to find alternative interpretations of information implying concerns.

The inquiry also highlighted the significant failures in the bodies responsible for oversight – the checks and balances that should have prevented serious systemic failures. This included the role of regulators; commissioners; Strategic Health Authority; public and patient bodies and the Department of Health.

The Francis report made a total of 290 recommendations relating to:

• Putting the patient first	• Fundamental standards of behaviour
• A common culture throughout the system	• Responsibility for, and effectiveness of, healthcare standards
• Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor & Health and Safety Executive functions	• Enhancement of the role of supportive agencies
• Effective complaints handling	• Commissioning for standards
• Performance management and strategic oversight	• Patient, public and local scrutiny
• Workforce: Medical training and education; nursing; leadership	• Openness, transparency and candour
• Professional regulation of fitness to practice	• Caring for the elderly
• Information	• Coroners and inquests
• Department of Health leadership	

[18] The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) Robert Francis QC

4. Requirements of Clinical Commissioning Groups.

QUICK SUMMARY:

CCGs have duties to take additional measures to safeguard patients who are unable to protect themselves from abuse and neglect.

CCGs must ensure all their commissioned services

i) Support patients to reduce risks of neglect and abuse- according to the patient's informed choices
ii) Reduce risks of abuse and neglect occurring within their service through the provision of high quality, person centred care.
iii) Identify and respond to neglect and abuse in line with local multi-agency safeguarding procedures

CCGs need to establish effective structures for safeguarding within their service. This includes a clear strategy; robust governance and a competent workforce that can lead and develop safeguarding across the local health economy.

CCGs need to make safeguarding adults integral across their commissioning cycle

- Planning services with patients to address the needs of patients at greatest risk of neglect and abuse.
- Securing contracts with services that set clear standards for safeguarding adults
- Monitoring services through comprehensive assurance framework that support improvements and address concerns.

CCGs have responsibilities to ensure high quality care is provided to all patients. However, CCGs have particular responsibilities to safeguard patients who may be unable to protect themselves from abuse and neglect

Neglect and abuse may occur within individual's homes and communities. Neglect and abuse may also occur through care provided by regulated health and social care services.

CCGs must ensure that all their NHS funded services:

i) Provide personalised care that supports patients in their choices about reducing risks of being abused and neglected within their homes and communities, for example through risk management planning with patients and carers.
ii) Provide services that deliver high quality personalised care, supported by robust systems and processes, in order to reduce risks of neglect and abuse occurring within their service.
iii) Identify and respond to neglect and abuse according to their local multi-agency safeguarding adults procedures.

In order to achieve authorisation, CCGs were required to demonstrate specific criteria relating to safeguarding adults.[19]

The National Commissioning Board guidance[20] details the statutory responsibility that the CCG has to ensure the organisations from which they commission services provide a safe system that safeguards children and vulnerable adults.

'Subject to the Care and Support Bill, CCG and the NHS CB will have statutory duties as members of the Safeguarding Adults Board to work in partnership with Local Authorities to fulfil their safeguarding responsibilities. …The NHS CB will be responsible for developing overall NHS policy on safeguarding providing oversight and assurance of CCG safeguarding arrangements and supporting CCGs in meeting their responsibility. The CCG and NHS CB work closely together – and in turn will work closely with local authorities, LSCBs and SABs – to ensure that there are effective NHS safeguarding arrangements across each local health community.'

Arrangements to secure children's and adult safeguarding in the future NHS The new accountability and assurance framework – interim advice; Sept 2012

4.1. Governance

The Quality Governance Framework[21] developed by Monitor identifies four key components for quality – these are equally applicable to safeguarding adults and commissioning.

Strategy	Drive the safeguarding adults agenda
	Understand potential risks to quality and safeguarding
Capabilities and culture	Leadership, skills and knowledge to lead the safeguarding adults agenda across the local health economy
Process and structure	Clear roles and responsibilities for safeguarding
	Clearly defined processes for escalating and resolving concerns
	Engagement with patients, carers, staff and partners
Measurement	Safeguarding information is analysed and challenged
	Information is robust and is used effectively

Good governance in safeguarding adults requires effective vertical and horizontal connections across the CCG. This connects aligned programmes of work so that safeguarding adults becomes an integral part of commissioning, for example, safeguarding being part of mental health and learning disability programme boards.

[19] Clinical Commissioning Group Authorisation (2012): Draft Guide for assessors Undertaking desk top review
[20] Arrangements to secure children's and adult safeguarding in the future NHS *The new accountability and assurance framework – interim advice*
[21] Monitor Quality Governance Framework 2010

Similarly vertical connections need to ensure an effective governance structure within the CCG so that there are clear structures and lines of accountability; reporting mechanisms and reporting requirement to the CCG Board and to the NHS National Commissioning Board. Performance reporting and monitoring is reviewed further in section 4.3.

CCGs cannot provide effective safeguarding adults arrangements in isolation. Connections will extend beyond the boundaries of the CCG to related partnerships such as Local Safeguarding Adults Boards (LSAB); Community Safety and the Health and Wellbeing Board so that information from operational practice is used to inform joint strategies and operational practice is in turn directed by joint strategies.

Each Clinical Commissioning Group should have a clear framework with strategies, policies and procedures for safeguarding adults. All strategies, policies and procedures should be joined-up with those of other local organisations and the LSAB.

Partnerships and multi-agency working is reviewed further in section 5.

- **Reporting**

Effective governance requires a clear process and a schedule for reporting safeguarding information to the CCG Board. The CCG Board should receive regular reports relating to provider performance and identifying any risks and the mitigation of those risks. In addition, there will be exception reporting relating to specific issues such as serious case reviews and reporting relating to the Local Safeguarding Adults Board.

The CCG reporting structure should provide opportunity for more detailed scrutiny of the information through the sub-committees of the Board. This will include performance reports detailing key areas and themes and trends relating to safeguarding. Performance monitoring and sharing information between the accountable bodies is reviewed further in section 4.3.

The CCG will also provide reports to the Local Safeguarding Adults Board, as part of the quality assurance functions of the LSAB.

4.2. Workforce and leadership

CCGs need to provide the leadership; skills; expertise and capacity to safeguard adults and ensure compliance with the Mental Capacity Act

'The CCG lead for safeguarding adults will need to have a broad knowledge of healthcare for older people, people with dementia, people with learning disabilities and people with mental health conditions…The CCG lead should be embedded in the clinical decision making of the organisation, with the authority to work within local health economies to influence local thinking and practice.'

Arrangements to secure children's and adult safeguarding in the future NHS The new accountability and assurance framework – interim advice; Sept 2012

Typically, the safeguarding and MCA lead will provide expert guidance in a range of commissioning and partnership activities.

The CCG safeguarding adults and MCA lead – typical roles include:

- Advising on complex and high risk care issues relating to individual patient care
- Working closely with the Local Authority in managing concerns about abuse or neglect in commissioned services.
- Providing expertise into the management of related complaints and serious incidents.
- Undertaking inspections and audits to provide scrutiny and assurance of provider's safeguarding arrangements and compliance with Mental Capacity Act and Deprivation of Liberty Safeguards.
- Providing expertise into the development of CCG strategies and newly commissioned services in order to develop effective preventative safeguarding practices and promote Human Rights based practice.
- Setting performance measures and incentives such as CQUIN within contracts.
- Ensuring the workforce has the necessary competence in safeguarding adults & MCA according to their role e.g. learning and development strategy
- Providing leadership for safeguarding adults and the Mental Capacity Act across the local Health economy, for example, development networks and leading local strategies.
- Provide skilled expertise into Local Safeguarding Adults Board business, for example training; procedures; multi- agency quality assurance
- Leading serious incident and serious case reviews on behalf of the local Health economy
- Reporting to the CCG Board; NHS CB and LSAB

'The NHS Commissioning Board and the local commissioners of services must be adequately resourced to enable proper scrutiny that providers are delivering the standard of service required under their contracts. The resource available to the commissioners to monitor the provision of contractual services should extend as necessary to the capacity to undertake audits, inspections and investigations of individual cases..'

Robert Francis QC; Report of Mid Staffordshire NHS Foundation Trust, Public Inquiry; Feb 2013

It is expected that leads will be employed within CCGs. In some areas there will be more than one CCG per local authority and LSCB/LSAB area, and CCGs may want to consider developing 'lead/hosting' arrangements for their designated professional team. It is expected that CCGs will need to ensure that a memorandum of understanding is in place to ensure and assure the effectiveness and compliance of such arrangements.

Whilst Commissioning Support Units or other commissioning support services will have a number of important roles to play in helping CCGs to commission effective services and assure themselves of the safety of those services, they are not considered as an appropriate vehicle for the 'hosting' of lead/designated safeguarding adults or children professionals.

- ### Safeguarding leads clinical support

CCGs and the NHS CB will want to provide appropriate support and advice to the safeguarding adults and Mental Capacity Act lead and access the widest possible expertise to support improving safeguarding practice.

In order to support this, the NHS NCB Area Teams will establish local Safeguarding Forums. The role of these forums should include

- Provision of supervision and support to safeguarding professionals.
- Provision of specialist advice and expertise to CCGs and Local Area Teams
- Driving improvement in safeguarding practice
- Underpinning system accountability through peer review based assurance that will be developed in line with the overall NHS CB approach to quality improvement.
- Ensuring succession planning and the commissioning of appropriate education and development for designated and lead professionals through engagement with Health Education England.

- ### Leadership and Accountability

Clinical Commissioning Groups should identify a senior lead for safeguarding adults to ensure that 'adults at risk' and their needs are at the forefront of local planning and service delivery.

Clinical Commissioning Groups should also identify a board executive lead for safeguarding adults who takes responsibility for governance, systems and organisational focus on safeguarding adults. This includes membership of the Local Safeguarding Adults Board and the Health and Well Being Board. This might be the same person.

The chief executive of any commissioned service/provider organisation takes ultimate responsibility for safeguarding within the organisation.

- ### Named leads within provider organisations

All commissioned services should have within their workforce, staff with the expertise and capacity to fulfil a leadership role for safeguarding adults within their organisation.

Though, unlike safeguarding children, there is not a statutory duty for Trusts to have a Named Nurse or Named Doctor for safeguarding adults, this model is strongly recommended in order to ensure sufficient dedicated specialist resource that this agenda requires.

As commissioners, CCGs should be challenging *all* providers to demonstrate that they have the necessary competence and capacity in place to provide leadership, guidance and supervision across the workforce. This should include demonstrating a network of expertise across the service rather than reliance on the safeguarding adults lead.

'…clinicians did not pursue management with any vigour with concerns they may have had. Many kept their head down…a system that is safe for patients requires a much more rigorous approach. The Trust lacked a sufficient sense of collective responsibility or engagement for ensuring that quality care was being delivered at every level.'

Robert Francis QC; Report of Mid Staffordshire NHS Foundation Trust, Public Inquiry; Feb 2013

- **Workforce competence and training**

All CCG staff should have basic levels of competence in relation to safeguarding adults and the Mental Capacity Act, recognising that safeguarding adults and safeguarding children may impact on all of us whether in personal or work life.

The CCG should develop a learning and development strategy setting out competence requirements according to staff role - Continuing Health Care teams; quality/complaints teams and programme leads for dementia care, are likely to require different levels of competence to finance staff.

Competence may be achieved through training sessions but could equally be achieved through other mechanisms such as case discussion, observations/shadowing etc.

Clinical Commissioning Groups have a responsibility to monitor the safeguarding training that commissioned services provide their staff and that they comply with CQC Essential Standards for Quality and Safety. This should form part of the performance indicators included within the assurance framework. The emphasis should be placed on demonstrating required levels of competence in safeguarding and not just numbers of staff trained.

CCG should also identify how providers are developing their workforce as part of a wider strategy for improving quality and preventing abuse and neglect within services.

Policies such as Compassion in Practice[22] promoting the '6 Cs' of Care; Compassion; Competence; Communication; Courage; Commitment, can make such an important contribution to developing the workforce and the wider agenda of quality and safeguarding.

[22] Dept. Health (2012) Compassion in Practice; Nursing Midwifery and Care Staff; Our Vision and Strategy; NHS National Commissioning Board, London DH

4.3. Safeguarding Adults across all aspects of commissioning

Safeguarding should be embedded across the CCG commissioning cycle to ensure that the needs of people who may be at greatest risk of harm are met.

The Quality of Health Principles[23] was developed to ensure that people who are 'vulnerable' have a good quality patient experience while using services. The principles were developed by people with learning disabilities in consultation with agencies representing older people; people with physical disabilities; people with sensory impairment and people with mental health issues

The Department of Health published a Self- Assessment and Assurance Framework (SAAF) that includes self-assessment indicators for commissioners to evaluate their safeguarding adults arrangements.[24]

Planning Services

Commissioners are responsible for ensuring that services meet the needs of all those in their communities including those who may be most marginalised and seldom heard and most at risk of neglect and abuse.

Quick reference: Planning services – What might this look like? Some examples	
Understanding populations most at risk of neglect and abuse within your community	Make connections between Health & Wellbeing Board; Local Safeguarding Boards and related partnerships e.g. Community safety Understand local demographics relating to groups at highest risk of neglect and abuse Use information from the Local Safeguarding Adults Board to inform strategic priorities through the Joint Strategic Needs Assessment and Strategy
Involvement	Plan services with patients/carers and representatives – meaningful involvement Seek expertise from partners; clinicians and 'experts by experience' in planning services for groups most at risk of neglect and abuse
Plan care that promotes wellbeing – understand risks	Use quality and equality impact assessments from the outset to identify how new services and revised care pathways will positively impact on reducing inequality and improving the health and wellbeing of groups most at risk of neglect and abuse – mitigate any negative impact. Apply best practice guidance in commissioning services in order to reduce risks of neglect and abuse– commissioning personalised care closer to home.

[23] Changing Lives (2012) Quality of Health Principles http://changingourlives.org/index.php/what-we-do/our-workstreams/quality-of-health-principles

[24] Dept. Health (2011) Safeguarding Adults Self-Assessment and Assurance Framework, DH Gateway Ref: 15738

Health and Social care commissioners should be commissioning integrated care around the needs of individuals. The Health and Wellbeing Board provides the forum where leaders from the health and social care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

Joint Strategic Needs Assessments (JSNAs) should use local demographics; information from safeguarding leads and from the Local Safeguarding Adults Boards (and related partnership Boards), to identify the needs of the local population who may be susceptible to abuse and neglect, and translate this information into the Joint Health and Wellbeing Strategy. (JHWS)

There are new opportunities to commission innovative services that bring care closer to home and offer individuals personalised care and greater choice and control. An example is the development of personal health budgets (PHB) that provide real opportunities for patients and their carers to tailor care for their needs.

People who will be using these services need to be involved in planning and commissioners need to ensure an inclusive approach that gives full consideration about the best ways means of involvement e.g. accessible communication. Consideration will also be needed in relation to managing any risks to individuals accessing PHBs, for example, financial exploitation or addressing poor/neglectful care.[25]

But remember….

Safeguarding is not about eliminating risk to safety – people (with mental capacity) may choose to take risks that in their view provide them with a better quality of life.

Safeguarding adults should be considered in all planning as part of the quality impact assessment - considering how the service positively contributes to safeguarding adults and identifying potential increased risks. This also supports the CCGs duties under the Equality Act. A range of guidance documents are available to support commissioners in commissioning care for particular groups. [26]

'*Too many people do not receive good quality care. The review found widespread poor service design, failure of commissioning, failure to transform services in line with established good practice and failure to develop local services and expertise to provide a person-centred and multidisciplinary approach to care and support'*

Transforming Care: A national response to Winterbourne View Hospital; Department of health Review: Final Report Dec 2012

[25] Dept. Health (2010) Practical Approaches to Safeguarding and Personalisation: DH gateway 14847.
[26] Example: www.improvinghealthandlives.org.uk/publications/1134 Improving the Health and Wellbeing of People with Learning Disabilities: An Evidence-Based Commissioning Guide for Clinical Commissioning Groups

Secure Services

All commissioned health care providers are required to comply with The Essential Standards for Quality and Safety and this is a basic requirement set into contracts. However, delivering high quality care demands pushing beyond minimum standards and establishing a culture where commissioners and providers work together to drive continuous improvement.

Quick reference: Secure services that safeguard adults– What might this look like? Some examples	
Set safeguarding in all contracts	Have a gateway process for all contracts, to ensure safeguarding requirements are included within service specifications and quality schedules. Consult and use expertise, (e.g. clinical specialists and CCG safeguarding lead) particularly where the contract relates to higher risk groups
Set performance indicators	Include performance indicators focused on prevention of neglect and abuse as well as effective responses to safeguarding incidents. Focus on outcomes rather than process. Use the Safeguarding Adults Self-assessment and Assurance Framework[27] within the quality schedule – adapt for local use and for use with smaller providers. Review indicators and KPIs for safeguarding and quality to ensure a comprehensive and consistent approach to improving quality and safeguarding.
Drive improvement	Use the quality schedule to drive improvements on local priorities and areas of high risk in adult safeguarding Use CQUIN to stretch and incentivise in areas related to safeguarding adults e.g. dementia care; carers support
Establish how this will be measured	Set reporting requirements into the contract. Develop a reporting schedule to the CCG, for example, a safeguarding dashboard. Set out a schedule of validation meetings for commissioners to review the provider's evidence of performance. Set out expectations for announced and unannounced inspection visits – 'granular,' qualitative assurance
Penalties	Define consequences for contractual default (and follow through)

[27] Dept. Health (2011) Safeguarding Adults Self-Assessment and Assurance Framework, DH Gateway Ref: 15738

'Commissioners of services, as the paying party for services they contract from providers, must ensure that those services are well provided and are provided safely. The fundamental standards to be policed by the CQC form the minimum level of service that should be provided, but the commissioner in its contracting arrangements will wish to set standards over and above that minimum standard for the services that it wishes to contract, and will set out re-dress for non-compliance with those contracted standards'

Robert Francis QC; Report of Mid Staffordshire NHS Foundation Trust, Public Inquiry; Feb 2013

In securing services, CCGs should ensure safeguarding adults and Mental Capacity Act/Deprivation of Liberty Safeguards requirements are clearly set out within the contracts, services specifications and quality schedule. CCGs may also use incentives such as CQUIN as levers to drive improvements in how services safeguard adults[28].

The safeguarding performance measures will form part of wider quality and safeguarding contractual requirements that work together to secure high quality care that protect patients most at risk of abuse and neglect.

Caution is needed to avoid perverse incentives; for example, seeking to reduce the numbers of safeguarding adults 'alerts' raised relating to service provision, is a disincentive to openness and transparency.

Attention is also required when setting key performance indicators to ensure they are outcome rather than process orientated. Organisations need to demonstrate they have effective arrangements in place and that these are leading to good outcomes for patients. Indicators will need to reflect effective strategy and governance; patient involvement; systems and processes for prevention and responses to abuse and neglect; workforce (including safe recruitment, supervision and whistleblowing); contribution to multi-agency partnership.

The Department of Health published a Self- Assessment and Assurance Framework (SAAF) that provides these indicators.[29] This can be an effective mechanism to set within the quality schedule to identify minimum standards and drive improvements. The SAAF is cross referenced to the CQC Essential Standards, assisting providers with their internal governance and assurance.

The SAAF, contributes to a wider performance and assurance framework that will contain additional requirements such as performance and safeguarding activity reporting; reporting on audits; requirements for announced and unannounced site visits by commissioners.

[28] NHS Commissioning Board (2012) Everyone Counts: Planning for Patients 2013/14
[29] Dept. Health (2011) Safeguarding Adults Self-Assessment and Assurance Framework, DH Gateway Ref: 15738

- **Sub-contracts**

Organisations with commissioned responsibilities, who subsequently commission other providers to carry out services, should require these providers to comply with all safeguarding adults policies, procedures, strategies and guidance. This includes contracts where estates staff are employed in healthcare settings – grounds maintenance, cleaning etc.

- **Commissioning Support Units**

Commissioning Support Units play an important role in helping CCGs to commission effective services and assure themselves of the safety of those services. As a new service within the changing NHS structures CSUs will be undertaking a range of functions on behalf of the CCGs, many of which are critical to safeguarding adults, for example, business intelligence; management of complaints.

The CCG needs to have confidence that the CSU has the necessary capacity and competence to make safeguarding integral to its functions and that it has robust mechanisms to identify and escalate concerns. This needs to be detailed within the CSU service specification and, as all other contracts, monitored accordingly.

- **Continuing Healthcare**

Continuing Healthcare teams commission services for patients with high dependency and complex needs. Patients receiving CHC funded care may be more susceptible to abuse and neglect, for example patients with age related frailty; dementia; learning and physical disabilities; needs arising from substance misuse; acquired brain injury; mental health needs. Given this vulnerability, particular care is required to ensure that the package of care is delivered by a high quality service and that the patient's care needs are regularly reviewed and managed, involving the patient and as well as their families/representatives as appropriate.

Nursing care homes and domiciliary care services provide an essential contribution to the health economy. CCGs must ensure that this sector receives sufficient oversight, development and scrutiny to drive improvements in care.

Safeguarding adults and Continuing Healthcare:

Ensure:

- **Contracts with care homes; domiciliary care; providers of individual packages of care have requirements relating to safeguarding adults; Mental Capacity Act and Deprivation of Liberty Safeguards clearly specified**
- **Service users and carers/representatives know what good standards of care to expect and where to report any concerns.**
- **There is effective quality assurance and monitoring of these providers, systems to draw together intelligence and working in partnership with Local Authority commissioners; Local Authority safeguarding service and regulators.**
- **The quality of the provider is assured prior to procuring the package of care**
- **All those contributing to the patient's care (including the patient and their families/representatives) are clear about the accountabilities for coordinating care and where to report any concerns. This is particularly important for out of county placements where patients are more isolated.**[30]
- **There is robust review of patients receiving CHC and funded nursing care.**
- **Staffs employed within CHC services have the required levels of competence in relation to safeguarding adults; Mental Capacity Act and Deprivation of Liberty Safeguards.**
- **CHC service has an understanding of the local care home and domiciliary care sector, including market analysis to identify gaps in provision and strategy for cross sector market development.**
- **Improvement initiatives to target common areas of poor clinical care.**

Where CHC services are commissioned from other bodies such as Commissioning Support Hubs, CCGs will need to ensure the service specification and monitoring arrangements reflect these requirements

[30] National protocol for notification of NHS out of area placements for individual packages of care (including Continuing Healthcare) 2012 - (pilot developed by the NHS Strategic Health Authority Adult Safeguarding leads)

Primary Care

From April 2013, the NHS National Commissioning Board became responsible for commissioning Primary Care.

Primary Care Services commissioned by NHS Commissioning Board	
• Essential and additional primary medical services through GP contract and nationally commissioned enhanced services	• Out of hours primary medical services (where practices have retained responsibility for providing OOH services)
• Dentistry and dental services;	• Community pharmacy services.
• Primary ophthalmic services.	

Primary Care provides an essential role in safeguarding adults. The GP team is at the centre of the patients care and may be the singular point of contact in a patient's otherwise isolated life. The GP team may be in the best position to identify neglect and abuse.

As with all regulated services, primary care providers are required to be registered with CQC and demonstrate compliance with the Essential Standards of Quality and Safety.

GP practices already have an identified lead for safeguarding children. This is an effective model that would be beneficial to mirror in safeguarding adults and supports the GP practice to build sound, cross generational safeguarding provision.

NHS NCB as commissioners, are responsible for ensuring that providers are delivering responsibilities in relation to safeguarding and driving continual improvements. This will need to encompass assurance about how their systems and processes are actually being used to contribute to multi agency safeguarding and achieving good outcomes for patients. NHS NCB will also need to consider how the management of related complaints and significant events are managed in line with multi agency safeguarding adults procedures.

CCGs retain a statutory responsibility to support the NHS NCB to improve the quality of primary medical care. CCGs and the CCG safeguarding adults lead will need to work closely with the NCB area teams to support the development of safeguarding across primary care providers and ensure a cohesive and coordinated approach to safeguarding across their local health economy.[31]

Guidance has been issued by The General Medical Council and British Medical Association that will support GPs in safeguarding and applying the Mental Capacity Act.[32]

[31] NHS Commissioning Board (2012) Securing Excellence in Commissioning Primary Care

[32] General Medical Council RCGP Mental Capacity Act Toolkit for Adults in England & Wales 2011; BMA (British Medical Association) The Safeguarding Vulnerable Adults – A toolkit for general practitioners (Oct 2011);

Monitor services

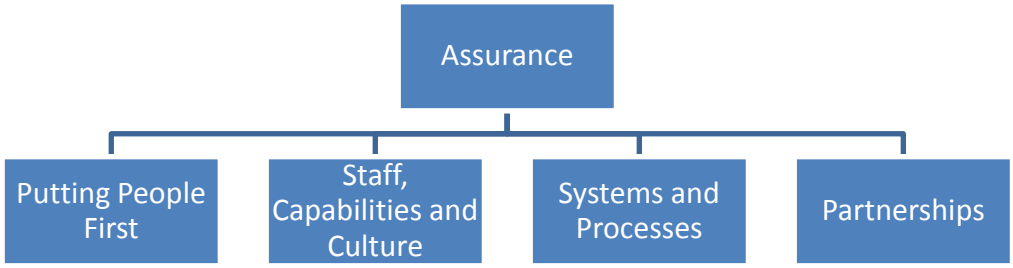
The tragic failings in care evidenced through the Winterbourne View and Mid Staffordshire inquiry, bear testimony to the importance of monitoring that goes beyond a desk top exercise.

'Undue comfort was taken from the assumption that others had responsibility in terms of quality and little if any attempt was made to collect quality information in a systematic way.'

Robert Francis QC; Report of Mid Staffordshire NHS Foundation Trust, Public Inquiry; Feb 2013

Assurance will be gained from an amalgamation of using the hard and soft intelligence, from provider, patients and partners. Importantly, assurance needs to go beyond reviewing information. Direct inspections and talking with patients confirms whether assurance given by providers, reflects reality on the ground.

The National Quality Board paper, Review of Early Warning Systems in the NHS, Acute and Community Services [33] identifies the combined processes that need to come together to provide robust assurance and to identify early warning signs. This is equally applicable to safeguard adults.



Quick reference: Monitoring services – What might this look like? Some examples	
Putting People First	Speaking with patients; carers/representatives as the most authentic form of assurance – real time feedback during site visits. Reviewing complaints and serious incidents for individual and thematic concerns. Case reviews – in depth analysis of the patient's and carer's experience Patient experience information relating to the process and outcomes from any safeguarding procedures. Patient experience data – ensuring providers use accessible means to

33 National Quality Board; Review of Early Warning Systems in the NHS, Acute and Community Services: Department of Health 2010

	seek patient and carer feedback about the quality of their care. Involving service users in assurance visits – assessing through the eyes of service users. Using Healthwatch as a key source of information
Staff, Capabilities and Culture	Leadership – is there effective leadership for strategic direction and evidence of achieving improved outcomes? Workforce data – training; staff surveys; vacancy rates Testing the culture and values of the service– open, learning environment where staff are clear about standards and supported to raise concerns Evidence of safe recruitment Soft intelligence – are their service areas that agency or trainee staff don't wish to go?
Systems and processes	An assurance framework that combines a range of hard data with soft intelligence and direct observation. Scrutinise performance indicators or frameworks such as the SAAF - test the evidence that this is delivered in practice – focus on outcomes not process. Gather pertinent data, analyse and use e.g. scrutinise the source and content of safeguarding alerts (or absence of alerts)related to services Use of audit tools to triangulate evidence from providers. Connect related information e.g. themes and trends in serious incidents; pressure care data Risk profiles and risk stratification – which providers present the highest risks and why? Clear stepped escalation procedures to manage emerging concerns as well as managing high level risks through de-commissioning and enforcement action by regulators. Specifying service improvements required - monitoring and supporting the improvements
Partnerships	Working closely with Local Authority safeguarding teams – be informed and involved in safeguarding alerts relating to your providers. Partnerships with providers – developing constructive, open and transparent relationships where providers feel enabled to share emerging concerns at an early stage and are supported in improvements. Working collaboratively across providers and partner agencies toward collect improvements – leadership in taking forward new initiatives and

	service improvements. Report information from providers and CCG into the Local Safeguarding Adults Board. Use information from the LSAB to identify areas of strength or early concerns. Local intelligence sharing meetings with key partners – e.g. Local Authority; Healthwatch; local CQC inspectors; clinical leads Quality surveillance groups across the NHS NCB local area - feeding in safeguarding related information Information sharing and protocols with NHS NCB in monitoring safeguarding within primary care.

CCGs need to establish effective monitoring for safeguarding that brings together relevant data but then uses this data to interpret, ask questions and seek out further lines of inquiry. An example is following up low levels of safeguarding adults 'alerts' or Deprivation of Liberty Safeguard referrals in a service area that has high numbers of patients with advanced dementia.

Safeguarding data (such as safeguarding alerts; Deprivation of Liberty Safeguards/Mental Capacity Act data; complaints; serious incidents and serious case reviews) needs to be triangulated with wider quality information received by the CCG, for example, data related to staff satisfaction surveys, in order to identify and address emerging concerns.

'Between January 2008 and May 2011, 40 safeguarding alerts were made to South Gloucestershire Council but these were treated as separate incidents. 27 were allegations of staff to patient assaults….NHS South of England's review highlighted the absence of processes for commissioners to be told about safeguarding alerts – some commissioners were aware of concerns- and failures to follow up concerns when commissioners became aware of them.'

Dept. Health Transforming Care: A national response to Winterbourne View Hospital; 2012

'Complaints, their source, their handling and their outcomes provide an insight into the effectiveness of an organisation's ability to uphold both the fundamental standards and the culture of caring. They are a source of information that has hitherto been undervalued as a source of accountability and a basis for improvement.'

Robert Francis QC; Report of Mid Staffordshire NHS Foundation Trust, Public Inquiry; Feb 2013

CCGs need to seek real information from patients and their families/representatives, about how well services prevented and responded to safeguarding incidents, for example through interviewing

patients and their families during site visits to providers. Patients will also bring expertise to the CCGs monitoring, for example, as part of an inspection team.

Healthwatch will provide an important and independent degree of external scrutiny and assurance to how well services are delivering safeguarding responsibilities. CCGs will need to work closely with their Local Authorities and Healthwatch to integrate their work into the CCGs safeguarding adults assurance framework.

'The concept of patient and public involvement in health service provision starts and should be at its most effective at the front line'

Robert Francis QC; Report of Mid Staffordshire NHS Foundation Trust, Public Inquiry; Feb 2013

- ### Serious incidents

The CCG must establish effective connection between safeguarding adults and their serious incident management process so that safeguarding related serious incidents are identified and referred through multi agency procedures. The CCG serious incident lead will need to hold competence in safeguarding adults and children; Mental Capacity Act and Deprivation of Liberty Safeguards in order to identify concerns and involve the CCG safeguarding lead accordingly. The CCG safeguarding lead should provide expertise into safeguarding related serious incident reports, comment on the quality of the investigation report and seek assurance that learning has been acted upon.

As with safeguarding adults alerts, serious incidents need to be considered in terms of the nature and degree of the individual incident and emerging clusters and themes.

CCG leads and providers will wish to work with their LSAB to agree processes to integrate safeguarding related serious incidents under multi- agency procedures to avoid duplication and ensure a robust process that meets requirements of the serious incident reporting requirements and local safeguarding adults procedures.[34]

'For a single patient, 286 incidents were documented and records of 12 serious untoward incidents over three years. Another patient's records document 100 incidents with seven Serious Untoward Incidents over two years. The extent of such incidents does not appear to have been shared during review meetings. Although Serious Untoward Incidents are pertinent to adult safeguarding, the hospital did not disclose their existence to South Gloucester Council Adult Safeguarding.'

South Gloucestershire Safeguarding Adults Board Winterbourne View; A Serious Case Review Aug 2012

[34] Dept. Health (2010) clinical governance and adult safeguarding: An integrated process, London: DH

- **Sharing intelligence and escalating concerns**

A common feature in public inquiries and serious case reviews is the failure of communication between agencies involved to share their knowledge of concerns.

'The review has demonstrated that the apparatus of oversight was unequal to the task of uncovering the fact and extent of institutional abuse at Winterbourne View Hospital… The insights arising from the efforts of individual agencies, sharing a common geographical and political context, confirm the difficulties of responding to the highly situational needs of patients when information about concerns, alerts, complaints, allegations and notifications are either unknown or scattered across agencies.'

South Gloucestershire Safeguarding Adults Board Winterbourne View; A Serious Case Review Aug 2012

The National Quality Board published a report setting out how quality will be maintained and improved in the new health system.[35] The report focuses on how the new system will prevent, identify and respond to serious failures in quality and the role of Quality Surveillance Groups as a mechanism for sharing intelligence between key partners and 'Risk Summits' as an escalation process for managing significant concerns.

The Quality Surveillance Groups are led through the NHS NCB area offices and CCGs will take a full role in these, feeding in information including safeguarding adults information. CCGs may also wish to consider establishing additional localised mechanisms for sharing information and intelligence with key partners, for example, regular set meetings with their Local Authority Safeguarding Service, Healthwatch and local CQC inspector.

CCGs will require clear mechanisms for escalating concerns within their governance structure and involving other responsible bodies. For some services that are commissioned by both Health and Social Care, such as Care Homes and Domiciliary Care, localised protocols and escalation policies should be agreed to enable a coordinated and early response to concerns.

- **Leading improvements**

Good commissioning also entails setting clear and achievable targets for improvements.

The CCG has a role in supporting providers to make these improvements, recognising that this is likely to provide the best outcomes for patients. Decommissioning a service as an urgent response to risk, is likely to have a highly disruptive and potentially traumatic impact on patients for example, patients with advanced dementia. There may also be wider repercussions across the local Health and Social Care economy.

This will need on going risk assessment between the responsible bodies, to weigh the risks involved. Ultimately, where improvements are not made, formalised action may be required through contractual and regulatory enforcement action.

[35] National Quality Board (2012) Quality in the new health System; Maintaining and Improving Quality from April 2013

5. Multi-agency Safeguarding Responsibilities for CCGs

QUICK SUMMARY:

Safeguarding adults is dependent on effective partnership working.

The Local Safeguarding Adults Board is the partnership that leads local safeguarding. CCGs need to be active members in the LSAB and ensure appropriate membership and contribution from the services it commissions.

Functions of the LSAB include assuring services individually and collectively safeguard adults. The LSCB also conducts serious case reviews. The CCG will take a leading role for the local health economy in contributing to this work.

Wider community safety and public protection functions are interconnected with safeguarding. This includes domestic violence; multi agency public protection and Prevent – anti terrorism strategy.

Effective arrangements to safeguard adults are dependent on shared responsibility and joint working with partners. In order to discharge this responsibility Clinical Commissioning Groups are to ensure that they, and commissioned services, work in partnership with other agencies in line with:

- Local Safeguarding Adult Board policies and procedures;
- Any local Safeguarding Adult policies and/or strategies;
- Related local multi-agency and integrated partnership strategies for example, integrated commissioning learning disability strategy; partnerships related to interpersonal violence and public protection.

Contributing to the multi-agency safeguarding arrangements is a key requirement of health services. Requirement to adhere to multi-agency policies and procedures needs to be explicit within provider's contracts.

5.1. Local Safeguarding Adults Board (LSAB)

As detailed in section 3.1, the Care and Support Bill is set to establish a Local Safeguarding Adults Board (LSAB) to help protect adults in its area, co-ordinate and ensure the effectiveness of its members.

Local CCGs and the NHS CB will be members of the LSAB, and the LSAB will be able to involve the NHS CB in ensuring full local NHS engagement. The CCG representative should have sufficient seniority in order to make strategic decisions on behalf of their organisation.

Commissioned services should have links with the Local Safeguarding Adults Boards (LSAB) in whose areas they provide services, and be familiar with their policies and procedures. Local Safeguarding Adults Boards determine their membership, governance and terms of reference and may use

national standards[36] to determine this. Trusts are likely to be expected to take a full and active role in contributing to the LSAB and the sub groups that deliver the Boards business. Involvement of private or independent, commissioned services is likely to be according to the size and nature of the service provided.

Commissioned services and the CCG, as LSAB partner agencies, should provide the LSAB with assurance about the effectiveness of safeguarding adults arrangement within their service. This will form part of the LSABs wider assurance about how agencies are working together to safeguard adults in their local community.

LSAB should connect with the Health and Wellbeing Board to provide interface and synergy between their respective roles. The LSAB should not be subordinate to or subsumed within local structures that might compromise its separate identity and role in holding services to account.

- ### Multi- agency safeguarding Hub (MASH)

Multi- agency safeguarding hubs are being developed across the country as a means of improving multi-agency working, sharing information and decision making. The hubs bring together different agencies including social care; police; probation and health to provide a central point for sharing information and agreeing the most appropriate intervention.

Most MASH units were first established as a model for safeguarding children but many are extending to provide the same model for safeguarding adults.

- ### Information sharing

Organisations should have in place a policy or procedure for sharing information where there are concerns for the welfare of an adult at risk or a child or young person.

Good practice in information sharing should be promoted within the organisation according to the published national guidance **INFORMATION SHARING: GUIDANCE FOR PRACTITIONERS AND MANAGERS (DCSF 2008)**.

https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00807-2008

NHS organisations working in the sector are partners to local agreements and are therefore expected to share appropriate and relevant personal information in line with the provisions of this protocol. They may also need to consider in some instances setting up service specific information sharing protocols

- ### Serious case reviews

Subject to legislation, the Care and Support Bill will require LSABs to arrange a review where an adult was experiencing abuse or neglect (or was suspected to be) and the adult dies or where there is significant harm and concern about how the LSAB, or a partner agency, has responded.

[36] Standards for Adult Safeguarding: Local Government Group 2011

This will put into statute a practice that most LSABs have already established according to ADASS guidance. [37]

Reviews may entail a full serious case review or another process such as a multi-agency case review where the level of concern is not to the degree to warrant a full serious case review but it is anticipated that there is learning to be gained.

Serious case reviews and multi-agency reviews support the duty of candour upon public bodies and identify key areas for improvement.

CCGs should be prepared to provide full contribution to the serious case reviews and to take a leadership role across the health economy, so that health services contribute to the review and there is oversight that any actions arising are implemented. This should form part of the contractual obligations in relation to adhering to local safeguarding adults policies and procedures.

5.2. Domestic Violence

The CCG should contribute to the strategic partnership relating to domestic violence. Commissioned services have responsibility for identifying and responding to concerns relating to domestic violence, recognising an individual's rights to make choices about remaining in abusive situations (where the person has capacity to do) but recognising risks to others, in particular, duties relating to safeguarding children and young people.

- **Multi Agency Risk Assessment Conference**

Multi Agency Risk Assessment Conference (MARAC) responds in situations of domestic violence where there is high risk of harm or homicide. Key agencies, including Health, contribute to the person's risk assessment and management plan. The person's consent to share information should be sought unless there is compelling reason not to e.g. it may put them at a greater degree of risk.

- **Domestic Homicide Reviews**

Domestic Homicide Reviews were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004). The provision came into force in April 2011 and carries statutory duties for agencies, including Health, to contribute to domestic homicide reviews.

The Act defines a "domestic homicide review" as a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by

(a) a person to who he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

Where victims of domestic homicide are aged between 16 and 18, a child Serious Case Review should take precedence over a DHR, however, any elements of domestic violence relating to the

[37] ADASS Vulnerable Adult Serious Case Review Guidance: Developing a Protocol

homicide are addressed fully and the review includes representatives with a thorough understanding of domestic violence.

The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professional and organisations work individually and together to safeguard victims;
- Identify clearly what those lessons are both with and between agencies and within what timescales they will be acted on, and what is expected to change as a result;
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

The overall responsibility for establishing a domestic homicide review rests with the Community Safety Partnership. The Chair of that partnership is responsible for establishing whether a homicide is to be subject of a DHR in consultation with local partners that have an understanding of the dynamics of domestic violence.

A review panel is convened according to the requirements of each particular homicide and should take account of any other ongoing reviews, (or the need for such reviews) such as a child or adult serious case review or Mental Health Investigation.

The process of the review follows similar methodology to that applied in children's and adults serious case reviews. CCGs should take a leadership role on behalf of the local health economy in ensuring full participation for the review and implementation of any actions arising from the learning. [38]

5.3. Public Protection

Safeguarding adults has an interface with other areas related to community safety.

- **Prevent**

The Government's counter terrorism strategy is known as CONTEST. Prevent is part of CONTEST and its aim is to stop people becoming terrorists or supporting terrorism.

CONTEST has four key principles:
• Pursue – stop terrorist attacks
• Prevent – to stop people becoming terrorists or supporting terrorism
• Prepare – where we cannot stop an attack, mitigate its impact
• Protect – strengthen overall protection against terrorism attack

The Health Service is a key partner in Prevent and encompasses all parts of the NHS, charitable organisations and private sector bodies which deliver health services to NHS patients.

Three national objectives have been identified for the Prevent strategy:

[38] For further information: Multi-agency statutory guidance for the conduct of Domestic Homicide Reviews 2011 www.homeoffice.gov.uk/publications/crime/DHR-guidance

Objective 1: Respond to the ideological challenge of terrorism and the threat we face from those who promote it.
Objective 2: Prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support.
Objective 3: Work with sectors and institutions where there are risks of radicalisation which we need to address.

Prevent focusses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorism related activity. Consequently the strategy is managed as part of the safeguarding adults' agenda.

Trusts are required to have Prevent implementation strategies in place to include leadership; policies and procedures and training across the workforce so that staff are able to identify and make referral.

- ### Multi-Agency Public Protection Arrangements (MAPPA)

The Criminal Justice Act 2003 requires local criminal justice agencies working in partnership to make arrangements to assess and manage the risk posed by sexual and violent offenders in their area.

These arrangements are known as MAPPA (Multi-Agency Public Protection Arrangements). The Act also requires them to publish an annual report setting out how the arrangements are working in their area.

MAPPA framework provides for assessment and risk management of those offenders who pose a serious risk of harm to the public.

MAPPA includes a 'duty to cooperate' and this applies to Health commissioners and providers. Mental Health Trusts are likely to have significant involvement due to the high incidence of MAPPA cases that involve offenders with a history of mental disorder.

The CCG should ensure there is senior contribution into MAPPA including the executive management group and level 3 reviews.

Further guidance can be obtained through

http://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf

6. Glossary, References and Further Resources

6.1. Glossary

ADASS- Association Directors of Adults Social Service

CCG- Clinical Commissioning Group

CQC- Care Quality Commission

CSP- Community Safety Partnerships

CHC – Continuing Healthcare

CQUIN- Commissioning for Quality and Innovation

CSU- Commissioning Support Unit

DHR- Domestic Homicide Review

DoLS – Deprivation of Liberty Safeguards 2007

HSCA - Health and Social Care Act

HWB – Health and Wellbeing Board

JSNA- Joint Strategic Needs Assessment

JSNS- Joint Strategic Needs Strategy

LSAB – Local Safeguarding Adults Board

LSCB- Local Safeguarding Children's Board

MASH- Multi Agency Safeguarding Hub

MAPPA- Multi Agency Public Protection Arrangements

MARAC- Multi Agency Risk Assessment Conference

MCA – Mental Capacity Act 2005

NCB – National Commissioning Board

PB- Personal Budgets

PHB- Personal Health Budgets

PIDA – Public Interest Disclosure Act

QIPP – Quality Innovation Prevention and Productivity

SCIE- Social Care Institute for Excellence

SAAF- Self Assessment and Assurance Framework

SCR – Serious case reviews

SI – Serious Incident

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