Safeguarding Adults:

The Role of NHS Commissioners

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Safeguarding Adults

The role of NHS Commissioners

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Executive Summary

Safeguarding Adults – a core responsibility in NHS Commissioning.

The Government reforms put patients and the quality of their care at the heart of the NHS. The Governments commitment to patient choice, control and accountability includes support and protection for those in the most vulnerable situations.

Commissioners have responsibilities for commissioning high quality health care for all patients in their area. However, they have particular duties for those patients who are less able to protect themselves from harm, neglect or abuse, for example, due to impaired mental capacity.

Safeguarding encompasses:

- Prevention of harm and abuse through provision of high quality care
- Effective responses to allegations of harm and abuse, responses that are in line with local multi agency procedures
- Using learning to improve service to patients.

The Government has agreed safeguarding principles that provide a foundation to achieve good outcomes for patients.

Safeguarding Adults Principles	
Principle 1 – Empowerment	**Principle 2 – Protection**
Principle 3 – Prevention	**Principle 4 – Proportionality**
Principle 5 – Partnership	**Principle 6 - Accountability**

Why is safeguarding adults relevant to commissioners?

Safeguarding adults is integral to:

- **Patient Care**. Achieving high quality care for patients. Safeguarding is particularly relevant to domains 4 and 5 of the NHS Outcomes Framework - patient experience and protecting people from avoidable harm.
- **Regulations.** Safeguarding is a fundamental requirement for registration and complying with the Care Quality Commission, Essential Standards for Quality and Safety.
- **Legislation**. Commissioners duty to comply with other legislation including the Human Rights Act; Equality Act; Mental Capacity Act and Safeguarding Vulnerable Groups Act.
- **Cost Effectiveness.** Quality Innovation Productivity and Prevention – harm neglect and abuse cost the NHS millions each year in avoidable admissions and care.
  Example: The total treatment cost for pressure ulcers in the UK is to be £1.4 - £2.1 billion annually, comprising 4% of NHS expenditure.

Lessons from inquiries such as Mid Staffordshire Foundation Trust have highlighted the need to make safeguarding integral to care. Prosecutions by the courts; enforcement measures by regulators and adverse media attention, all demonstrate the high cost to services, staff and patients, where there are failures in safeguarding patients.

Safeguarding adults and the NHS reforms

The changing health landscape brings new challenges for safeguarding. Changes such as demographics of vulnerable patients, the plurality of providers and the range of settings in which care is provided present new challenges for commissioners in assuring the safety of patients.

Commissioners will need to ensure that responsibilities to safeguard adults are safely managed and maintained through the transitions to new commissioning arrangements

Making safeguarding adults part of commissioning.

Prevention and effective responses to neglect, harm and abuse need to be addressed in all aspects of commissioning:

1. Making safeguarding a strategic objective
2. Making safeguarding integral to commissioning activity by:
- Putting patients first in how services are commissioned and assured.
- Leading a culture that safeguards patients.
- Using systems and processes that support safeguarding and connect aligned areas.
- Developing partnerships with patients, public and multi agency partners.
3. Using robust assurance to understand and improve safeguarding adults arrangements.

Commissioners work with providers, regulators and multi agency partners to address concerns in services.

Conclusion

Six fundamental actions for safeguarding adults:

1. Use the safeguarding principles to shape strategic and operational safeguarding arrangements.
2. Set safeguarding adults as a strategic objective in commissioning health care.
3. Use integrated governance systems and processes for assurance to act on safeguarding concerns in services.
4. Work with the local Safeguarding Adults Board, patients and community partners to create safeguards for patients.
5. Provide leadership to safeguard adults across the health economy.
6. Ensure accountability and use learning within the service and the partnership to bring about improvement.

1. Introduction: Safeguarding Adults – a core in commissioning health care.

This document reminds NHS commissioners of their responsibilities to safeguard adults. It aims to assist them to commission care that safeguards adults. The document supports, No Secrets,[1] the statutory multi agency guidance.

Further information for managers & boards of health services and for operational staff can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882

The Government reforms put patients and the quality of their care at the heart of the NHS. The Government's commitment to patient choice, control and accountability includes support and protection for those in the most vulnerable situations.

Commissioners have responsibilities for commissioning high quality health care for all citizens in their area. However, they have particular duties for those patients who are less able to protect themselves from harm, neglect or abuse.

In keeping with the government's approach to decentralisation and local flexibility, this document does not prescribe processes or targets. However, the Government has agreed safeguarding principles that can provide a foundation for achieving good outcomes for patients.

Safeguarding Principles

Principle 1 – Empowerment
Presumption of person led decisions and consent
Principle 2 – Protection
Support and representation for those in greatest need
Principle 3 – Prevention.
Prevention of neglect harm and abuse is a primary objective.
Principle 4 – Proportionality
Proportionality and least intrusive response appropriate to the risk presented
Principle 5 – Partnerships
Local solutions through services working with their communities
Principle 6 – Accountability
Accountability and transparency in delivering safeguarding

1 No Secrets; Guidance on Developing and Implementing Multi Agency Policies and Procedures to Protect Vulnerable Adults from Abuse; Dept Health 2000

The Department of Health has developed a self assessment and assurance framework that can be adapted and developed for local use by commissioners and providers:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882

Annex 1 provides examples of safeguarding adults across the commissioning cycle.

Annex 2 provides some questions to assist commissioners in reviewing their arrangements.

1.1 What is safeguarding?

Safeguarding adults involves a range of additional measures taken to protect patients in the most vulnerable circumstances, patients that are currently defined within No Secrets as 'vulnerable adults'. This may be due to illness, impaired mental capacity, physical or learning disability or frailty brought about by age or other circumstance.

Safeguarding adults includes:

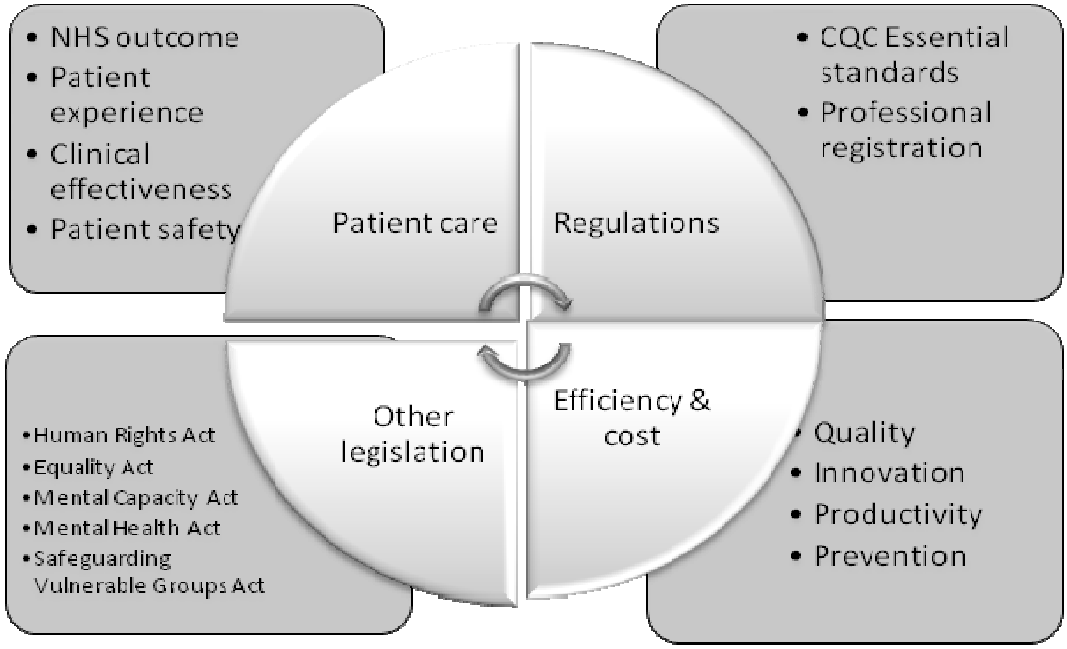
Responsibilities relate to:

- Commissioning high quality care for patients in the most vulnerable circumstances
- Addressing failures in care with providers, in line with multi agency procedures.

1.2 Why is safeguarding adults policy relevant to healthcare?

> The health and strength of a society can be measured by how well it cares for its most vulnerable members.
>
> *Sir Jonathon Michael; Healthcare for All; Dept Health 2008*

Prevention and effective responses to neglect, harm and abuse is a basic requirement of modern health care services.



Patient Care

Safeguarding is also central to the quality of care and the NHS outcomes framework[2], particularly:

- Domain 4 - Ensuring people have a positive experience of care.
- Domain 5 -Treating and caring for people in a safe environment and protecting them from avoidable harm.

Regulations

The Care Quality Commission, Essential Standards for Quality and Safety[3] set specific outcomes for safeguarding and safety as a requirement for registration. However all the CQC outcomes are fundamental to preventing neglect, harm and abuse.

Commissioners have responsibilities to address failures of care in addition to the responsibilities of the CQC. Where the CQC take enforcement action, commissioners have a key role in managing the impact this has on the local health economy.

> A series of Trusts were made subject to conditions or had their registration withheld by The Care Quality Commission, due to serious concerns and breach of standards relating to 'Safeguarding people who use services from abuse'
>
> *Care Quality Commission 2010 Inspection Reports*

2 NHS Outcomes Framework 2010/11; DH 2010

3 Guidance about compliance, Essential Standards for Quality & Safety; Care Quality Commission 2010

Legislation

People have fundamental rights contained within the Human Rights Act 1998. Commissioners as public bodies have statutory obligations to uphold these rights and protect patients who are unable to do this for them selves. Other legislation particularly relevant to safeguarding adults includes:

- Equality Act 2010
- Mental Capacity Act 2005
- Safeguarding Vulnerable Groups Act 2006
- Mental Health Act 1983.
- NHS Act 2006

Effective, Efficient and Cost Saving Care.

Failures of care are costly for the NHS as well as the patient. Safeguarding adults is a significant factor in reducing costs incurred in avoidable harm, avoidable admissions, delayed and unsafe discharges.

> Pressure ulcers not only have psychological & physical impact for patients. The total treatment cost in the UK is estimated to be £1.4 - £2.1 billion annually, comprising 4% of NHS expenditure
>
> *NHS Institute for Innovation & Improvement, High Impact Actions for Nurses and Midwives 2009*

Using Learning

Learning from inquiries[4] identifies recurring themes of neglect and poor care.

- Absence of effective prevention and early warning systems
- Neglect and abuse not recognised
- Lack of transparency and a lack of multi agency investigation
- Safeguarding is seen as the responsibility of others
- Patients and carers voices are not heard

4 Care and Compassion; Report of the health Service Ombudsman on ten investigations into NHS care of older people; Parliamentary and Health Service Ombudsman 2011

Safeguarding adults: report on the consultation on the review of No secrets, Department of Health (2009)

Francis Report: Independent Inquiry into the Care Provided by Mid Staffordshire NHS Foundation Trust: Department of Health 2010

Death by Indifference; MENCAP 2007

Prosecutions by the courts; enforcement measures by regulators and adverse media attention, all demonstrate the high cost to services, staff and patients, where there are failures in safeguarding.

Practice example – Commissioners held to account
A public hearing was initiated in 2010 into Mid Staffordshire Foundation Trust. The hearing examined the role of commissioners, supervisory and regulatory bodies in the failures of care.

1.3 Safeguarding adults and the NHS reforms.

The Health and Social Care Bill introduces reforms that are highly relevant for commissioners and how they safeguard adults[5].

The changing health landscape also brings new challenges for how commissioners safeguard patients.

- **Demographic trends** increasing vulnerabilities e.g. rising numbers of patients with impairments such as dementia.
- **Location of health care**. Healthcare is increasingly provided in people's homes. This does not automatically increase risks – the 2011 Ombudsman report[6] highlights the failure of care in institutional settings. However, provision of care in people's homes has other risks arising from less scrutiny and increased pressures on carers.
- **Personal budgets**. Some patients may need additional support to manage personal budgets safely e.g. setting standards for care; safe recruitment, monitoring quality of provision.
- **Increasing plurality and numbers of providers.** Increases the complexity of contracts, monitoring and assurance for safeguarding.

5 Liberating the NHS: Legislative Framework and Next Steps; Department of Health 2010

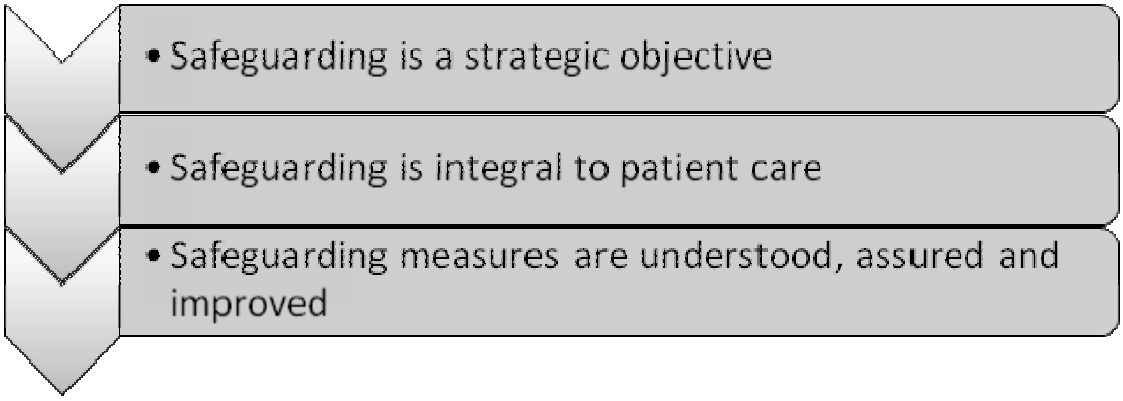
6 Care and Compassion; Report of the health Service Ombudsman on ten investigations into NHS care of older people; Parliamentary and Health Service Ombudsman 2011

- **Complexity of partnerships**. Achieving strategic commissioning for safeguarding across boundaries between different Local Authorities, GP Consortia and regional commissioning boards.

These challenges will need strong strategic and clinical leadership by NHS commissioners working with their local multi agency partnership. Commissioners will need to ensure that responsibilities to safeguard adults are safely managed and maintained through the transitions to new commissioning arrangements so that:

2. Making safeguarding adults integral to commissioning.

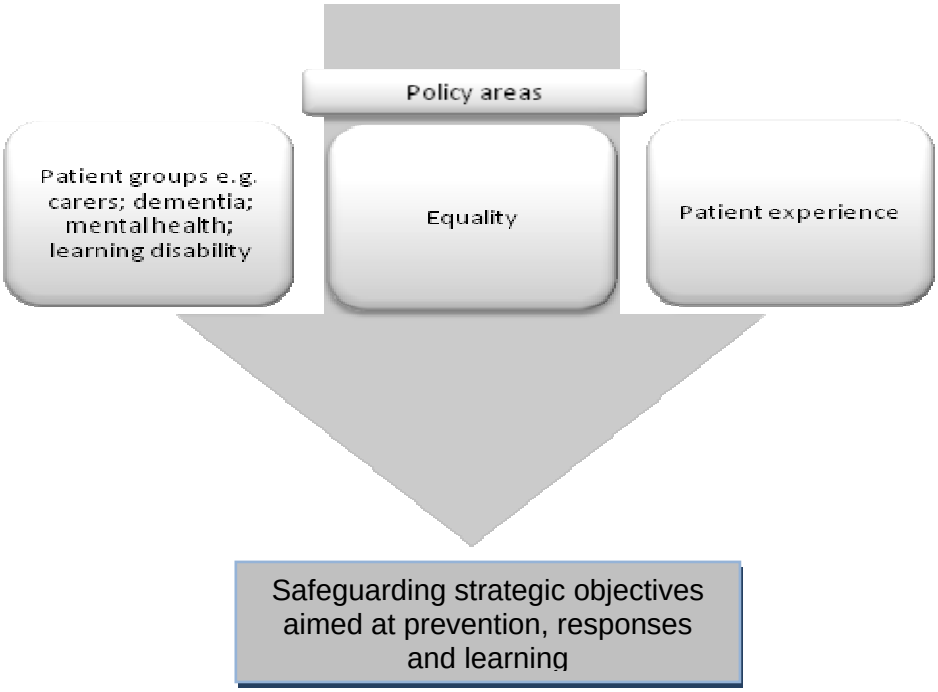
Safeguarding adults involves integration across all aspects of commissioning



2.1 Safeguarding as a strategic objective

Safeguarding adults needs to be firmly set as a strategic objective for commissioners and their strategic partnerships e.g. through the health and wellbeing strategy.

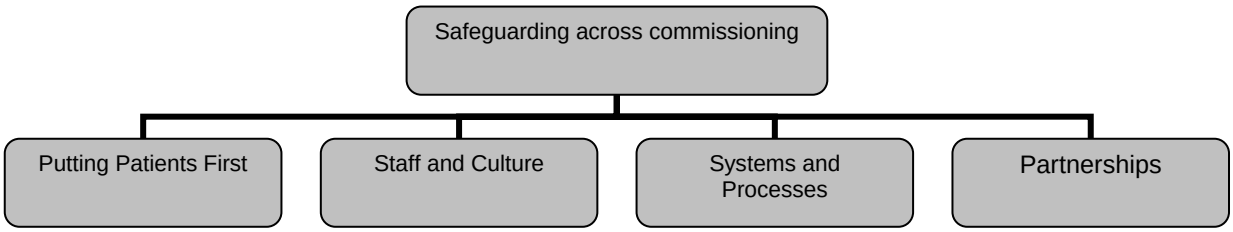
Commissioners will safeguard adults most comprehensively where they align related policy areas and aspects of quality and use this to inform priorities for safeguarding adults.



2.2 Safeguarding adults across commissioning.

The National Quality Board report 'Review of Early Warning Systems in the NHS' [7]reviewed a range of factors required to deliver high quality care. These factors provide a useful framework for commissioners to consider:

1. How they commission healthcare to safeguard adults
2. The assurance they have that providers are safeguarding adults.



Annex 1 provides a table giving examples of safeguarding adults across the commissioning cycle.

2.2.1 Putting Patients First

The safeguarding principles of empowerment, partnership & accountability reflect the central role of involving patients in safeguarding adults.

Empowerment relates to the involvement of patients in all aspects of care.
Patients must have choice and control over their care and treatment, including responses to harm and abuse.

Commissioning needs to support patients to make decisions and manage risks. Compliance with the Mental Capacity Act 2005 and Equalities Act 2010 are key to safeguarding and need to be clearly specified within contracts and monitored as part of assurance for safeguarding.

This legislation provides important protection for patients who may be particularly at risk of harm e.g. people with impairments. There is a mounting body of case law and prosecutions where due regard has not been given to the Mental Capacity Act or Equality Act. The courts will hold individuals and services to account for poor care in such areas as wilful neglect, unauthorised restrictive care; failure to make reasonable adjustments to meet individual need.

Partnerships with patients and carers includes involvement in service and pathway design. Where commissioners work in partnerships with patients and their carers to commission services, they will deliver more personalised, culturally responsive care that helps prevent

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

neglect, harm and abuse. The Government's carers' strategy[8] outlines the importance of recognising the expertise of carers. Commissioning support for carers is an important component of prevention and responses to harm and abuse.

Accountability. Patients need information about the standard of care they can expect and how to exercise their rights where that care falls short.

Commissioning closer to patients improves the ability of commissioners to seek views from patients. However commissioners may also need to take additional measures to listen to patients and their families who may be most vulnerable and marginalised i.e. communication that is culturally competent and appropriate to the needs of disabled people.

Assurance from providers needs to include information from patients and carers about their experiences of care and how well services worked with them to safeguard them.

HealthWatch, advocacy and advice services, will be important mechanisms to support patients to make informed choices and to complain. HealthWatch will ensure the views of patients, carers and the public are represented to commissioners and influence change.

Practice Examples – Putting Patients First

A GP consortia involve their learning disability partnership in developing pathways of care. They use experiences of patients with learning difficulties; information from their Joint Strategic Needs Assessment and an audit of learning disabilities services to improve prevention of and responses to safeguarding concerns.

A quality review meeting between commissioner and mental health services routinely uses information from patients and carers about their experiences of care, including how well any safeguarding concerns were addressed.

2.2.2 Leadership, Staff and Culture

Leadership, staff and culture is a key aspect for:

- The commissioner's own workforce.
- Commissioning health providers to have a safe and capable workforce.

- **The commissioning service.**

Where the organisation has a culture that safeguards adults, commissioning staff will consider this in all aspects of commissioning.

8 Recognised valued and supported. Next steps for the Carers Strategy; Dept Health 2010

Commissioners have specific responsibilities to address failures of care with providers and need staff capable to carry out these roles in line with multi agency procedures.

The increasing plurality and numbers of health providers requires strong leadership. Leadership sets the direction for safeguarding, develops best practice and leads within the multi agency partnership.

Practice example – Leadership across health providers

Hampshire commissioners lead the Hampshire Health Consortium, a network of local health service safeguarding adults leads. Commissioners lead the consortium in reviewing and developing best practice in safeguarding adults.

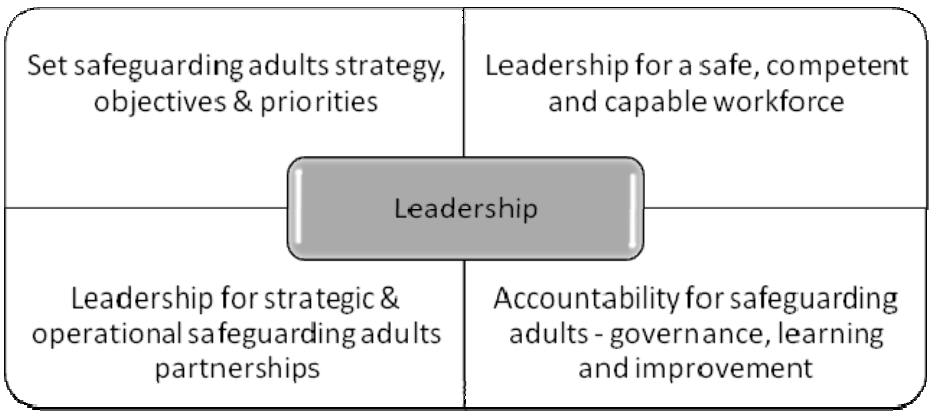
The Health consortium provide a specialist sub group for their local Safeguarding Adults Boards.

- **Commissioning services with a safe and capable workforce**

Providers need to have strong leadership in place, staff that see safeguarding as integral to care and staff that are capable of carrying out roles within the multi agency procedures.

Safeguards for patients are improved where services are commissioned to have a safe and capable workforce and contracts include standards, for example, for safe recruitment; supervision and training.

Strong leadership is needed across the health economy:



Non-executive directors and lay members also have a vital role to play in embedding the safeguarding agenda. They have an opportunity to provide independent scrutiny and hold commissioners to account. They can also help ensure that quality and safety are not pushed from the agenda by other operational or financial pressures.

Practice example – Leadership
An NHS commissioner has an executive and non-executive director for safeguarding. The non-executive director is also chair to the Quality & Risk Assurance committee. As a member of the local learning disability partnership, she combines these roles to provide constructive challenge and maintain focus on care of patients who may not have their voice heard.

Commissioners and provider services need to have in place staff that can deliver the following functions:

The structure, capacity and designation of this workforce will depend upon the size, structure, and complexity of the organisation along with the skills and competence of staff employed. Responsibilities for safeguarding should be reflected within job descriptions and competences such as the NHS Knowledge, Skills Framework.

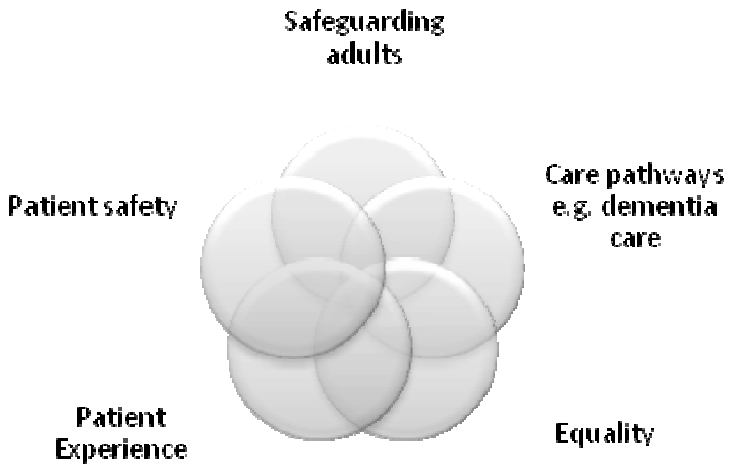
Annex 3 provides examples of the functions needed by the workforce to safeguard patients.

2.2.3 Systems and Processes to Support Safeguarding

Systems and processes support the commissioning organisation to build safeguarding into its core functions. Systems also enable health provider services to manage and be accountable for safeguarding adults.

Systems and processes for the commissioning service

Safeguarding adults needs to form part of commissioning pathways as well as commissioning services for particular groups. This involves making connections between related programmes of work so that information, objectives & learning feed into aligned areas, for example



Systems and processes help commissioners to set safeguarding across all commissioning activity.

Practice Example

Yorkshire and Humber commissioning leads worked together to develop exemplar standards for safeguarding adults for use in all contracts.

Commissioners in Eastern and Coastal Kent involve their safeguarding commissioning group in designing services to ensure that the impact for safeguarding adults is considered at each key stage in commissioning a new service.

NHS North of Tyne lead a forum for provider and partner agencies that includes learning from incidents and near misses and related policy areas such as multi agency public protection arrangements MAPPA

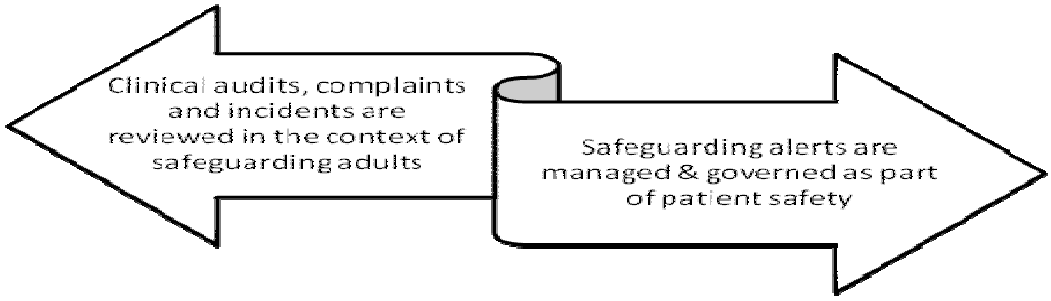
Systems and processes for provider services.

Commissioners will need to be assured that the systems that providers use to manage safeguarding are effective.

Providers need to integrate safeguarding adults into their governance arrangements so they can ensure they are complying with CQC standards. Providers need robust systems for early warning about risks of neglect, harm or abuse within their service.

Commissioners will also need assurance that where harm or abuse occurs, responses are in line with local multi-agency safeguarding adults procedures and national frameworks for investigating patient safety incidents[9].

9 National Framework for Reporting and Learning from Serious Incidents Requiring Investigation; National Patient Safety Agency, 2010 : Clinical Governance and Adult Safeguarding - An Integrated Process, Department of Health (2010)



Systems for providers include:

- The development of good management systems
- Setting, auditing and benchmarking clinical standards
- Making continuous improvement through education, research and development.
- Effective clinical risk management - using a wide range of information to detect trends and patterns and act on emerging concerns
- Use of audit to review how well safeguarding concerns have been managed

Section 2.3 considers assurance further

Practice Example

University Hospitals Birmingham Chief Nurse leads their 'Root Cause Analysis of Clinical Care' group. Data relating to serious incidents, complaints, safeguarding adults referrals are reviewed to identify emerging themes, trends and learning.

The group assure learning has led to change through a detailed quarterly assurance review. Information from this group feeds into a higher level 'Care Quality Group' that develops the Trusts work on areas such as patient experience, equality, dignity in care and high impact interventions. This group is chaired by the Chief Nurse and include non-executives and governors.

Learning has led to initiatives such as 'Ability, Not Disability' toolkits to assist in reasonable adjustments and communications.

2.2.4 Partnerships

The Governments NHS and Public Health white papers[10] set out a vision for a less insular and fragmented NHS, with improved partnerships between commissioners, the Local Authority and the local community.

10 Equity and Excellence: Liberating the NHS Dept Health 2010; Healthy Lives Healthy People Dept Health 2010

Partnerships in safeguarding involve:

Health and Wellbeing Boards and the strategies that will be developed from them, provide a mechanism for health and social care to develop a more cohesive and comprehensive approach for citizens in the most vulnerable and marginalised situations.

Public health teams provide a vital role in understanding population based needs and risks. NHS commissioners need to use this information as part of their wider responsibilities in commissioning services and being assured that those services safeguard adults.

Local Safeguarding Adults Boards (SAB) is the multi agency partnership responsible for leading the strategic and operational safeguarding adults work within each Local Authority area. Commissioners need to provide leadership for health and be active members of the local SAB.

Safeguarding principles of partnership and accountability means

- Working collaboratively with local SAB partners
- Contributing to the setting and achievement of local SAB objectives
- Demonstrating transparency in how safeguarding is being delivered
- Sharing learning with patients, public, multi agency partners, providers and regulators.

In 2005, the Association of Directors of Adult Social Services produced a framework of standards for the safeguarding partnership[11]

11 A National Framework of Standards for Good practice and Outcomes in Adult Protection; ADASS 2005

Strong partnerships are important in strategic and operational safeguarding. Leaders can provide a role model for productive partnerships, demonstrating:

2.3 Safeguarding measures are understood, assured and improved

The Care Quality Commission as regulator will seek evidence that health services are complying with Essential Standards of Quality and Safety, and that they are using information to identify and manage risks of non-compliance. The CQC has developed a protocol setting out it's role in safeguarding and the role it takes where safeguarding concerns arise within regulated services.[12]

However, these processes will not necessarily provide the sustained relationship that commissioners can have with providers to improve safeguarding. The role of CQC complements that of commissioners in relation to safeguarding but does not replace it.

Good governance systems, including equality data monitoring, will allow commissioners to understand how well services are meeting individual needs and delivering safeguarding – where there are strengths and where improvements are needed. Crucially, robust governance delivers essential early warning of poor care that may lead to neglect and abuse.

A tool to help commissioners and health services assess and benchmark their safeguarding arrangements can be found at:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882

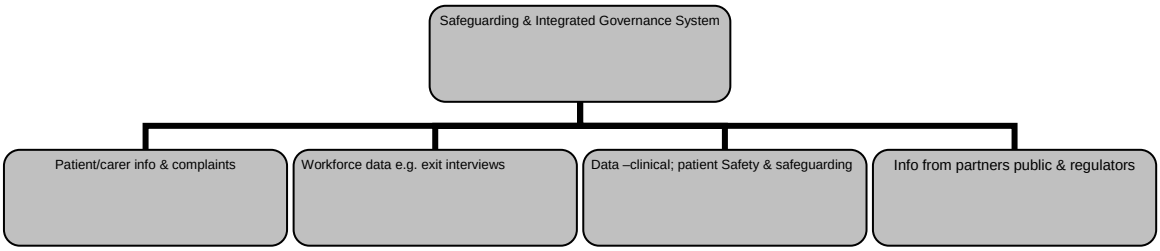
2.3.1 Gathering Information

Understanding is gained from drawing information from a range of sources. The quality of information is assured where it is 'triangulated' i.e. using information from high level national data sets, through to 'granular' information such as individual patient stories[13].

12 Care Quality Commission; Our Safeguarding Protocol; The Care Quality Commissions commitment to safeguarding

13 Recommendation Mid Staffordshire NHS Foundation Trust; Dr D.C. Thome

This provides the opportunity to use information so that measures for prevention and responses to harm and abuse can be understood.



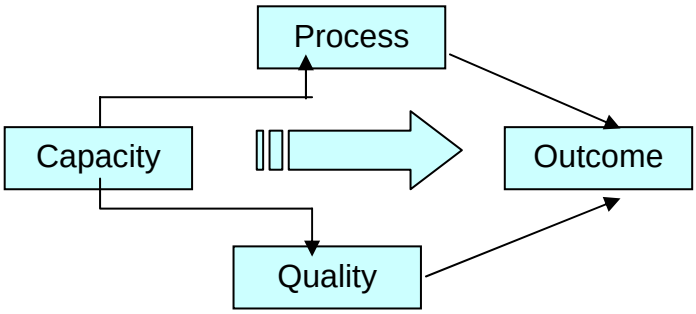
Data about responses to harm and abuse.

Gathering the right information about responses to harm and abuse can be complex. There is a risk of being over reliant on process indicators so that providers concentrate on this rather the outcomes for patients.

The best quality information will be information based on outcomes for the patient, but this may need to be supported by information about how the outcomes were achieved, for example:

- Process indicators – e.g. compliance with timeliness of procedures; policy/procedures in place
- Capacity indicators – e.g. numbers of staff trained at varying levels
- Quality indicators – e.g. qualitative reports/audits on the referral process; analysis of use of restraint/deprivation of liberty safeguards authorisations; data aggregated by protected characteristics
- Outcomes – e.g. patient experience reports - analysis of improved/desired outcomes; changes to services as a result of lessons learned

Performance Indicators[14]



2.3.2 Using Information to Manage Risks.

Using information from a range of sources enables commissioners to understand risks in individual services and across the health economy.

14 National Safeguarding Delivery Unit 2009

Risks may relate to:

Commissioners can use this information to identify priorities and incentivise improvements, for example targeting pressure care through the Commissioning for Quality and Innovation (CQUIN) payment framework

This may also highlight the need to provide targeted interventions across providers, use contractual levers and work with regulators to drive improvements

Practice Examples - Managing Risks.

Commissioners in Northamptonshire, work with care homes, pharmacists and link GPs to reduce medication errors and develop best practice in prescribing. Their team of quality monitoring nurses, work directly with care homes, extending the best practice and targeting aspects of care that predominate in safeguarding referrals.

Commissioners in Wakefield hold a multi agency 'reportable concerns' meetings to discuss emerging concerns in care homes. They draw together information from incident reports, complaints, information from their ambulance service, staff and partner agencies to give a fuller picture and early indication of a potentially failing service.

Managing safeguarding as part of the organisations governance systems identifies wider pressures that may impact upon safeguarding, for example, tackling financial deficits. This is particularly important during periods of significant change where the loss of systems, responsibilities and organisational memory increases risk.

Practice Example - Lessons from Mid Staffordshire Foundation Trust

'.. (The Trust) became focused on promoting itself as an organisation, with considerable attention given to marketing and public relations. It lost sight of its responsibilities to deliver acceptable standards of care to all patients…'

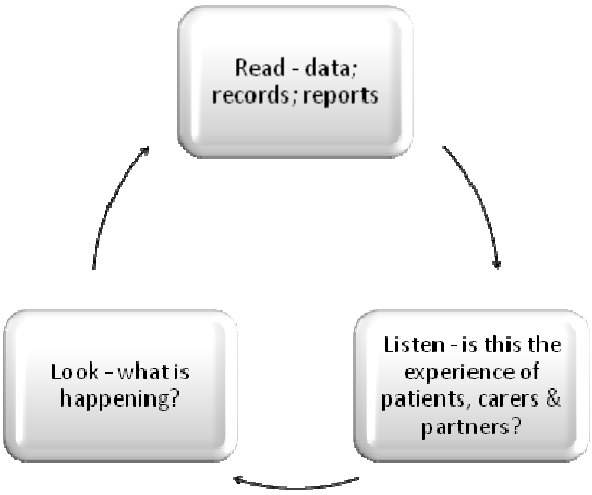
Thome Report, Dept Health 2009

Useful resources include:

- Manchester Patient Safety Framework www.nrls.npsa.nhs.uk/resources/?entry45=576
- World Health Organisation patient safety alliance site www.who.int/patientsafety
- Using equality duty to make fair financial decisions www.equalityhumanrights.com/advice-and-guidance/public-sector-duties/guidance-and-codes-of-practice/using-the-equality-duties-to-make-fair-financial-decisions/

2.3.3 Assurance, learning and improvement

Robust assurance requires more than a desktop exercise to read data or confirm policies and procedures are in place. Assurance requires understanding that those policies are leading to high quality care for patients.



The safeguarding principles of accountability and partnerships support robust assurance. Assurance will be strongest where services are open and transparent and involve external partners in validation.

Assessment by patient groups, HealthWatch (currently LINKs) and overview and scrutiny committee provide effective ways for commissioners to gain assurance through the eyes of patients.

Reports to and from the local Safeguarding Adults Board provide important assurance about a service's safeguarding activity.

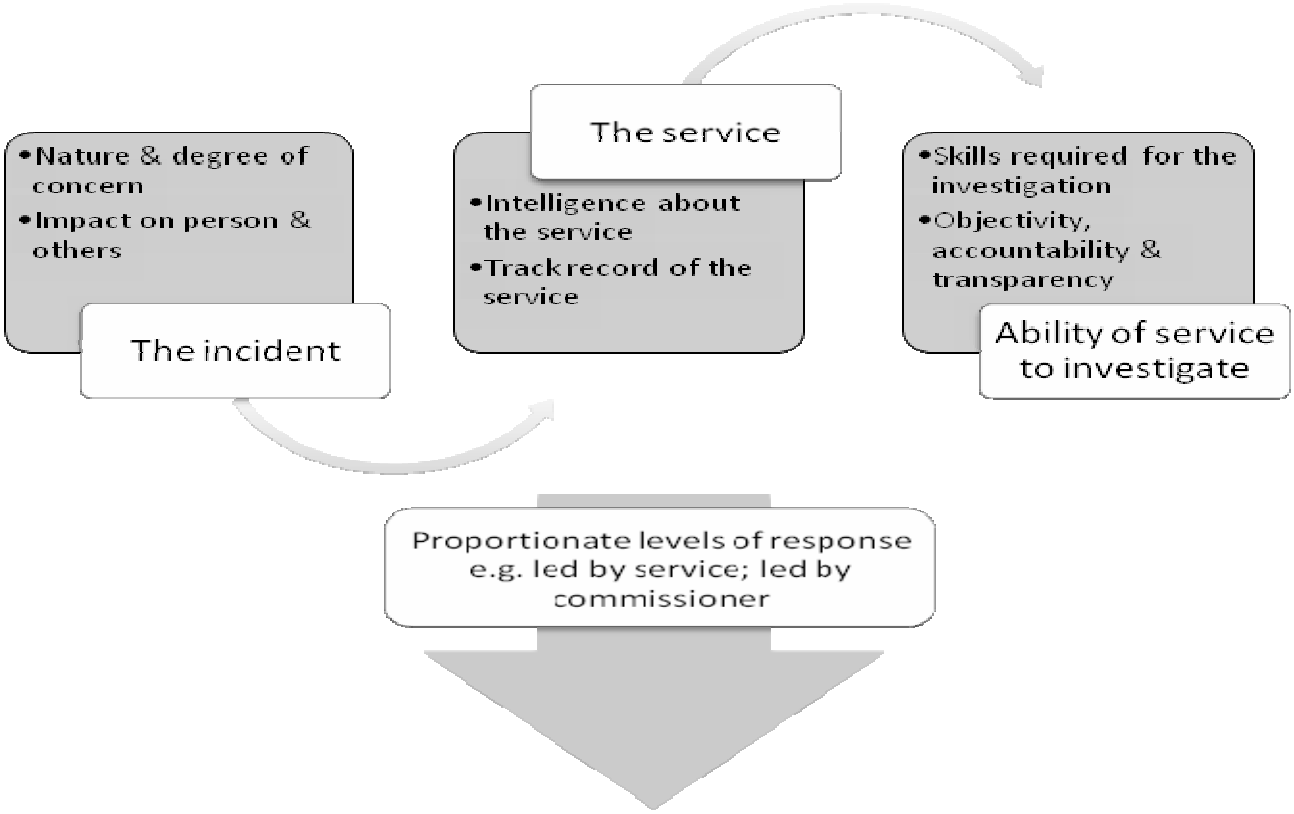
Practice Example - Assurance

An acute Trust involves their commissioners, local SAB and HealthWatch in assuring how they safeguard adults. Commissioners carry out site visits to talk with patients about how fundamental aspects of care, such as dignity, culturally competent care and nutrition are managed. Site visits focus on particular aspects of care for example, how well staff address issues of mental capacity and use of restriction and restraint.

NHS South East Coast provide support and training for learning disabled people and their families to be involved in validating provider's self assessment audits.

Assurance processes also provide opportunities for learning and improvement, both in relation to prevention and learning when things go wrong.

When safeguarding incidents occur, commissioners and regulators have responsibilities for assuring that providers address the concerns. Local multi agency procedures will detail how commissioners, regulators, providers and the local safeguarding adults service work together to agree proportionate responses, based upon:



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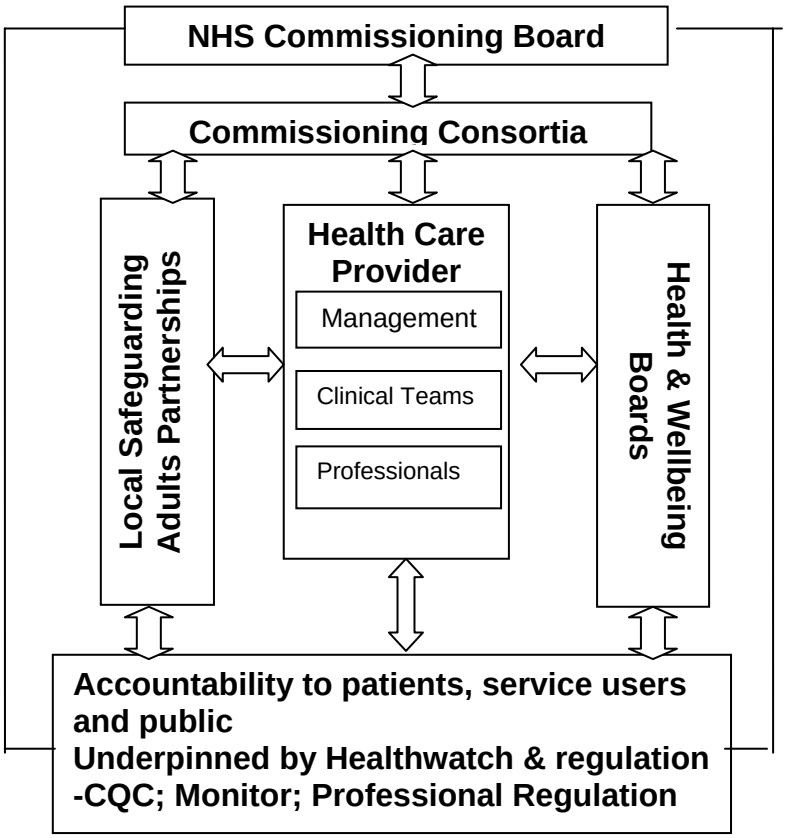
Practice Example – Commissioners role in multi agency procedures

Bradford and Leeds multi agency procedures include pathways for responding to allegations of neglect and abuse in regulated services. Commissioners play an active role in coordinating and overseeing investigations related to health services.

There is often learning for health services in relation to gaps or communication deficits between parts of the health or wider multi-agency system. The commissioner 'orchestrates' this pathway, in partnership with other agencies, and has the responsibility to oversee learning and improvement across it.

Serious case reviews are an important mechanism to understand whether there are lessons to be learned about how professionals and services worked together. They provide accountability and transparency within the service, to patients, public and the multi agency partnership.

Importantly, the review provides the opportunity to highlight good practice, equality issues and learning across the multi agency partnership.



3. Conclusion

Close attention to safeguarding adults is core to delivering quality care, complying with statute and achieving the cost effective outcomes expected of modern health care services.

Commissioners play an essential role in safeguarding patients in the most vulnerable situations. Six basic measures will help commissioners comply with legislation and achieve good outcomes in how they safeguard adults.

Six fundamental actions for safeguarding adults:

1. Use the safeguarding principles to shape strategic and operational safeguarding arrangements.
2. Set safeguarding adults as a strategic objective in commissioning health care.
3. Use integrated governance systems and processes for assurance to act on safeguarding concerns in services.
4. Work with the local Safeguarding Adults Board, patients and community partners to create safeguards for patients.
5. Provide leadership to safeguard adults across the health economy.
6. Ensure accountability and use learning within the service and the partnership to bring about improvement.

Glossary

Care Quality Commission – Regulators of Health and Social Care

CQUIN – Commissioning for Quality and Innovation payment framework that provides financial incentive for achieving local improvement goals

Essential Standards for Quality and Safety – Essential standards set by The Care Quality Commission, that all regulated health and social care services are required to meet.

GP Consortia – Groups of GP practices who, subject to legislation, will commission the majority of NHS services

HealthWatch – a new independent consumer champion within the Care Quality Commission. Subject to legislation, Local HealthWatch will replace Local Improvement Networks and support the Local Authority in promoting choice and complaints advocacy. Local HealthWatch will have the power to recommend poor services are investigated.

Health and Wellbeing Boards - subject to legislation, structures led by the Local Authority, to promote partnership working and integrated service delivery of public services

Local Improvement Networks – Organisations run by local individuals and groups to give citizens a stronger voice in how health and social care services are run. LINkS are to be replaced by HealthWatch.

Local Safeguarding Adults Board – a multi agency partnership, coordinated by the Local Authority with responsibility for leading and overseeing all strategic and operational inter-agency safeguarding adults work within the Local Authority area.

Local Safeguarding Adults Service – Local service, coordinated by the Local Authority to manage safeguarding adults concerns through multi agency procedures

National Patient Safety Agency – Promotes patient safety and manages the national clinical assessment service, the national research ethics service and confidential enquiries. Responsibilities will be transferred to the NHS Commissioning Board in 2011.

Commissioners – Within this guidance 'Commissioners' refers to commissioners of care funded by the NHS. This includes Primary Care Trusts and newly emerging commissioning structures of the NHS Commissioing Board and GP consortia. The term also includes provider organisations where they sub contract services.

NHS Commissioning Board – a newly established independent Board to lead on allocation and accountability for NHS Resources and to securing improved health outcomes.

Overview and Scrutiny Committee - statutory powers under the 2001 Act to review and scrutinise any matter relating to the planning, provision and operation of health services in the area of its local authority.

Quality Accounts – an annual report to the public about the service offered by NHS Trusts

Provider Boards – within this guidance 'provider boards' refers to the executive or senior management structures in place across NHS Trusts and within other NHS funded services through the independent and voluntary sector.

Safeguarding Adults -"Safeguarding" is a range of activity aimed at upholding the fundamental right of all adults to be safe with particular focus upon 'vulnerable adults'

Safeguarding Adults Procedures Local procedures that define the formal multi agency responses to be used where a safeguarding adults concern arises.

Vulnerable Adult defined within No Secrets guidance as a person:
"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".*

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Annex 1: Safeguarding across the commissioning cycle

Plan
Set safeguarding as a commissioning strategy, aligned to local safeguarding partnership strategies.
Plan services with and for vulnerable groups and their carers.
Use the Joint Strategic Needs Assessment to understand and meet the individual needs of people who may be in vulnerable situations such as disabled people
Work with local Safeguarding Adults Boards to identify and address priorities in safeguarding adults.
Think 'safeguarding' when planning wider care pathways and services.
Procure
Set safeguarding quality standards and compliance with regulations into contracts.
Use quality standards to connect patient empowerment, personalisation, risk enablement, compliance with Mental Capacity Act and Equality Act.
Develop standards and indicators for safeguarding that measure improved outcomes for patients
Provide appropriate and culturally competent means for patients and carers to make informed choices about whether services will meet their needs e.g. easy access information; decision aides; advocacy
Avoid creating 'perverse incentives' that increase safeguarding risks e.g. disincentives to report safeguarding concerns
Commission for accountability, openness and transparency with patients, public and safeguarding partners.
Monitor
Use a range of information to assess strengths and risks in services e.g. from patients, national and local data, from direct observation.
Actively engage partners, patients and public groups in assurance
Identify and act on early warnings – emerging concerns about a service or aspect of care
Support and incentivise services to improve e.g. peer development fora; Commissioning for Quality (CQUIN) payment framework
Work in partnership with providers to improve and innovate
Provide leadership for collaborative approaches to common risks e.g. cross service protocols for pressure care
Revise
Use contractual levers to manage risks and improve.
Work with providers, safeguarding partners and the CQC to share information and act on concerns
Develop in line with multi agency safeguarding procedures, escalation plans and proportionate responses to safeguarding concerns that arise in services
Work with partners to define roles and responsibilities of providers, commissioners and regulators within multi agency procedures e.g. investigation, referral and notifications to professional and regulatory bodies.
Develop contingency plans for decommissioning in the event of serious and/or recurrent failures in services

Annex 2

Table 1 – Example Questions for Commissioners
Safeguarding as a Strategic Objective
What is our strategy for safeguarding adults and is it aligned to other core aspects of quality such as patient safety and equality?
Is information from the JSNA and from patients, carers, public and partners used to identify priorities?
How do we work strategically with safeguarding partners e.g. through Health and Wellbeing Boards and the Local Safeguarding Adults Board? Are our plans aligned?
How do we show leadership across the provider economy?
Safeguarding as Integral to patient care
Do we have a process for setting safeguarding adults into all contracts?
Do standards and indicators focus on outcomes for patients?
How is safeguarding considered in designing care pathways?
Are we confident that key commissioning staff understand safeguarding adults and build it into their role?
How are we commissioning best practice in safeguarding? For example in commissioning care pathways, do we make connections between safeguarding, carers, mental capacity and equality?
How do we work across the provider economy to support safeguarding?
How as commissioners do we support patients to hold services to account for their care?
How is good practice shared?
Safeguarding measures are understood, assured and improved
Are we accessing information from patients and their carers about whether individual need is being met and how safeguarding concerns are managed?
Are we involving HealthWatch / LINks in assurance?
How is information being used to address equality?
Are we using a range of information to monitor contracts? Would we be able to identify emerging concerns?
Do we work with safeguarding partners to identify patterns and trends in safeguarding?
How are we involved in sharing information with safeguarding partners and with the CQC?
How are we quality assuring decisions about referral through multi agency procedures?
How are decisions made about when services can lead an investigation or when independent investigation is needed – is this robust and proportionate?
How do we know that providers are acting on concerns?
How is openness, transparency and accountability being demonstrated?
Do we use learning in planning services?

Annex 3

Safeguarding adults and roles within the workforce.	
Role	**Key Functions**
Executive/ Senior Management Lead	Leadership across the organisation Set strategic safeguarding objectives. Connect aligned strategic areas Accountability for the governance of safeguarding – to the service, partners and regulators Leadership for a partnership approach & within the Local Safeguarding Adults Board.
Non executive and elected leads	Champion & maintain focus on safeguarding Provide independent scrutiny Hold executive directors and Boards to account
Operational lead	Deliver strategic objectives & lead across the service Manage the safeguarding workforce Provide systems and structures to support safeguarding e.g. procedures, training Quality assure safeguarding adults practices Manage complex or high risk situations Work collaboratively with partners
Safeguarding Specialists	Clinical leadership & expert practice Lead improvements, innovations and best practice Develop and delivers training Provide supervision
Decision maker e.g. senior clinician; line manager; team leader	Make decisions about referrals to the Local Safeguarding Adults service Manage any immediate protection issues Coordinate referral and safe transfer of responsibilities. Coordinate any alternative action plan
Roles in Multi Agency Procedures	Potentially including: Lead/ coordinate Investigate standards of health care delivered by services or individuals Contribute specialist expertise to an investigation Assess the patient's needs Assess the needs of those causing harm Coordinate or contribute to the protection plan and recovery of the patient or those causing harm
Wider workforce	All staff are responsible in identifying and responding to concerns about quality and adult safeguarding

Annex 4

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