



# **Clinical Governance and Adult Safeguarding**

*An Integrated Process*

## Clinical Governance and Adult Safeguarding- An Integrated Process

### DH INFORMATION READER BOX

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<b>Description</b>	The aim of this guidance is to enable NHS organisations in England to develop local robust arrangements to ensure that clinical governance systems and adult safeguarding are fully integrated.
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<b>Cross Ref</b>	Safeguarding Adults Report on the consultation on the review of 'No secrets'
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<b>Action Required</b>	All NHS organisations should review and develop their local arrangements accordingly.
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<b>For Recipient's Use</b>	
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# Clinical Governance and Adult Safeguarding-

## *An Integrated Process*

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# Contents

Executive Summary	Page 5
Flow Chart	Page 6
Guidance Notes	Page 7
1. Why do we need an integrated process for Clinical Governance and Adult Safeguarding?	Page 7
2. Why do we need to report?	Page 7
3. What is Safeguarding?	Page 7
4. Step-by-step use of the flow chart	Page 8
5. Referral to the Police	Page 9
6. Direct Referral	Page 9
7. Examples	
• Box 1	Page 10
• Box 2	Page 11
• Box 3	Page 12
8. Terms and Definitions	Page 13
9. Which Adults are vulnerable?	Page 14
10. Definition of Abuse	Page 14
11. Forms of Abuse	Page 14
12. Neglect	Page 15
13. References	Page 15

## Executive summary

'No secrets' (DH 2000) gave local Social Services authorities lead responsibility for coordinating local multiagency systems, policies and procedures to protect vulnerable adults from abuse. In October 2008, the Department of Health carried out a large national consultation on safeguarding adults from abuse and harm called '*Safeguarding Adults*', *the review of the No secrets guidance*. The consultation set out to understand how far *No secrets* had progressed across agencies and to find out how it could be improved. Over 12,000 people took part in the consultation including 3,000 citizens. There were around 500 responses, 67 responses were from NHS organisations.

One of the key findings was the absence of adult safeguarding systems within the NHS to ensure that healthcare incidents that raise safeguarding concerns are considered in the wider safeguarding arena.

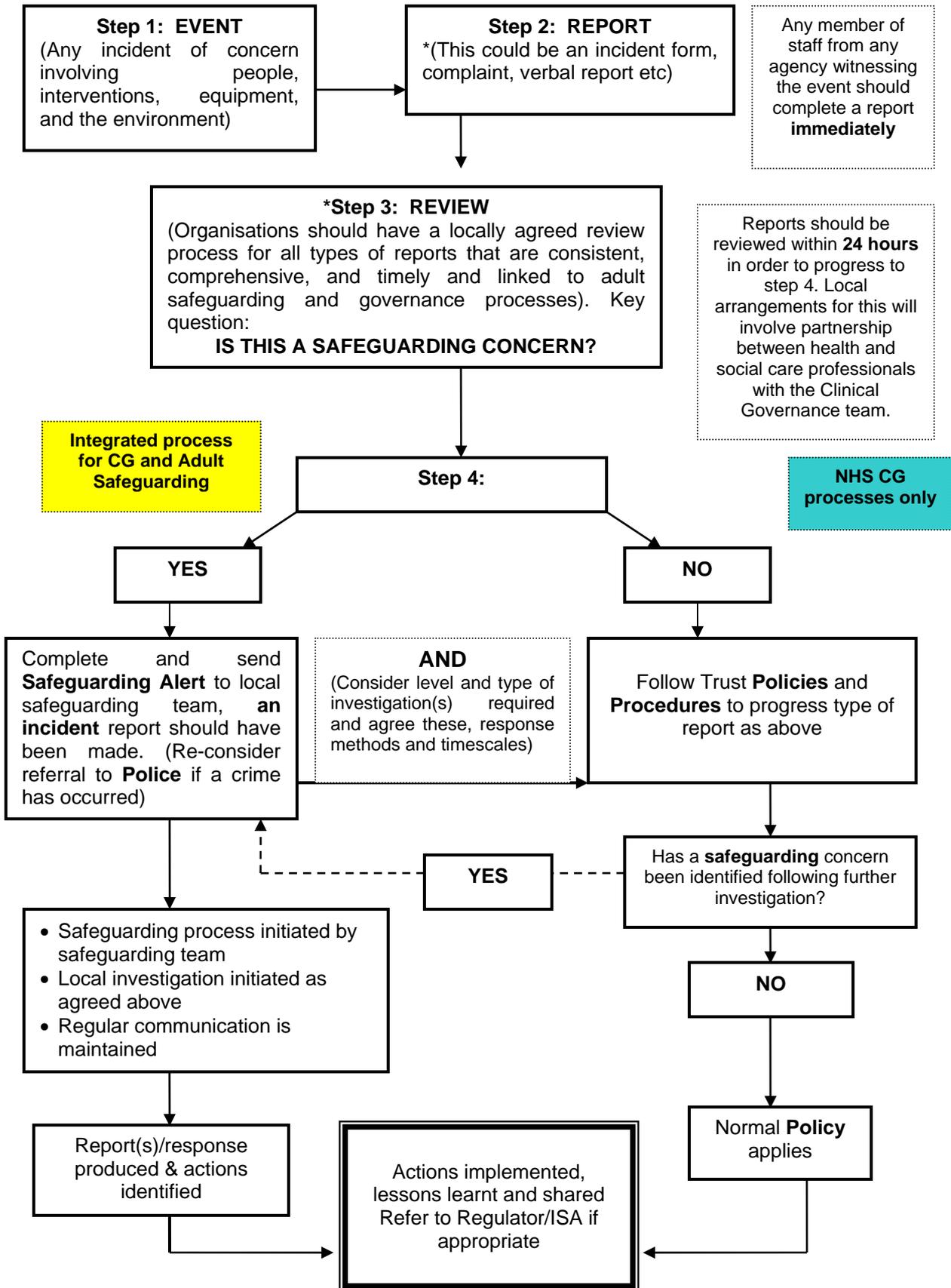
The consultation report identified the key role that healthcare professionals can play in safeguarding adults: first, in the identification of abuse, harm and neglect, and second, in developing appropriate responses to it. Although much progress has been made NHS Clinical Governance systems do not yet formally recognise the need to work in collaboration with Local Authorities when adult safeguarding concerns arise during healthcare delivery.

There was also a clear request from NHS respondents for guidance to clarify the relationship between adverse incident reporting, complaints, and safeguarding in order to encourage reporting in a way that supports the investigation and empowers staff in the process.

The aim of this guidance is to encourage organisations to develop local robust arrangements to ensure that adult safeguarding becomes fully integrated into NHS systems. This will result in greater openness and transparency about clinical incidents, learning from safeguarding concerns that occur within the NHS, clarity on reporting and more improved positive partnership working.

# Clinical Governance and Adult Safeguarding- An Integrated Process

## Flow Chart



### Guidance Notes

#### Why do we need an integrated process for Clinical Governance and Adult safeguarding?

- The Department of Health published a report on the outcomes of the review of the '*No secrets*' guidance in July 2009. The report highlighted that there was a perception across all agencies that incidents within the NHS were largely dealt with 'in-house' through clinical governance systems and were rarely thought of in the wider safeguarding context.
- The report also showed that there were opportunities to be gained from streamlining and integrating systems where investigations could be undertaken in parallel and the learning from both could be informative and help to develop communication between safeguarding teams and health agencies. The report suggests that a clear distinction needs to be made between the two processes to avoid duplication and to use opportunities where one investigative process can meet the requirements of both sets of procedures. There was also concern about the potential high level of adverse incidents that would be reportable as safeguarding concerns if the two processes came together. This issue has been carefully considered and used to inform the development of this integrated process.
- The aim of this guidance is therefore to encourage organisations to develop local robust arrangements to ensure that safeguarding becomes fully integrated into NHS systems. This will result in greater openness and transparency about clinical incidents, learning from safeguarding concerns that occur within the NHS, clarity on reporting, and more positive partnership working.

#### 2. Why do we need to report?

- In organisations as large and complex as the NHS, things will sometimes go wrong. Incident reporting is one of the key methods for alerting other parts of the organisation to issues that if left unattended may pose a risk in future to patients or the health and safety of staff, visitors, contractors and others.
- The purpose of the reporting system is to enable the NHS to actively learn from incidents and to ensure that where required changes are identified they become embedded in practice. This includes those incidents that occur on NHS premises, in the provision of NHS commissioned services or when an NHS employee is carrying out a work-related task on non-NHS premises. It will however also be useful for staff from non-NHS organisations to assist in understanding how NHS processes work alongside multi-agency safeguarding procedures.

#### 3. What does Safeguarding mean?

- Safety from harm and exploitation is one of our most basic needs. Being or feeling unsafe undermines our relationships and self-belief. "Safeguarding" is a range of activity aimed at upholding an adult's fundamental right to be safe. It is of particular importance for people who, because of their situation or circumstances, are unable to keep themselves safe.
- Safeguarding vulnerable adults from abuse and harm is everyone's business and is now becoming an important part of everyday healthcare practice.

## Clinical Governance and Adult Safeguarding- An Integrated Process

- The following guidance notes have been developed predominantly to assist NHS staff and/or any other person involved in healthcare delivery to identify when **safeguarding processes** should be followed in conjunction with traditional NHS reporting mechanisms.
- Each clinical area should have access to local 'No secrets' multiagency policies and procedures for adult safeguarding which will assist the teams to identify and respond to concerns.

### 4. Step by step use of the flow chart

#### Step 1: Event or incident

1. An incident of concern has occurred (this could include an oral or written complaint or concern being raised by anyone with regard to a person, place or act, or any type of incident). This report can be made by any member of staff from any agency witnessing the event and should be completed immediately after the event has occurred. It can also be made directly to the PCT.
2. Consideration should be given as to whether a crime has been committed.
3. Consideration should be given to the person at the centre of the event (e.g. a member of staff or a patient, or both) so that the right information is given to the person about the event, the support they will need post-event is identified and given, regular communication is maintained with them and the conclusions are shared.

#### Step 2: Report

1. The person discovering/witnessing the event or receiving the initial complaint reports this/forwards this, in line with local organisational procedures (also, in the case of a complaint, the 2009 Regulations) , e.g. completion of an incident form. (Reports may be raised as an incident, a Serious Incident (SI), as a result of Whistleblowing, and through PET or PALS reports).
2. Details about any immediate or on-going care for the person are recorded within the patient's notes/HR files as appropriate.

#### Step 3: Review

1. The incident form/complaint is reviewed **within 24 hours** for any potential safeguarding issues (to identify if harm has occurred that requires a safeguarding response). (This will be in addition to any action subsequently to be taken under the Local Authority Social Services and NHS Complaints (England) Regulations 2009)
2. **Consider Trigger question, is this a safeguarding concern?** Organisations should have established and robust local processes in place to ensure that this review is comprehensive, timely and effective. Ideally, this should be linked into existing governance processes such as incident reporting/complaints, etc, so that the review forms part of this process rather than create a separate one.
3. Locally agreed processes may vary but are likely to involve regular dialogue and negotiation between health and social care professionals and safeguarding practitioners (refer to local protocols, policies and procedures). Some examples are given in these guidance notes.
4. Local clinical governance systems will also ensure that appropriate notifications are made to the NPSA, and that communication with Commissioners, Providers and Strategic Health Authorities are maintained according to national guidelines.

### Step 4: YES or NO

1. A 'yes' or 'no' route is then selected.
2. In the event that there is a safeguarding concern, an alert form should be completed immediately in line with local procedures and sent to the safeguarding team who will contact the referrer. (An **incident form** should still have been completed in addition)
3. Normal trust policies and procedures for follow on actions will **still** apply and should be carried out in partnership with the safeguarding process.
4. If there are no apparent safeguarding concerns, normal procedures for investigation etc. should apply. However, if through the investigation process a safeguarding concern should emerge an alert should be raised immediately and progressed as above.

### 5. Referral to the Police

- A referral to the police must be made at any step in the process if there is reason to believe that a crime has been committed. (Where a complaint is received in these circumstances, discussions should take place with the police to determine whether progressing the complaint might prejudice subsequent legal or action - if so, the complaint should be put on hold, and the complainant will be advised of this fact.)

### 6. Direct Referral

- In the unlikely event, that a safeguarding concern is not progressing satisfactorily within local NHS systems the referrer may send/discuss the concern directly with the local authority safeguarding team (see local Adult Safeguarding policies and procedures) and directly with the PCT.

### 7. EXAMPLES

#### Box 1:

**An allegation is made against a community nurse for inappropriate touching of an elderly woman with dementia. The carer made a complaint through the Patient Experience Team (PET) at the Primary Care Trust.**

#### **Process followed:**

1. The clinical governance team (CG) review the complaint received and logged by PET and raise an SI. The CG team contacts the safeguarding lead within the health team. (Immediate action within 24 hours)
2. The safeguarding lead informs the police and raises a safeguarding alert.
3. The nurse is suspended pending investigation.
4. The police hand the case back to the safeguarding team as there is no evidence of an offence being committed.
5. A strategy meeting of the wider safeguarding team takes place to identify the individual actions required. The safeguarding team agree the process to be followed, which involves the health team appointing an investigating officer (IO) and leading the investigation. Regular feedback is given to the wider safeguarding team.
6. Following a timely investigation the IO concludes that no inappropriate conduct has taken place.
7. The IO shares the findings with the wider safeguarding team and they jointly review the actions for both organisations.
8. Remedial actions are implemented (see below).

It was established early on in the strategy meeting that the investigating officer would be appointed from within the health team, as they were the most appropriate in this case. Regular communication with the social care team was maintained throughout the process.

The safeguarding team prompted a review of the patients needs to establish whether there were any issues that may have changed and to ensure that the carers (son) was receiving the appropriate support.

The investigation identified a number of recommendations that the community nursing team needed to implement as a result. The nurse received support throughout the whole process and was enabled to return to work.

#### **Learning Points:**

The patient was known to be suffering with severe dementia; she was unable to communicate and was bed bound. The nurse was a new worker (male) and had been given written handover notes, which did not reflect the patient's special needs. Two members of staff always attended to the patient at a time and this was not appropriately conveyed to the nurse.

The community team revised the local system for allocating patients and giving verbal handover to all staff at the beginning at end of each shift, including how to support new and bank/agency staff. Named and link nurses were allocated to the patients with special needs to improve continuity. Plans were shared and agreed by the patient's carers. Community 'Personal Care' policy was revised in partnership with all staff concerned in the incident.

### Box 2:

**A patient developed a grade 3 pressure ulcer during an episode of care in an acute hospital ward.**

#### Process:

1. The pressure ulcer was reported and an SI raised.
2. An appropriate health IO is appointed and information gathering commenced.
3. The IO continues with the investigation and maintains regular communication about the progress of the investigation with all key staff within the safeguarding team, CG team, staff within the clinical area affected and the patient and carers/relatives.
4. The investigation showed that the initial risk assessment of pressure areas highlighted the 'high' level of risk. The patient was moved from ward to ward three times within the first week. A pressure-relieving mattress was identified as part of the care plan but was not applied until day 4 of the admission. The patient had a broken area by day 4. The mattress had been ordered but due to the numerous moves, and shift changes inadequate information had been passed on and reviewed. The equipment was therefore delayed in getting to the patient.
5. The IO ruled out any intentional harm or neglect, demands on beds had resulted in the patient making at least one unnecessary move.
6. The IO shared the investigation report, recommendations and learning with all stakeholders.
7. The safeguarding team considered how this information should be sent through to the local authority safeguarding team and how it could be included in the report for the safeguarding adult's board to highlight the learning.

#### Notes:

- During the process of information gathering, **if** the IO suspects that 'neglect' (see definition) has taken place a **safeguarding alert** will be raised.
- If a safeguarding alert is raised the clinical governance team will discuss and agree the next steps with the safeguarding team. In most cases, it is likely that the health IO will continue the whole process and conclude the report.
- If the ulcer has still occurred despite all efforts to reduce the risks then the IO will not raise a safeguarding alert and will still complete a report for sharing and learning within the CG setting and within the organisation.
- Sharing of information to regulators, professional bodies, ISA etc should be considered **if** appropriate at the end of the investigation and at the conclusion of any disciplinary hearings.

#### Learning Points:

1. Root cause analysis was completed and shared with the clinical teams.
2. The procedures for moving high-risk patients from ward to ward before receiving essential care was reviewed and revised.
3. The Matron introduced an emergency access to equipment procedure.
4. Feedback was given to each clinical area to make the agreed changes to practice.
5. A report was presented to the internal clinical governance team and local safeguarding adult's board to highlight the issues associated with pressures on acute beds and the risks to patients and the learning from this event.

### Box 3:

**While receiving rehabilitation in a community hospital following a fall, a patient discloses that a neighbour has been stealing money from her.**

#### Process:

1. The nurse completed an incident form and raised a safeguarding \*alert.
2. The safeguarding clinical lead liaised with the local safeguarding team who arranged a strategy meeting.
3. At the strategy meeting, it was decided that social care would perform the IO role with support from the clinical lead when required.
4. The clinical lead reported progress regularly to the clinical governance team.
5. Discharge home was deliberately delayed until the investigation was completed.
6. The outcome of the investigation informed the discharge planning arrangements and the patient was safely discharged home with a care package.

#### Notes:

\*If the nurse had only raised an incident form, the **clinical governance team** would have triggered an alert as **step 3 in** the process, and given feedback to the ward.

#### Learning:

The IO discovered that the patients neighbour had been collecting her pension and her shopping. The neighbour had been keeping half the pension each week and only provided her with small amounts of shopping. The patient had become malnourished and anxious which contributed to her fall. The safeguarding team worked with the ward team to arrange a supportive care package to be put in place on discharge, and a system for collecting her pension and shopping. The neighbour was spoken to by the safeguarding team although no criminal charges could be brought against the neighbour, an expectation of future behaviour was set out. The patient received counselling from the trust chaplain at home.

The partnership between the safeguarding team and the clinical team enabled a safe discharge home for the patient.

### 8. Terms and Definitions

- **Event:** The term 'event' is used here to signify any incident or occurrence that has the potential to cause harm and/or has caused harm to a person or persons. This might happen as a consequence of an intervention, relating to a piece of equipment and/or as a consequence of the working environment.
- **SI:** Serious Incident requiring investigation is defined as an incident that occurred in relation to NHS funded services and care resulting in; unexpected or avoidable death, permanent harm, a scenario that prevents a provider organisations ability to continue to deliver health care services, a person suffering from abuse, never events and adverse media coverage. (Please refer to the NPSA National Framework for full definition):  
<http://www.npsa.nhs.uk/nrls/reporting/patient-safety-direct/>
- **Complaint:** In general use, a complaint is an expression of dissatisfaction. All complaints should always be considered in relation to safeguarding particularly when the complaint involves poor care, poor care culture, neglect or omissions.
- **Patient Related Incident:** A patient incident is an incident that has occurred in an environment where health care is provided. It may be as a result of prescribed or unprescribed care, administration of procedures and interventions. For example 'trips' and 'falls', a medication error, shortage of staff, incorrect procedure, an episode of aggression, unsafe storage of equipment etc.
- **PET:** 'Patient Experience Teams' are being developed in some organisations to help to implement a set of behaviours in the NHS that will improve the emotional experience for patients.
- **PALs:** PALs often diffuse potential complaints and are able to work with teams to identify concerns from the patient/public perspective. Some of the concerns may require a formal report.
- **Whistle blowing:** Whistle blowing policies and procedures are in place to enable staff to raise serious concerns that cannot or have not been addressed through normal line management routes. The issues raised through whistle blowing could be of a clinical nature or about the culture of care.
- **Significant Event:** A significant event is a term used by GP's to describe a positive or negative incident that has occurred in primary care and is similar to a patient incident report.
- **Safeguarding Team:** The safeguarding team varies from organisation to organisation. It could be a team of dedicated posts across health and social care, or a virtual team of people with safeguarding interest and expertise that form part of a local partnership with the safeguarding board at the local authority. Each local authority area has multiagency policies and procedures in place for safeguarding.
- **NPSA:** National Patient Safety Agency is the national reporting and learning service, which provides support, advice and guidance to NHS organisations to promote national learning from serious incidents.

## Clinical Governance and Adult Safeguarding- An Integrated Process

- **IO:** An investigating officer is an appropriate person across health and social care that has the skills and experience to undertake a comprehensive investigation of the incident using the appropriate tools e.g. Root cause analysis, *No secrets* policies and procedures.

### 9. Which Adults are Vulnerable?

- The Safeguarding Vulnerable Groups Act (2006) recognises that **any adult** receiving any form of healthcare is vulnerable.
- There is no formal definition of vulnerability within health care although some people receiving health care may be at greater risk from harm than others, sometimes as a complication of their presenting condition and their individual circumstances. The risks that increase a person's vulnerability should be appropriately assessed and identified by the health care professional at the first contact and continue throughout the care pathway.
- '*No secrets*' Definitions (DOH 2000), a vulnerable adult is a person aged 18 years or over, **"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"**.

### 10. What is Abuse?

- Abuse is a violation of an individual's human and civil rights by any other person or persons. Consideration needs to be given to a number of factors. Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

### 11. Forms of Abuse

1. Physical abuse, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions
2. Sexual abuse, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting
3. Psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks
4. Financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits
5. Neglect and acts of omission, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating
6. Discriminatory abuse, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

### 12. Neglect

• Neglect and poor professional practice also need to be taken into account. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems and this is sometimes referred to as institutional abuse.

### 13. References

- *No secrets*: Guidance on developing multi-agency policies and procedures to protect vulnerable adults from abuse (Department of Health and Home Office 2000)
- National Patient Safety Agency; (2010) National Framework for reporting and learning from serious incidents requiring investigation
- Safeguarding adults: report on the consultation on the review of No Secrets (DH 2009)
- Safeguarding Vulnerable Groups Act (2006)