Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Safeguarding and Protecting Vulnerable Adults in Wales

A review of the arrangements in place across the Welsh National Health Service

March 2010

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Contents

1. Background and introduction

"I drew the curtains and sat in the dark until 2.30am, stressed out."

1.1 The above quote is an extract from the journal of Fiona Pilkington who took her life and that of her 18 year old disabled daughter on 23 October 2007, following years of abuse by local hooligans. Fiona and her daughter Frankie were vulnerable and had been let down by local agencies who failed to take adequate action to protect them.

1.2 Sadly, during 2008-2009 there were 4,451[1] alleged cases of abuse of a vulnerable adult reported across Wales. The figures represented a 5% increase on cases reported the previous year with the most common victim of alleged abuse being an older woman. The next largest category of alleged victims of abuse is individuals with a learning disability. While Fiona and Frankie's tormentors and abusers were mindless local hooligans, for many other vulnerable adults their abusers are closer to home and may be loved ones or individuals into whose care they have been entrusted.

1.3 As is the case in relation to the safeguarding of children, those working in the healthcare sector have a key role to play in protecting vulnerable adults and identifying possible abuse. However, the understanding of who may be a vulnerable adult and what constitutes a safeguarding issue is less clear and while there is a growing acceptance that adult abuse exists, it is still not universally accepted as being a widespread issue.

1.4 Over the last three years Healthcare Inspectorate Wales (HIW)[2] has taken forward thematic reviews, inspections, investigations and Mental Health Act monitoring visits. These have unfortunately highlighted under-developed adult safeguarding arrangements and processes across NHS Wales and

[1] CSSIW Protection of Vulnerable Adults Monitoring Report 2008-2009

[2] A summary of the roles and responsibilities of HIW can be found at Appendix A

concerns in relation to the vulnerability of individuals accessing healthcare which are linked to issues of respect, privacy and dignity. It was imperative therefore that we further increased our focus on the safeguarding and protection arrangements that are in place for vulnerable adults.

1.5 In this report we have aimed to answer two simple but fundamentally important questions:

- *Are those working in healthcare organisations aware of their responsibilities in relation to the protection of vulnerable adults and do they know how to properly deal with suspected adult protection/safeguarding issues?*
- *Are vulnerable adults safe when accessing healthcare services?*

1.6 To enable us to answer these questions fully, in the spring of 2009 we visited every NHS Trust in Wales and a sample of 88 GP practices to look more closely at the arrangements that are in place to ensure the protection of vulnerable adults. In tandem we rolled out a programme of unannounced 'dignity and respect spot checks' that now form part of our routine work programme[3].

1.7 As part of our unannounced dignity and respect spot checks, we observe the general environment of care and the way patients are treated and spoken to. We also consider the level of training and awareness staff have in respect of adult protection and safeguarding issues, review patient records and care plans, interview staff and speak to patients, their carers and family members to assess how effective adult protection procedures and processes are in practice.

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[3] Our reports for individual NHS Trusts, Health Commission Wales and Local Health Boards can be accessed from our website www.hiw.org.uk or by writing to us at Healthcare Inspectorate Wales, Bevan House, Caerphilly Business Park, Van Road, Caerphilly, CF83 3ED.

1.8 In addition to these specific pieces of work, in preparing this report we have also drawn on the information gathered from various other work streams that we have taken forward over the past three years. A full description of the work that has helped form this report is provided at **Appendix B.**

2. National policy and legislation in Wales

National policy

2.1 The focus on the protection of vulnerable adults in health and social care policy increased significantly during the 1990s culminating in the publication, in 2000, of *In Safe Hands*[4]. This national guidance was issued following the social services White Paper *Building for the Future*[5], which raised awareness of the vulnerability of many adults particularly those who are older or have a learning disability.

2.2 In Wales, the guidance was issued under Section 7 of the Local Authority Social Services Act 1970, establishing the framework for the development of local policies and procedures for the protection of vulnerable adults and providing the basis for social services departments in Wales to co-ordinate a process of local policy development to prevent, identify, respond to and ameliorate abuse of vulnerable adults in all settings and to take appropriate action against perpetrators of abuse. Other agencies and organisations, including NHS bodies and the police, were expected to work co-operatively with local authority social services departments on the identification, investigation, treatment and prevention of abuse of vulnerable adults at the local level.

Legislation

2.3 While the legislative framework relating to safeguarding children is clear and well set out, in respect of the safeguarding of vulnerable adults it is less clear and un-coordinated. The main driver for improvements to adult

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[4] *In Safe Hands: Implementing Adult Protection Procedures in Wales*. National Assembly for Wales, July 2000. Supplementary guidance to *In Safe Hands* was subsequently issued on financial abuse, in 2003[4] and in 2009[4].

[5] *Social Services Building for the Future*. *A White Paper for Wales.* Presented to Parliament by the Secretary of State for Wales, March 1999. London: The Stationery Office. CM 4051

safeguarding arrangements across the UK has been the Human Rights Act 1998 as it ensures that the force of law is used to drive respect for the rights of individuals and provides a framework that encourages public bodies to have high standards of practice; placing a general common law 'duty of care' on them.

2.4 In 2000, requirements were placed on care providers outside of the NHS by the Care Standards Act 2000 and related regulations, to ensure that they had procedures in place to protect individuals under their care from the risk of harm or abuse. The only other piece of legislation that places a requirement on an individual or organisation to safeguard vulnerable adults from possible or actual harm is the Mental Capacity Act 2005[6]. This Act introduced two new offences of mistreatment and wilful neglect in respect of people who are considered to lack 'mental capacity'.

2.5 Many consider a key gap to be the development of legislation that places a statutory duty on the agencies involved in safeguarding adults to co-operate and work together. There has been much debate across the UK as to whether the requirement to safeguard adults should be placed on the same statutory basis as safeguarding children.

[6] S63 and Schedule 3 of the Mental Capacity Act 2005 give effect to the Convention on the International Protection of Adults, signed at The Hague on 13 January 2000

2.6 In recognition of the need to strengthen adult safeguarding policy and the related legislative framework, the Welsh Assembly Government commissioned the Welsh Institute for Health and Social Care at the University of Glamorgan, to undertake a review of the *In Safe Hands* guidance in order to judge its effectiveness, appropriateness and robustness, to ensure it reflects new legislation and to recommend improvements. The report of this review is due to be published in the spring. The review process has stimulated debate around the need for new legislation, clearer guidance and definitions, improved national arrangements and greater clarity for the public, NHS staff and regulators. The findings from this review will be fed to the University of Glamorgan team.

2.7 Similarly, earlier this year the Minister of State Department of Health published the Government's response to the review of the *No Secrets* guidance,[7] England's equivalent of *In Safe Hands* following national consultation. Key messages from this consultation include the need for stronger national leadership, for local arrangements to be placed on a statutory basis and for revision and updating of the *No Secrets* guidance. The review highlighted that adult safeguarding systems are under developed within the NHS in England and stressed the need to clarify the relationship between adult safeguarding, adverse incident reporting, patient safety, and complaints.

[7] Safeguarding adults: report on the consultation on the review of No Secrets. Department of Health July 17 2009

3. Are those working in healthcare organisations aware of their responsibilities in relation to the safeguarding and protection of vulnerable adults and do they know how to deal properly with adult protection concerns?

3.1 Our review work has highlighted that there is wide variation across NHS Wales, in relation to the extent to which *In Safe Hands* has been implemented and embedded. Although NHS organisations have signed up to local safeguarding procedures, there is insufficient knowledge of the issues at an operational level and a lack of emphasis on the need to comply with the procedures.

3.2 As part of our reviews we routinely ask staff if they understand who may be considered to be a 'vulnerable adult', test awareness of the local multi-agency procedures that they should follow and explore the knowledge and awareness they have of signs and symptoms of potential abuse. Our enquiries have highlighted that there is limited understanding amongst front-line staff of who and in what circumstances an individual may be considered to be a 'vulnerable adult'. Generally when asked, staff refer to older people, fewer mention people with disabilities or other impairments. In this respect we consider that while the *In Safe Hands* definition of a vulnerable adult [8] includes people with a physical or sensory disability, learning disability, mental health problems, including dementia and those who are old and frail, the restriction of this definition to situations and circumstances that focus on 'vulnerability' that is permanent, is unhelpful.

8 "a person 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 is or may be unable to take care of him or herself, or is unable to protect him or herself from significant harm or serious exploitation"

3.3 The reference in the definition to those in need of community care services is particularly unhelpful as it excludes those who are being cared for in hospital or at home by relatives. The recent report[9] on the consultation on the review of *No Secrets* the English equivalent of *In Safe Hands* has highlighted similar concerns and widespread support for the definition to be revised. The question of whether the definition should be revised in Wales will be picked up by the review, being conducted by the University of Glamorgan, which has been referred to earlier in this report.

3.4 There is no shared understanding across the NHS and its partner agencies as to what 'safeguarding' means in respect of adults and who may be vulnerable. This lack of a shared understanding leads to confusion and a lack of clarity in relation to roles and responsibilities and to poor reporting of POVA issues; as evidenced by the POVA referral data for 2008-09, which shows that only 7% of completed referrals originated from primary and community health care and 10% from secondary care.

3.5 The relatively low POVA referral rates from primary and secondary care highlight that there are issues in relation to the level of understanding of NHS staff of what constitutes a safeguarding issue and in particular what is abuse.

3.6 *In Safe Hands* defines abuse as "a violation of a person's human, civil or legal rights by another person or persons"[10]. Abuse may occur once, it may be repeated, or it may be multiple acts of abusive practice or behaviour. Abuse may be perpetrated as a result of deliberate intent, or of negligence or ignorance. Five categories of abuse are identified in *In Safe Hands*[11] :

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[9] Safeguarding Adults – Report on the Consultation on the review of 'No Secrets', 2009

[10] *In Safe Hands*, National Assembly for Wales, 2000, p14

[11] *In Safe Hands*, National Assembly for Wales, 2000, p14-15

- **physical abuse** including hitting, slapping, over or misuse of medication, undue restraint, or inappropriate sanctions;
- **sexual abuse,** including rape and sexual assault or sexual acts to which the vulnerable adult has not or could not consent and/or was pressured into consenting;
- **psychological abuse** including threats of harm or abandonment, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks;
- **financial or material abuse** including theft, fraud, pressure around wills, property or inheritance, misuse or misappropriation of benefits; and
- **neglect** including failure to access medical care or services, negligence in the face of risk-taking, failure to give prescribed medication, poor nutrition or lack of heating.

The wide ranging nature of abuse makes it difficult to spot, particularly when individuals are reluctant to raise concerns about a carer upon whom they have become reliant. Sometimes abuse and neglect is recognisable only with hindsight.

3.7 A large proportion of POVA referrals are made by the independent care home sector, many of the issues of concern highlighted by these referrals also arise in the NHS yet very few such referrals are made. NHS organisations and health professionals have difficulties grasping that poor practice and abuse occur within healthcare organisations themselves and this leads to abuse being underplayed as poor practice or a complication of treatment. Often there is genuine confusion amongst staff as to what constitutes a safeguarding issue as opposed to a clinical incident or complaint.

3.8 Some hospital and community staff are very good at responding to safeguarding issues in terms of documenting evidence, highlighting risks and vulnerabilities in care plans and reporting through appropriate channels. Others however take more of a “what can we do about it” attitude with little

awareness of their responsibilities under POVA or professional codes of conduct. In one investigation we carried out for example it was clearly demonstrated that staff, not recognising early signs of abuse, failed to institute POVA arrangements in respect of an individual who later became the victim of a homicide.

3.9 Awareness of signs and symptoms of potential abuse of a vulnerable adult requires an understanding of some of the risk factors a vulnerable adult may present with. The 2007 UK national prevalence survey of elder abuse in domestic settings showed that out of the four UK nations, Wales had the highest rate (6%) of abuse reported by people aged 66[12] and over. The prevalence of abuse has been found to increase with declining health and increasing age. Almost three quarters (70%) of older people reporting abuse across the UK had told someone like a health professional, social worker or family friend. The survey researchers estimated just 3 per cent of these reports resulted in referral into POVA systems. Greater awareness is needed not only amongst health and social care staff but also amongst the general public. A finding from the Modernising Adult Social Care Initiative[13] was that service users, carers and their families hold different views from those held by professionals about the meaning of the term 'adult protection' and have little awareness of systems that exist.

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[12] O'Keeffe, M., Hills, A., Doyle, M., McCreadie, C., Scholes, S., Constantine, R., Tinker, A., Manthorpe, J., & Biggs, S., Erens, B. (2007). *UK Study of Abuse and Neglect of Older People. Prevalence Survey Report.* London: Comic Relief, June. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076197

[13] Partnership and Regulation in Adult Protection: the effectiveness of multi-agency working and the regulatory framework in Adult protection. University of Sheffield, Kings College London and Social Care Workforce Research Unit. Funded by the Department of Health under the Modernising Adult Social Care Initiative, 2007.

We therefore recommend that:

POVA awareness training and what to do if abuse is suspected should be mandatory for those working in NHS organisations and contracted services. Update training should be undertaken at least every three years. The Welsh Assembly Government should ensure that nationally commissioned services reflect this requirement.

Training should address:

- ***the integration of incidents and complaints;***
- ***the sharing of information across and between organisations;***
- ***providing feedback to patients/service users and their relatives; and***
- ***the importance of ensuring dignity and respect.***

[Recommendation 1]

NHS organisations should test and evaluate the effectiveness of training on a regular basis; at least annually. **[Recommendation 2]**

GPs and independent contractors

3.10 Dentists, pharmacists, optometrists and in particular GPs have a key role to play in the safeguarding agenda as they are in an ideal position to identify safeguarding concerns, given their relationship with individual patients and their families. However our GP practice visits highlighted that awareness of adult safeguarding issues is inconsistent, with POVA procedures found to be unavailable in some practices and out of date in others. Only a small percentage of adult safeguarding referrals are made by GPs each year and more needs to be done to support independent contractors to fulfil the important role they have to play in relation to the adult safeguarding agenda.

3.11 Often the non-clinical staff working in GP practices, such as receptionists, will identify the early signs of vulnerability or abuse. However, they rarely report their concerns because they lack the confidence and support to do so. For this reason it is essential that administrative and support staff who come into contact with potentially vulnerable people are included in awareness raising and training programmes.

We therefore recommend that:

Health Boards should take further steps to raise awareness and levels of expertise in adult protection at GP and primary healthcare team level. Consideration should be given to include adult safeguarding measures in the Quality and Outcomes Framework (QOF).
[Recommendation 3]

Health boards should work with primary care contractors, particularly GPs, to ensure their engagement in adult protection multi agency groups. **[Recommendation 4]**

Accident & Emergency and Minor Injury Unit staff

3.12 The staff we spoke to across A&E and Minor Injury Units, generally had a good awareness of who may be a vulnerable adult, of what to do when they suspect abuse and what procedures to follow.

3.13 All-Wales POVA monitoring data show physical abuse of vulnerable adults is the category most often recorded in Wales and incidents of recorded abuse are most likely to be of people known to social services[14]. While it is unclear as to how many of the cases reported had involved an assessment by A&E or Minor Injury staff, it is reasonable to assume that many will have been. However, NHS organisations are not required (as they are with child protection) to ensure that at least one member of staff trained in POVA is on duty in A&E at all times. It is important that staff trained and aware of POVA issues and who are aware of the local referral arrangements are on duty in A&E and Minor Injury Units at all times to ensure that potential abuse is picked up and appropriate action taken.

We therefore recommend that:

Health boards should ensure that at least one member of staff trained in POVA is on duty in A&E and Minor Injury departments at all times.

[Recommendation 5]

Mental health and learning disability services

3.14 There are growing concerns, generally across the UK that the level of safeguarding referrals made by mental health and learning disability services are low and hence the level of abuse underestimated. This coupled with concerns in relation to the correct application of the Mental Capacity Act and related Deprivation of Liberty safeguards[15] leads us to consider mental health and learning disability services to be areas where a particular focus is needed.

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[14] *Protection of Vulnerable Adults Monitoring Report, 2007-2008.* Care and Social Services Inspectorate of Wales, January 2009.

[15] Mental Health Act 2005: Deprivation of Liberty safeguards.

3.15 There appears to be a lack of appreciation amongst some staff that assessment of 'capacity' is a decision that is time specific. We often see a blanket assumption that an individual has or doesn't have capacity. Some examples include patients with mental health problems being assessed as having capacity and providing consent for treatment but when we spoke to them they seemed unclear about their treatment or lacked insight. We have also identified examples of nurses administering medication to patients where appropriate capacity certification or consent was not in place.

We therefore recommend that:

All NHS organisations should have training in place in relation to Mental Capacity and Deprivation of Liberty safeguards. Such training should not be restricted to only those working in mental health.
[Recommendation 6]

Leadership and partnership working

3.16 Strong leadership is needed to drive the adult safeguarding agenda forward; there is a lot to be done. As we have stated earlier in this report there is no statutory duty placed on public bodies to cooperate in relation to the POVA or to investigate potential abuse of a vulnerable adult. Consequently, and in contrast to the children's safeguarding agenda, there is no statutory requirement on NHS organisations to appoint lead officers or to designate a lead for the POVA.

3.17 The new Health Boards and NHS Trusts will need to ensure that sufficient resource is made available to drive the adult safeguarding agenda forward and that sustainable structures are put in place. It is important that adult safeguarding is seen as everyone's business and that a team approach is encouraged. Boards should ensure that all staff are clear about their individual role and responsibilities in respect of safeguarding and that there are clear lines of accountability from the Board through to frontline staff.

3.18 It is pleasing to note that despite not being required to appoint a designated POVA lead, all NHS organisations in Wales have one. This is a significant step towards improving understanding of the adult safeguarding agenda across the NHS in Wales and ensuring that vulnerable adults are properly protected while accessing NHS services. However, according to recent research undertaken by the RCN[16] many POVA leads are relatively new to their positions and for that reason have only had time to focus on ensuring formal procedures are in place for such things as Criminal Record Bureau (CRB) checks.

3.19 Further, there is currently a risk across Wales that the focus on adult safeguarding issues could be further diluted as we are aware that some NHS organisations are considering combining the roles of child and adult protection leads into one. This would be a retrograde step as child and adult safeguarding issues are very different and require very different responses. The recent report on the consultation on the review of *No Secrets* highlighted many differences between child and adult protection and most importantly recorded that vulnerable adults do not want to be treated like children.

[16] Acting for Vulnerable Adults. Nursing Times. July 15 2008

We therefore recommend that:

The Board of every Welsh NHS organisation should ensure that:

- ***sufficient resources are made available to drive the adult safeguarding agenda forward;***
- ***sustainable safeguarding structures are put in place;***
- ***individual staff members are clear of their roles and responsibilities in relation to safeguarding; and***
- ***there are clear lines of accountability for adult safeguarding from the Board through to front line staff.***

[Recommendation 7]

Boards should ensure that the learning from POVA incidents and audits are used to improve safeguarding arrangements.

[Recommendation 8]

Partnership working

3.20 Good partnership working provides many benefits to the safeguarding agenda not least in terms of the:

- sharing of information;
- sharing of skills, knowledge and expertise; and
- shared decision making, ownership and responsibilities.

However, for the full benefits of partnership working to be realised there needs to be a commitment from all organisations involved to work together. This includes ensuring that the right level of resources is made available, that information is shared in a timely manner and that there is absolute clarity in relation to the roles and responsibilities of individuals and partnership organisations.

3.21 Following the publication of *In Safe Hands,* four regional adult protection forums were formed in Wales. Each regional forum has led the development of regional adult protection policies and procedures which are in line with the requirements of the national guidance. Each forum includes representation from social services, police and the NHS and has a remit that includes overseeing the implementation of adult protection policies and procedures developing multi agency training, and reviewing regional data to identify learning.

3.22 We have found that the level of commitment by NHS organisations, in terms of regular attendance at Forum meetings is variable. Often those NHS representatives in attendance do not have sufficient seniority to allow for effective decision making and are not in a position to influence at a strategic level within their own organisations.

3.23 In order to move the adult protection agenda forward NHS organisations must show commitment to partnership working through their support of Regional Adult Protection Forums and other multi agency groups such as Area Adult Protection Committees. This support must be demonstrated through regular attendance at multi agency groups and ensuring that those who attend are empowered to make decisions and share information.

We therefore recommend that:

NHS organisations should show commitment and support to Regional Adult Protection Forums and Area Adult Protection Committees by ensuring sufficient resources are made available and that a senior member of staff attends, who has in-depth knowledge of the safeguarding agenda and who is of sufficient seniority to make decisions and commit resources on behalf of their organisation.

[Recommendation 9]

4. Are vulnerable adults safe when accessing or visiting NHS services?

4.1 All NHS organisations and those who provide NHS services under contract, have a duty of care to those who enter or visit NHS premises. The most vulnerable groups of people in society are by definition, frail older people, those with a physical or sensory disability, mental health problem or learning disability and so, when assessing whether vulnerable adults are safe when accessing or visiting NHS services, we have focused on:

- the robustness of recruitment and vetting procedures;
- the suitability of the environment of care, including physical security;
- care and discharge planning;
- the security of patient information; and
- procedures for empowering individuals and for raising concerns.

The robustness of recruitment and vetting procedures

4.2 Many staff that are recruited or contracted to work in and for the NHS, may provide care to, or come in to contact with, an adult who is vulnerable and/or have access to their medical records. It is essential that procedures are put in place to ensure that this privileged position is not abused and that confidential and personal information is not misused.

4.3 Following Sir Michael Bichard's inquiry[17] published in 2004 there was much focus on the need for all public bodies employing staff who may come in contact with children and/or vulnerable adults to ensure that appropriate checks were undertaken prior to the employment of new staff. As a direct consequence in March 2005, the Welsh Assembly Government issued

[17] The Birchard Enquiry Report published on 22 June 2004. A public inquiry report on child protection procedures in Humberside Police and Cambridgeshire Constabulary.

guidance to the NHS[18] in the form of a Welsh Health Circular (WHC). This confirmed that Criminal Records Bureau (CRB) disclosures would become mandatory for all new, eligible staff. This included medical, nursing and other staff with direct patient contact and staff whose normal employment duties provide access to patients, for example, cleaners, porters and maintenance staff. In addition the circular advised that employers would need to consider vetting for contract staff such as electricians and plumbers and if required, the most appropriate level of disclosure.

4.4 While there is no specific legal requirement on NHS bodies to carry out retrospective (or periodic) CRB checks on staff, they should have appropriate policies and procedures in place to demonstrate how they make decisions based on risk in relation to which members of staff should be CRB checked and the frequency with which repeat checks on existing staff are undertaken[19].

[18] WHC (2005) 029 *Mandatory Criminal Records Bureau (CRB) Checks for All Eligible New NHS Staff*. Welsh Assembly Government,18 March.

[19] NHS staff will be introduced onto the Vetting and Barring Scheme (VBS) between 2011 and 2015. The VBS was introduced as a result of the Safeguarding Vulnerable Groups Act 2006, and is run by the Independent Safeguarding Authority (ISA). First registration with the ISA will include an enhanced CRB check.

4.5 The Rehabilitation of Offenders Act 1974 provides for anyone who has been convicted of a criminal offence and has been sentenced to less than two and a half years in prison, to be regarded as rehabilitated after a specified period of time with no further convictions. After this period of rehabilitation the conviction is considered as 'spent'. In normal circumstances, once a conviction is spent, the convicted person does not have to reveal this to a future employer when applying for a job. However, in order to protect the vulnerable, the Rehabilitation of Offenders Act 1974 (Exceptions) Order 1975 exempts some professions within the health and care sectors from this approach. Where posts have been identified as exempt under the Exceptions Order, employers are entitled to know about all previous convictions regardless as to whether they are considered 'spent' or 'unspent'. To justify the seeking of an Enhanced CRB Disclosure, as well as having access to patients in the course of normal duties, the position must involve regularly caring for, training, supervising or being in sole charge of persons aged under 18 or vulnerable adults.

4.6 By law, employers can only request a standard or enhanced disclosure for any position that is identified as exempt from the Act. For all other positions, employers may only request details of any unspent (current) convictions.

4.7 The NHS (General Medical Services) (Amendment) (No 2) (Wales) 2002 and NHS (General Medical Services Supplementary List) Wales Regulations 2002, introduced reforms to general practitioner listing in 2002. General Practitioners (GPs) are required to declare criminal convictions and other investigations into their professional behaviour. They are also required to provide references. Since 16 August 2002, all GPs applying for listing in Wales have consented to having a CRB check.

4.8 Since 1 April 2004, GPs applying to join a Health Boards medical performers' list have had to provide an Enhanced Disclosure as part of their application. As we reported in *our review of safeguarding and protection arrangements for children in the NHS*[20], our visits to NHS Trusts and a sample of GP practices in March and April 2009 found inconsistencies[21] in the way RB checks are undertaken across NHS Wales. We found staff, for example administrative and reception staff in primary care, who had never had a CRB check, others who had not been re-checked for many years and others who were uncertain if they had been checked or not. While checks are undertaken for new employees and when staff change jobs, the systems that are in place for updating checks are unclear.

4.9 The Vetting and Barring Scheme, introduced by provision of the Safeguarding Vulnerable Groups Act 2006 and run by the Independent Safeguarding Authority (ISA) came into effect on 12 October 2009. It is now a criminal offence for individuals barred by the ISA to work or apply to work with children or vulnerable adults in most NHS jobs. Employers face criminal sanctions for knowingly employing a barred individual. The three former barred lists (Protection of Children Act, Protection of Vulnerable Adults Act and List 99) have now been replaced by two new ISA-barred lists.

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[20] *Safeguarding and Protecting Children in Wales.* Healthcare Inspectorate Wales, October 2009.

[21] It should be noted that all Health Boards and Trusts comply with statutory requirements. The inconsistencies we have identified relate to steps being made to drive good practice that is above statutory requirements.

4.10 Employers, local authorities, professional regulators and other bodies now have a duty to refer to the ISA, information about individuals working with children or vulnerable adults where they consider them to have caused harm or pose a risk of harm. The ISA has responsibility for maintaining lists of people barred from working with vulnerable adults; these replace the POVA list which was introduced in 2004. Over time, all staff working with vulnerable adults will have to be ISA-registered.

We therefore recommend that:

All NHS organisations and NHS contracted services, ensure they have the necessary systems and procedures in place to demonstrate compliance with the Vetting and Barring Scheme, introduced in October 2009, under the Safeguarding Vulnerable Groups Act 2006.

[Recommendation 10]

Suitability of Environments of Care including physical security

4.11 It is important that individuals accessing healthcare feel safe and that the environment in which they are cared for keeps them safe. While *In Safe Hands* provides a definition of what constitutes a vulnerable adult it is recognised widely that this is very narrow and there is a growing understanding that vulnerability needn't be a permanent state and that any one of us may and can become vulnerable at a point in time. For example we may suffer from temporary confusion following a knock to the head or a reaction to medication. It is important therefore that all healthcare environments provide appropriate safeguards. One could say that just being 'a patient' makes you feel vulnerable.

4.12 To lessen the feeling of vulnerability and to ensure individuals are safeguarded staff must have a focus on maintaining the safety and dignity of all those who access NHS facilities. Thoughtful use of the environment of care

by NHS staff can help to maintain both safety and dignity. A great deal of work is being taken forward across NHS Wales in relation to dignity and respect not least Fundamental of Care[22] Audits which are helping to benchmark practice and drive improvement at ward level.

4.13 However, there is still a lot of work to be done to ensure equity and consistency of care. Our visits have highlighted some excellent environments of care. That said we also identified the environment of care and arrangements in place to manage gender mix have not been conducive to safeguarding those who are most vulnerable. Although most NHS organisations manage to limit the use of mixed sex bays to A&E and Medical Admission Units, mixed sex wards and mixed sex bathroom, shower and toilet facilities continue to exist. Such facilities seriously compromise the safety, privacy and dignity of patients and give rise to feelings of vulnerability.

4.14 We are particularly concerned about mental health services; both acute and elderly mental health. Mental health wards are often mixed gender[23] and patients with wide-ranging mental health issues are being cared for together, making the management of the environment of care difficult. The layout of some wards means that there are areas where staff observation is made difficult; there are particular problems at night when lights are dim. We are aware of several allegations of sexual abuse and intimidation being made by female patients in mental health settings and have found staff attitudes towards friendships and relationships between patients in mental health or learning disability settings to be variable. Staff must be alert at all times for the potential of abuse or harm and the vulnerability of older and female patients.

[22] Fundamentals of Care: Guidance for health and social care staff. Welsh Assembly Government, 2003.

[23] While wards are mixed gender, bedroom accommodation is single sex.

4.15 Older people with a mental health problem such as dementia often have long stays in hospital and it is important that the environment of care supports the maintenance of independence and encourages patients to bring familiar objects from home. However, wards are often 'clinical' without free access to outside space. The lack of windows and use of strip lighting makes it difficult for individuals to distinguish between night and day and confusion can increase quickly.

4.16 Our unannounced cleanliness spot checks have highlighted wards that are below expected cleanliness standards, are cluttered and in bad repair. Such environments do not support good care and dignity and respect is compromised.

We therefore recommend that:

NHS organisations should review their arrangements for the management of gender mix to ensure that they are appropriate and robust. The appropriate management of the safety and dignity of patients should be key to decisions made in relation to patient management. **[Recommendation 11]**

Ward layout and case mix should be considered as part of any patient risk assessment. **[Recommendation 12]**

Physical security

4.17 Generally we found the physical security arrangements in place on wards and units caring for vulnerable individuals to be appropriate. Exits and entries have appropriate security arrangements with supporting procedures that take account of Deprivation of Liberty safeguards.

4.18 Often staff have to manage a difficult balance in terms of the locking of wards to protect those who are vulnerable and the allowing of free access. This is a particular problem on mental health wards where you may have a patent mix that includes patients who are there on an informal basis and those who are detained under the Mental Health Act.

4.19 Staff have a duty of care to all patients under their care and must therefore ensure that they are aware of the whereabouts of patients at all times. We have identified many instances where both detained and informal patients have been able to leave wards unnoticed or unrecorded.

4.20 A particular example that highlights the potential safety issues caused by not having appropriate mechanisms in place is the death in 2009 of a patient detained under the Mental Health Act. This individual prior to his death had been granted two hours of unescorted leave from the ward each day, which he usually used to get a takeaway. On the day of his death he was not seen leaving the ward and when he was noted as not being on the ward, staff assumed he had gone out for his takeaway as normal. As no one knew the exact time of his leaving the ward concerns about his whereabouts were not raised immediately and there was a delay in action being taken to find out where he was. He was found dead later that evening.

We therefore recommend that:

NHS organisations must have clear 'locked door' and 'leave from ward' policies in place that comply with best practice in terms of patient safety and Deprivation of Liberty safeguards. **[Recommendation 13]**

Care and discharge planning

4.21 The responsibility of health professionals in relation to the safeguarding of vulnerable adults starts as soon as the individual is admitted into their care and does not stop when that individual is ready for discharge. Health professionals have a responsibility to ensure that appropriate and safe care and discharge arrangements are put in place.

4.22 While there are some excellent examples of coordinated care and discharge planning, often there are gaps and shortcomings. Generally, for example, we have found that while religious and cultural issues and preferences are noted in care plans, little is done to take them forward. One of the key gaps we have identified across mental health and learning disability services is in respect of therapeutic support and stimulation, which leads to greater confusion amongst those with dementia and those with a learning disability not achieving their full potential. The lack of stimulating therapies and exercises leads to individuals becoming 'institutionalised' quite quickly and gives rise to behavioural issues which are often managed by medication.

4.23 Planning for discharge should commence prior to any elective admission and immediately upon any emergency admission. However, we have noted many instances when discharge planning has been delayed due to late and uncoordinated care planning. Such delays combined with a lack of therapeutic support have a major impact on individuals, particularly those who are older. We have seen and been told of many examples where individuals, while having lived relatively independently prior to admission to hospital, have become so institutionalised that they can only be discharged to a care home. One has to question whether the NHS's approach to 'caring' can sometimes have a negative impact on an individual's independence.

4.24 We have also been alerted to a number of incidents where older vulnerable people have been discharged from hospital at inappropriate times of the day to unsafe home environments. For example, an elderly lady was

discharged from an acute hospital late on a Friday afternoon to a home that had no heating, where there was no food and no family or support services available to ensure her well-being. Sadly, this is just one example of a number of similar stories related to us by patients and carers.

4.25 We are also aware of individuals suspected of being in a vulnerable situation at home not being appropriately supported and a POVA referral not being made. Staff do not always consider acting in relation to the risks that may impact on an individual on discharge from hospital. In particular, our review of Substance Misuse services highlighted weaknesses in the risk assessment arrangements in place for people on opiate substitute programmes (methadone).

4.26 A key factor in the consideration and implementation of discharge arrangements for individuals who have challenging and/or abusive behaviour is the risk to their carer. Often the carers of adults with a learning disability or mental health problem are their elderly parents or elderly spouse. Sometimes carers, through a lack of consideration of their support needs, may also become vulnerable.

4.27 Our review work has identified little evidence of carer assessments being undertaken. It is fundamentally important that these assessments are made and regularly revisited as they are key to establishing whether the carer is vulnerable and also to identify early signs of crisis so that respite and support can be provided. Many cases of abuse and neglect arise because proper support is not provided to carers; they become tired and frustrated and may lash out.

4.28 Appropriate risk assessment, management and care planning is integral to the protection of vulnerable adults and there needs to be greater focus on these issues across the NHS in Wales.

We therefore recommend that:

All NHS organisations must put robust risk assessment, management and care planning processes in place to ensure that those who are vulnerable or who are likely to become vulnerable are appropriately safeguarded. Carer assessments should form part of these processes. **[Recommendation 14]**

Security of patient information

4.29 Arrangements in place for computer and paper records have generally improved over the last few years. Access to computer records is password-protected and paper records appear, generally, to be secure. That said, we are aware of occasions when patient records have been lost or mislaid and all staff need to be vigilant, ensuring that they do not leave patient records unattended at any time, especially during busy clinics and ward rounds.

4.30 In general practice, medical records are generally stored away from patient areas and computer screens are not visible to patients. We have however found examples of poor practice in primary care such as paper records stored on shelves behind an open reception desk, open boxes for prescriptions patient health details left unattended and visible.

We therefore recommend that:

All healthcare staff including independent contractors must put systems and processes in place to ensure that patient records, prescriptions and other confidential information is not visible to the public or anyone who has no right to see it. **[Recommendation 15]**

Procedures for empowering those who are vulnerable and for raising concerns

4.31 One of the most important aspects of safeguarding is ensuring that those who are vulnerable are given a voice. There are various mechanisms in place for members of the public, a vulnerable adult or member of staff to raise concerns about the care and treatment generally within the NHS and specifically about the potential abuse of a vulnerable adult. However, such guidance is not always easily accessible or in formats that are easily understood.

4.32 The tendency for vulnerable adults to be spoken to and examined in the presence of their carer or relative does not give them the opportunity to raise issues about their carer, should they be neglecting of abusing them. It is a particular issue for ethnic minority groups where carers and relatives are often used as translators. Further, the limited availability of advocacy support generally across Wales means that vulnerable adults often have no one to support them to raise concerns about their care.

4.33 We have mentioned earlier our concerns that the belief of NHS staff that everyone in the NHS is there to 'do their best' is impacting on the level of POVA referrals and this means that they do not probe or take allegations of abuse or neglect by colleagues seriously. Often those with a mental health issue or learning disability are regarded as being 'unreliable witnesses' and so their concerns and allegations are not properly investigated. Also they are often afraid to raise their concerns in case they are punished for raising them.

4.34 The Nursing and Midwifery Council is currently consulting on new guidance for nurse and midwives on how to raise concerns. It is focussed on supporting staff to better understand worries and concerns and aims to provide guidance on how and when to escalate through the most appropriate channels. This guidance is a useful step forward.

We therefore recommend that:

NHS organisations must ensure that those who are vulnerable are given 'a voice' by putting mechanisms in place that provide support to enable them to raise concerns. Such mechanisms should include advocacy arrangements and opportunities to discuss issues with individuals without carers or relatives present. Adequate translation services are needed to do this. **[Recommendation 16]**

NHS organisations should ensure guidance is in place for staff to enable them to be empowered to raise concerns about colleagues. **[Recommendation 17]**

NHS organisations must ensure that they publicise across local communities, primary and secondary care, how concerns about care and treatment of vulnerable adults within the NHS or of potential abuse of a vulnerable adult, can be raised. **[Recommendation 18]**

NHS organisations must ensure that service users and their carers or families are given the opportunity for involvement in adult protection processes and are kept fully informed. **[Recommendation 19]**

5. Conclusion and next steps

5.1 It has been ten years since the publication of the national adult protection guidance *In Safe Hands* and we had hoped that the cornerstones of effective adult safeguarding, such as sound and consistent training, awareness of signs and symptoms of potential abuse, knowledge and understanding of local policies, procedures and processes, would have been better embedded across the NHS in Wales.

5.2 While the NHS, as a partner in local and regional adult protection multi-agency arrangements, has systems, structures and processes in places to disseminate POVA guidance and offer training, little monitoring or evaluation of training takes place, Further, little monitoring and testing of staff awareness and compliance with safeguarding requirements happens. Consequently, awareness of vulnerability in adults, understanding of signs and symptoms of abuse and application of POVA procedures are extremely variable.

5.3 Systems and processes to train and equip staff to protect vulnerable adults are necessary but achieve little if staff, including administrative and other non-clinical staff, do not take up training or have the confidence in their own decision making to use the referral procedures. Therefore tools to assist decision making and a campaign to raise awareness about how to raise concerns is necessary in addition to strengthened training strategies.

5.4 Proactive leadership and management are necessary to ensure that safeguarding is understood and vulnerable adults properly safeguarded.

5.5 In order to move forward, policy makers need to identify the reasons why the NHS in Wales has not grasped and progressed the adult safeguarding agenda. Possible reasons may include a lack of ownership by the NHS because the requirement to coordinate multi-agency work has been placed firmly in the lap of Local Authorities under *In Safe Hands*. It is also possible that the important role that the NHS has to play in identifying and reporting

abuse in adults was not fully recognised in this early guidance. There is an opportunity now to rectify this for both the NHS and Welsh Assembly Government policy makers.

5.6 The NHS has an important role to play in identifying and reporting abuse but it needs to accept that a key part of that role is ensuring that vulnerable adults are safeguarded when accessing healthcare. Before this responsibility can be taken forward fully those working in healthcare need to accept that poor care - whether it be over medicating an elderly patient with dementia; not providing therapeutic support and stimulation so that confusion increases and independence is lost earlier; not providing sufficient pain relief or leaving a patient on a commode for longer than necessary constitutes neglect and at its worst abuse.

5.7 NHS staff also need to understand that 'vulnerability' is not just something that older people or individuals with a learning disability or a mental health issue experience. Anyone of us may become 'vulnerable' in an instant through a knock to the head, an allergic reaction to medication or by being 'spiked' on a night out. It is important that we are all alert to safeguarding issues and work together to get it right.

Appendix A

The roles and responsibilities of Healthcare Inspectorate Wales

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of all healthcare in Wales. HIW's primary focus is on:

- making a significant contribution to improving the safety and quality of healthcare services in Wales;
- improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative and employee;
- strengthening the voice of patients and the public in the way health services are reviewed; and
- ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all;

HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Assembly Government and healthcare providers that services are safe and good quality. Services are reviewed against a range of published standards, policies, guidance and regulations. As part of this work HIW will seek to identify and support improvements in services and the actions required to achieve this. If necessary, HIW will undertake special reviews and investigations where there appears to be systematic failures in delivering healthcare services to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent healthcare providers in Wales and is the Local Supervising Authority for the statutory supervision of midwives.

HIW carries out its functions on behalf of Welsh Minister and, although part of the Welsh Assembly Government, protocols have been established to safeguard its operational autonomy. HIW's main functions and responsibilities are drawn from the following legislation:

- Health and Social Care (Community Health and Standards) Act 2003;
- Care Standards Act 2000 and associated regulations;
- Mental Health Act 1983 and the Mental Health Act 2007;
- Statutory Supervision of Midwives as set out in Articles 42 and 43 of the Nursing and Midwifery Order 2001; and
- Ionising Radiation (Medical Exposure) Regulations 2000 and Amendment Regulations 2006.

HIW works closely with other inspectorates and regulators in carrying out cross sector reviews in social care, education and criminal justice and in developing more proportionate and co-ordinated approaches to the review and regulation of healthcare in Wales.

Appendix B

Summary of the work that has helped form this report

Unannounced review visits made during 2009

Departments and GP practices visited during March and April 2009

As part of our review of adult protection arrangements, the following surgeries, departments and wards were visited during March and April 2009.

Abertawe Bro Morgannwg University NHS Trust	▪ Accident and Emergency (A&E) Department at the Princess of Wales Hospital. ▪ Minor Injuries Unit at Neath Port Talbot Hospital. ▪ Elderly Mental Health Wards at Glanrhyd, Tonna and Maesteg Community Hospitals. ▪ Acute Medicine Ward at the Princess of Wales Hospital. ▪ Medical Admissions Unit at Neath Port Talbot Hospital.
Cardiff and Vale NHS Trust	▪ Accident and Emergency (A&E) Department at the University Hospital of Wales (UHW) and Minor Injuries Unit at Barry Hospital. ▪ Elderly Mental Health Wards at St. David's and Barry Hospitals. ▪ Medical Admissions Units (MAU) at the University Hospital of Wales (UHW) and Llandough Hospital. ▪ Elderly Medical Ward E6 and Medical Ward W1 at Llandough Hospital. ▪ Medical Ward C7 at UHW
Cwm Taf NHS Trust	▪ Accident and Emergency (A&E) Departments at Royal Glamorgan and Prince Charles' hospitals. ▪ Minor Injuries Units at Llwynypia and Aberdare hospitals. ▪ Elderly Mental Health Ward at Dewi Sant and St Tydfil's hospitals. ▪ General Medical Ward at Prince Charles' Hospital. ▪ Medical Assessment units at Royal Glamorgan and Prince Charles' Hospital. ▪ Cardiac Ward at Royal Glamorgan Hospital.

Gwent Healthcare NHS Trust	▪ A&E Departments at Caerphilly Miners Hospital, the Royal Gwent Hospital and Nevill Hall Hospital. ▪ MIU departments at County Hospital, Chepstow Community Hospital and Monnow Vale Health and Social Care Centre. ▪ Elderly Mental Health Wards at Chepstow Community Hospital, Maindiff Court Hospital, County Hospital Pontypool, St Woolos Hospital and Ystrad Mynach Hospital. ▪ Acute Medicine Wards at Nevill Hall Hospital, the Royal Gwent Hospital and Caerphilly Miners Hospital.
Hywel Dda NHS Trust	▪ Accident and Emergency (A&E) Departments at: West Wales General Hospital, Prince Phillip Hospital, Withybush General Hospital, Bronglais General Hospital. ▪ Elderly Mental Health Wards at: West Wales General Hospital (Morlais Ward), Prince Phillip Hospital (Bryngolau Ward), Bronglais General Hospital (Enlli Ward) and Bro Cerwyn Hospital (St Nons Ward), ▪ Acute Medical Wards at: West Wales General Hospital (Steffan Ward), Bronglais General Hospital (Iorwerth Ward), Withybush General Hospital (Ward 7 and the Acute Clinical Decision Unit), ▪ Minor Injuries Units at: Llandovery Hospital, Tenby Cottage Hospital, South Pembrokeshire Hospital and Cardigan Memorial & District Hospital.
North West Wales NHS Trust	▪ Accident and Emergency (A&E) Departments at: Ysbyty Gwynedd. ▪ Elderly Mental Health Wards at Ysbyty Gwynedd, Penrhos Stanley Hospital and Llandudno Hospital. ▪ Acute Medical Wards at Ysbyty Gwynedd, and Llandudno Hospital. ▪ Minor Injuries Units at Llandudno Hospital and Penrhos Stanley Hospital.

North Wales NHS Trust	▪ Accident and Emergency (A&E) Departments at Wrexham Maelor and Ysbyty Glan Clwyd. ▪ Medical Assessment Units at Wrexham Maelor and Ysbyty Glan Clwyd. ▪ Acute Medical Wards at Wrexham Maelor and Ysbyty Glan Clwyd. ▪ Elderly Mental Health Wards at Wrexham Maelor, Ysbyty Glan Clwyd, Glan Traeth (Rhyl). ▪ Holywell Hospital, Flint Hospital, Denbighshire Infirmary and Ruthin Community Hospital. ▪ Minor Injuries Unit at Holywell Hospital, Flint Hospital, Mold Hospital, Denbighshire Infirmary and Ruthin Community Hospital.
Cancer Centre of the Velindre NHS Trust	▪ Princess Margaret, Chemotherapy Ward. ▪ First Floor Ward (General Oncology). ▪ Acute Support Unit (Palliative Care and Oncology). ▪ Outpatients Department (OPD). ▪ Ambulance Patient Transport Reception (within OPD).

GP Practices

Anglesey	▪ Coed y Glyn surgery, Church Street ▪ Benllech surgery ▪ Amlwch surgery
Bridgend	▪ New Street Surgery ▪ Nantyffyllon surgery ▪ Ashfield surgery ▪ Newcastle surgery ▪ Llynfi surgery
Blaenau Gwent	▪ Llanhilleth ▪ Aparavita surgery ▪ Blaina Medical Centre ▪ Six Bells, Abertillery ▪ The Bridge Centre, Foundry Bridge
Cardiff	▪ Birchgrove Surgey ▪ Cathays Surgery ▪ Cliften Surgery ▪ Grange Surgery ▪ North Road Practice ▪ Grange Medical Practice ▪ Llwyncelyn Surgery ▪ Danescourt Surgery ▪ Greenmount Surgery ▪ Meddy Cannce Surgery ▪ Ely Bridge Surgery ▪ Fairwater Health Centre

	▪ Landowne Surgery ▪ Brynderwen Surgery ▪ Llanrumney Medical Group ▪ Llanederyn Health Centre ▪ Crws Medical Group ▪ Llwynbedw Medical Centre ▪ Llanishen Court Surgery ▪ North Cardiff Medical Group
Ceredigion	▪ Ashleigh surgery ▪ Oxford Street surgery ▪ Ystwyth Medical Group ▪ Llanilar
Gwynedd	▪ Meddygfa Deiniol ▪ Minfor Surgery ▪ Victoria Place, ▪ Meddygfa Rhydbach ▪ Bron Seiont ▪ Market Street Surgery ▪ Ty Doctor ▪ Felinheli Surgery ▪ Menai Bridge
Merthyr Tydfil	▪ Pantglas surgery ▪ Bridge Street ▪ Cardiff Road surgery
Neath Port Talbot	▪ High Street Practice, Glyngarth ▪ Health Centre, Glyncorrwg ▪ Gwilym Road Surgery ▪ Alfred Street ▪ Ystalyfera surgery ▪ Cymmer Health Centre
Powys	▪ Wylcwm Street surgery ▪ Haygarth Medical Centre ▪ Glaudwr Park Surgery ▪ Glantwymaen Surgery ▪ Rhyader Group Practice ▪ Llanidloes Health Centre ▪ Machynlleth Health Centre
Rhondda Cynnon Taff	▪ Tylorstown surgery ▪ Greenfield Porth ▪ Penrhiwceiber Medical Practice ▪ Regent Street ▪ Cwmaman surgery ▪ New Trap surgery ▪ Maerdy place surgery ▪ Taff Valley practice

Swansea	▪ Sway Road practice ▪ Llwyn Brwydrau, Llansamlet ▪ High Street, Swansea ▪ Cwmfelin Medical Centre ▪ Clydach, Swansea ▪ Port Tennant Surgery ▪ Gowerton Medical Centre ▪ Kings Road surgery, Mumbles ▪ Greenhill Medical Centre ▪ Penybryn surgery
Vale of Glamorgan	▪ Vale Family Practice Barry ▪ High Street Practice, Barry ▪ Highlight Park, Barry ▪ Waterfront, Barry ▪ Cowbridge & Vale

Unannounced 'dignity and respect' visits made during October-December 2009

St David's Hospital, Cardiff	▪ Hamadryad and Glan Ely wards
St Tydfil's Hospital, Merthyr Tydfil	▪ Cwmdare and Trecynon wards
Royal Alexandra and Colwyn Bay community hospitals	▪ Glan Traeth and Bryn Hesketh wards
Chepstow Community Hospital, Monmouthshire	▪ Llanvair and St Pierre wards
Brecon War Memorial Hospital, Powys	▪ Crug and Bannau wards
Ystrad Mynach Hospital, Caerphilly	▪ Heddfan, Anwylfan, Ty Glas, Bron Cartref and Glyn Mynach wards
Ystradgynlais	▪ Tawe Ward and Day Hospital

Appendix C

Summary of recommendations

1.	POVA awareness training, and of what to do if abuse is suspected, should be mandatory for those working in NHS organisations and contracted services. Update training should be undertaken at least every three years. The Welsh Assembly Government should ensure that nationally commissioned services reflect this requirement. Training should address: ▪ the integration of incidents and complaints; ▪ the sharing of information across and between organisations; ▪ providing feedback to patients/service users and their relatives; and ▪ the importance of ensuring dignity and respect.
2.	NHS organisations should test and evaluate the effectiveness of training on a regular basis; at least annually.
3.	Health Boards should take further steps to raise awareness and levels of expertise in adult protection at GP and primary healthcare team level. Consideration should be given to include adult safeguarding measures in the Quality and Outcomes Framework (QOF)
4.	Health boards should work with primary care contractors, particularly GPs, to ensure their engagement in adult protection multi agency groups.
5.	Health boards should ensure that at least one member of staff trained in POVA is on duty in A&E and Minor Injury departments at all times.

6.	All NHS organisations should have training in place in relation to Mental Health Capacity and Deprivation of Liberty safeguards. Such training should not be restricted to only those working in mental health.
7.	The Board of every Welsh NHS organisation should ensure that: ▪ sufficient resources are made available to drive the adult safeguarding agenda forward; ▪ sustainable safeguarding structures are put in place; ▪ individual staff members are clear of their roles and responsibilities in relation to safeguarding; and ▪ there are clear lines of accountability for adult safeguarding from the Board through to front line staff.
8.	Boards should ensure that the learning from POVA incidents and audits are used to improve safeguarding arrangements.
9.	NHS organisations should show commitment and support to Regional Adult Protection Forums and Area Adult Protection Committees by ensuring sufficient resources are made available and that a senior member of staff attends, who has in-depth knowledge of the safeguarding agenda and who is of sufficient seniority to make decisions and commit resources on behalf of their organisation.
10.	All NHS organisations and NHS contracted services, ensure they have the necessary systems and procedures in place to demonstrate compliance with the Vetting and Barring Scheme, introduced in October 2009, under the Safeguarding Vulnerable Groups Act 2006.
11.	NHS organisations should review their arrangements for the management of gender mix to ensure that they are appropriate and robust. The appropriate management of the safety and dignity of patients should be key to decisions made in relation to patient management.
12.	The ward layout and case mix should be considered as part of any patient risk assessment.

13.	NHS organisations must have clear 'locked door' and 'leave from ward' policies in place that comply with best practice in terms of patient safety and Deprivation of Liberty safeguards.
14.	All NHS organisations must put robust risk assessment, management and care planning processes in place to ensure that those who are vulnerable or who are likely to become vulnerable are appropriately safeguarded. Carer assessments should form part of these processes.
15.	All healthcare staff including independent contractors must put systems and processes in place to ensure that patient records, prescriptions and other confidential information is not visible to the public or anyone who has no right to see it.
16.	NHS organisations must ensure that those who are vulnerable are given 'a voice' by putting mechanisms in place that provide support to enable them to raise concerns. Such mechanisms should include advocacy arrangements and opportunities to discuss issues with individuals without carers or relatives present. Adequate translation services are needed to do this.
17.	NHS organisations should ensure guidance is in place for staff to enable them to be empowered to raise concerns about colleagues.
18.	NHS organisations must ensure that they publicise across local communities, primary and secondary care how concerns about care and treatment of vulnerable adults within the NHS, or of potential abuse of a vulnerable adult, can be raised.
19.	NHS organisations must ensure that service users and their carers or families are given the opportunity for involvement in adult protection processes and are kept fully informed.

Appendix D

Glossary of terms used

Abuse –*In Safe Hands*[24] defines adult abuse as "a violation of an individual's human and civil rights by any other person or persons". Abuse may take different forms: **physical abuse** (e.g. hitting, slapping, over or misuse of medication, undue restraint, or inappropriate sanctions); **sexual abuse** (including rape and sexual assault); **psychological abuse (**including threats of harm or abandonment, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks); **financial or material abuse (**including theft, fraud, pressure around wills, property or inheritance, misuse or misappropriation of benefits); **neglect** (including failure to access medical care or services, negligence in the face of risk-taking, failure to give prescribed medication, poor nutrition or lack of heating).

Adult Protection Committees – each local authority social services department is required to establish a multi-agency Adult Protection Committee (APC) with members drawn from all key partner agencies (Social Services, Police, CSSIW, Health Boards) and such other agencies the APC sees fit. Each APC oversees the adult protection work in their local authority area, promoting prevention, effective investigation and appropriate aftercare for victims of abuse.

Clinical Governance - a "framework" through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish"[25] .

Clinical Information - (1) information about treatments given to a patient by a health professional. (2) Information about clinical practice collected by an organisation for management purposes.

Commissioning - the purpose of identifying local health needs, drawing up plans with strategic partners to meet those needs, identifying appropriate health services and making agreements with health service providers to ensure that services are delivered.

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[24] *In Safe Hands* (2000: 14-15).

[25] Quality Care and Clinical Excellence: NHS Wales. Cardiff: Welsh Office, August 1998.

Criminal Records Bureau (CRB) - an executive agency set up to help organisations make safer recruitment decisions by providing wider access to criminal record information. The CRB helps employers in the public, private and voluntary sectors identify candidates who may be unsuitable for certain work, especially that involving contact with children or other vulnerable members of society.

Data Protection - a requirement upon public bodies and others to act responsibly in managing personal data. Such responsibilities are covered by the Data Protection Act 1984 and the Computer Misuse Act 1990, designed to safeguard data held on individuals.

Deprivation of Liberty Safeguards (DOLs) Deprivation of Liberty safeguards were introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007. The DOL safeguards apply to anyone aged over 18 who suffers from a mental disorder or disability of the mind (such as dementia or a profound learning disability) and who lacks the capacity to give informed consent to arrangements made for their care and/or treatment and for whom deprivation of liberty is considered after independent assessment to be necessary in their best interests to protect them from harm. The safeguards cover patients in hospitals, and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements.

General Practitioners (GPs) - medically qualified practitioners who provide healthcare in the community.

Healthcare Standards - nationally agreed standards for healthcare providers to achieve.

Human Resources (HR) - the branch of management practice dedicated to recruitment of staff.

Information Management and Technology (IM&T) - the structures and systems through which an organisation manages data, information and knowledge to address the challenges it faces in providing services and ensure high quality outcomes.

Learning Disability - a term covering people with incomplete intellectual development who find some activities that involve thinking and understanding difficult, and who need additional help and support with their everyday lives. People with learning disabilities have difficulties understanding, learning and remembering new things, and in generalising any learning to new situations.

Local Health Boards (LHB) - the reorganisation of NHS Wales, which came into effect on October 1st 2009, has created single local health organisations. These are responsible for delivering all healthcare services within a geographical area, rather than the Trust and Local Health Board system that existed previously.

The seven Health Boards are:

- Aneurin Bevan Health Board;
- Abertawe Bro Morgannwg University Health Board;
- Cardiff & Vale University Health Board;
- Hywel Dda Health Board;
- Cwm Taf Health Board;
- Betsi Cadwaladr University Health Board; and
- Powys Teaching Health Board.

They are responsible for planning, designing, developing and securing delivery of primary, community, secondary care services and specialist and tertiary services for their areas, to meet identified local needs within the national policy and standards framework set out by the Minister.

There are in addition three specialist NHS Trusts:

- Welsh Ambulance Services NHS Trust;
- Velindre NHS Trust; and
- The Public Health Wales NHS Trust

National Health Service (NHS) Trusts – self-governing bodies within the NHS, which provided health services. Trusts employ a full range of healthcare professionals including doctors, nurses, dieticians, physiotherapists etc.

National Public Health Service (NPHS) - an NHS body bringing together the public health resources of the five former health authorities in Wales, which includes input from academic departments, with those of the Public Health Laboratory Service in Wales, which includes the Communicable Disease Surveillance Centre.

Local Authority - a local government body that is responsible for delivering public services to the people in its community. There are 22 local authorities in Wales.

Patient Involvement - the amount of participation that a patient can have in her/his care or treatment. It is often used to describe how patients can change, or have a say in the way that a service is provided or planned.

Primary Care - family health services provided by GPs, dentists, pharmacists, opticians, and others such as community nurses, physiotherapists and some social workers.

Quality Outcomes Framework (QOF) - rewards primary care teams for providing good quality care for their patients. The QOF has four “domains”: clinical, organisational, patient experience and additional services. Each domain is divided into areas (ten clinical, five organisational, two patient

experiences and four additional service areas) that are then further divided into individual indicators or standards in the four domains, each of which has a number of points allocated to it. The points in the original QOF reflect the amount and difficulty of the work required by the primary care team, in the area.

Regional Adult Protection Forums – four regional adult protection forums were formed in Wales following the publication of *In Safe hands*. Each region developed its own regional adult protection policy and procedures, in line with the requirements of the national guidance. The four regions have played a key role in developing, agreeing and implementing policies and procedures for the protection of vulnerable adults.

Secondary Care - specialist health care, usually provided in hospital after a referral from a GP or health professional.

Serious Case Review – unlike in safeguarding children, there is currently no mandatory requirement on Area Adult Protection Committees to conduct a review into the involvement of agencies and professionals with the child and family when a vulnerable adult dies, and abuse or neglect are known or suspected to be a factor in the death.

Social Services - the agency responsible for delivering personal care and support that is funded by local authorities.

Stakeholders - a range of people and organisations that are affected by, or have an interest in, the services offered by an organisation, in relation to health services includes, for example: patients, carers, staff, unions, voluntary organisations, community health councils, social services.

Vetting and Barring Scheme (VBS) was introduced under the Safeguarding Vulnerable Groups Act 2006 on 12 October 2009 and is run by the Independent Safeguarding Authority (ISA). It is a criminal offence for individuals barred by the ISA to work or apply to work with children or vulnerable adults in most NHS jobs. ISA-registration for the VBS will start for new workers or those moving jobs in July 2010; ISA-registration will become mandatory for these workers in November 2010. Other staff will be phased into the scheme from 2011.

Vulnerable adult – *in Safe Hands,* national guidance in place at the time this review was carried out, defines a vulnerable adult as:

> *"a person over 18 years of age 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 himself or herself, or unable to protect himself or herself against significant harm or serious exploitation"*
> *Law Commission (1997)*[26]*.*

People with learning disabilities or mental health problems, older people and disabled people may fall within this definition, particularly when their situation is complicated by additional factors, such as physical frailty or chronic illness, sensory impairment, challenging behaviour, social or emotional problems, poverty or homelessness.

Welsh Health Circular - a formal notice distributed by the Welsh Assembly Government for NHS and other interested officials.

[26] Lord Chancellor's Department (1997). *Who decides? Making decisions on behalf of mentally incapacitated adults*. London: HMSO. (Cm 3803.).