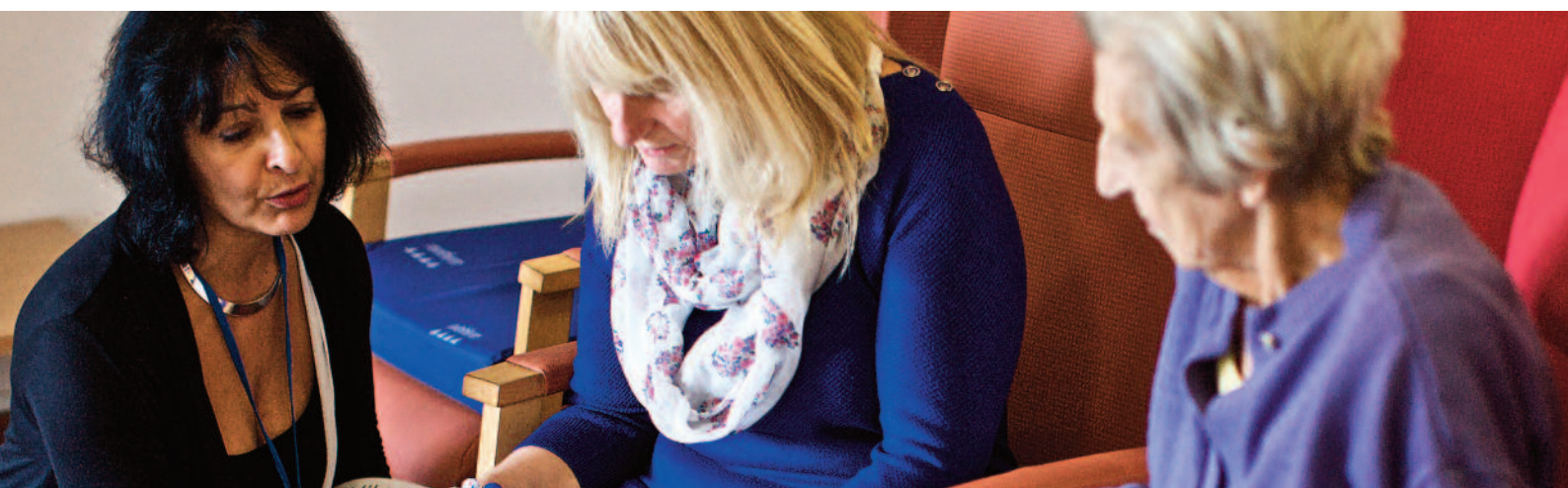


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SAFEGUARDING, SAFETY AND RISK

SCOPING REVIEW 13



PROFESSOR YVONNE BIRKS AND DR FIONA ASPINAL

THE UNIVERSITY *of York*



The School for Social Care Research

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Safeguarding, safety and risk: A scoping review

Context specific understanding and implications for application and learning in social, health and integrated care services

ABSTRACT

Keeping individuals safe from harm and exploitation is a clearly articulated goal within health and social care sectors. Two key terms associated with achieving this aim are safety and safeguarding, and these are commonly used in health and social care guidance and practice. Guidance refers to both these terms and outlines the steps providers need to take to ensure that they comply with regulations and manage risk appropriately. In practice, however, there appears to be little knowledge or exploration of how these two terms may be understood across different care contexts.

This review aims to redress a gap in the literature by exploring, through a scoping review of evidence, policy and guidance documents, the extent to which definitions, discussions and practice of safety and safeguarding across different care sectors are shared or may vary.

The findings suggest that health and social care may use and understand the terms safety and safeguarding differently: safeguarding in health appears to centre on abuse and neglect, while in social care the wider understanding of keeping people safe appears to be held. Despite the volume of health and social care literature that discusses safety, safeguarding and risk separately, there was little work that explicitly acknowledged the lack of congruence about how they were understood in different service contexts or that attempted to explore them in the context of integrated care.

In the light of the findings from this review, and as organisations and service provision become more integrated, it is essential that: clear and shared understandings of 'safety', 'safeguarding' and 'risk' are developed and that these definitions have resonance and can be owned by health and social care organisations and practitioners alike; more work is undertaken to understand the management and assessment of risk in the context of integrated service provision; shared and clear strategies are developed to help apply core principles for professional and organisational learning across different care environments; and the implications for a new agenda of personalisation of care in relation to risk and governance are explored.

KEYWORDS

safety, safeguarding, integrated services, risk

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1 Scope of this report

This report summarises a review that was undertaken to understand how the related concepts of safety and safeguarding might be understood in and across the health and social care contexts, especially in England. There is an extensive literature that deals with safety and safeguarding as separate concepts and in separate disciplinary fields, but our review concentrated on literature that focused on areas where both concepts may appear together. The literature included in this review is from a variety of sources but primarily includes guidance and policy documents, opinion pieces and limited evidence from research. The review aimed to explore how these two terms may be interpreted and understood with particular relevance to integration of services.

2 Introduction

Keeping individuals safe from harm and exploitation is a clearly articulated goal within health and social care sectors. Two key terms associated with achieving this aim, as illustrated in recent guidance from the Care Quality Commission (CQC) (Care Quality Commission 2010) are safety and safeguarding, and these are commonly used in health and social care guidance and practice.

Guidance refers to both these terms and outlines the steps providers need to take to ensure that they comply with regulations and manage risk appropriately. Recent guidance from the CQC (Care Quality Commission 2010) on quality and safety standards for those who deliver health and social care draws attention to the importance of both safety and safeguarding. In practice, however, there appears to be little knowledge or exploration of how these two terms may be understood across different care contexts. This review explored the literature to investigate conceptual understandings of safety and safeguarding in instances where both concepts are referred to together to ascertain how clear understandings of each concept are articulated across different sectors and locations of care provision.

This is particularly important in the current climate where there are continued and increasing calls for integrated service provision. However the challenge of delivering this has been acknowledged by a number of individuals and organisations (Ham and Smith 2010; Ham *et al.* 2011). Establishing the extent to which there is a shared understanding of concepts and approaches to governance would seem to be important and timely.

This review aims to redress a gap in the literature by exploring, through a scoping review of evidence, policy and guidance documents, the extent to which definitions, discussions and practice of safety and safeguarding across different care sectors are shared or may vary.

3 Integration background

Historically, health and social care policy has emphasised the importance of securing integration across and within health and social care boundaries (Lewis 2001). This emphasis on integration continues to be evident in current literature and policy and aims to remove unnecessary gaps and duplication between services by 'enabl[ing] partners to join together to design and deliver services around the needs of users rather than worrying about the boundaries of their organisations' (Darzi 2008 13–14).

There have been repeated attempts since the inception of the National Health Service (NHS) to facilitate integration by changing policy and directing practice (Lewis 2001). Across the policy environment there are frequent calls for the need to deliver 'seamless' care through integrated

approaches (National Collaboration for Integrated Care and Support 2013; Aspinall *et al.* 2014). However, problems in achieving integration have grown in recent years due to increased specialisation, technological advances, and changes to where care is delivered (Reid *et al.* 2002). In addition, changes to the English health and social care systems, which have resulted in a wider range of service providers, have increased the number of boundaries across which integration needs to occur. Achieving integration in this increasingly complex system has become more difficult to negotiate (Hardy *et al.* 1999; Mur-Veeman *et al.* 2003). Despite this, or perhaps because of the changing nature of provision, the importance of integration has been reiterated in recent policy changes (Department of Health 2011a, 2012b, a, c; NHS Networks 2015).

The mixed economy of social and health care provision in England means that it is perhaps more important than ever to ensure that all providers are delivering uniformly high quality and safe support and care to service users. Ensuring that commissioners, providers and practitioners in social and health care share an understanding of the concepts, approaches and governance processes that are in place to monitor and maintain the safety of service users is, therefore, of utmost importance.

Integration means different things to different people, including integration of organisations, providers and commissioning, improving collaboration and co-ordination with the voluntary and other sectors, or pooling budgets to create integrated health and social care funds. It may also mean integrating governance and regulatory systems. There is a dearth of literature exploring the similarities and differences in how the health and social care sectors deal with governance (i.e. the process through which services are governed). Different definitions and policy influences can lead to different structural and process-based responses to issues that arise with regard to keeping adults safe. Similarly, there is a lack of evidence about managing governance across sectoral boundaries to promote appropriate and consistent recording, learning and responding to safety/safeguarding concerns. With the move towards more integrated approaches to commissioning and service provision, the extent to which understanding of concepts such as safety and safeguarding are shared may prove to be part of the inherent challenge for service commissioners, managers and practitioners who are aiming to develop and deliver support that is more integrated.

4 Aims

This review aimed to investigate conceptual understandings of safety and safeguarding and the related concept of risk in different organisational contexts in an effort to assess whether any differences in understanding might influence the effectiveness of integrated service provision or act as barriers to closer working and integration of health and social care. It is important to note that while the concept of risk was not the primary focus of this review, the close relationship between risk and the key concepts of safety and safeguarding made it impossible to explore them without referring to evidence on risk and risk management.

We explored the existing literature to determine:

- how the terms 'safety' and 'safeguarding' (and 'risk') are used and understood in different contexts
- if, where, and how, they overlap and diverge
- how the governance of safety and safeguarding (and risk), are described in different contexts
- any implications of the prevailing understanding and the current governance of safety, safeguarding (and risk) for integrated service provision.

5 Method

Scoping methods

Scoping reviews are used to examine the extent, range and nature of research activity in a particular topic area and to summarise research findings (Arksey and O'Malley 2005; Levac *et al.* 2010). In addition, they can be used to clarify a complex concept and so refine subsequent research questions and studies (Davis *et al.* 2009). Given that the aim of this study was to establish the extent of shared understanding of the concepts and processes around safety and safeguarding and to identify robust research questions for future research in this field, a scoping review was considered to be appropriate in this instance.

Scoping review methods also allow researchers to collate and summarise a range of evidence, including empirical and other forms of less evidence-based material (Anderson *et al.* 2008; Davis *et al.* 2009). This was particularly important for this review given that a wide range of evidence sources, including policy, practice guidance and serious case reviews, were necessary if we were to be able to explore, clarify, define and develop the working definitions and conceptual boundaries of the topic area. The aims and search strategy were informed by initial reading of seminal documents, for example, the national response to Winterbourne View inquiry (Department of Health 2012d) and the No Secrets guidance (Department of Health 2000). While the review concerns itself chiefly with the integrated care context, seminal documents from social and health care contexts were reviewed to explore the nature of underlying conceptualisations which may have bearing on any ambiguity for integrated governance.

In this scoping review, we collated information from national policy reports, national guidance and case reviews as well as research evidence on:

- the conceptualisation of safety in different care settings
- the conceptualisation of safeguarding in different care settings
- governance approaches applied to safety, safeguarding (and risk) in different care settings.

Evidence searches

We identified published and unpublished literature by conducting systematic searches of electronic databases, consulting publications from experts in the field and reference checking of identified sources. A range of databases was searched to ensure coverage from the fields of social, health, nursing and allied health care. These included Social Policy and Practice (that is, relevant OVID databases), CINAHL Plus, Social Care Online, MEDLINE, PsychInfo, HMIC and Embase. In addition to their coverage of journal articles, the Social Care Online, Social Policy and Practice and HMIC databases provide some coverage of reports, including case reviews and policy/guidance documents, and unpublished documents. This meant that the available relevant grey literature could be reviewed.

Searches commenced in December 2013 and were restricted to English language publications and research carried out in England. This restriction was imposed because of the difficulties in assessing the relevance and applicability of research from different health and social care cultures and systems.

On all the databases, keyword searches were made for the three main concepts reported in this paper (safety, safeguarding and risk), with these searches limited by publication language (English) and publication year (1996-2014) for all databases. For the OVID databases and CINAHL Plus, we further limited these searches by population type (humans; adults (18+)). We initially intended to search only the literature that followed the publication of the 'No secrets' guidance in 2000

(Department of Health 2000). However, to ensure that we developed an understanding of the relevant policy and practice arena immediately prior to this publication, we extended the search years to 1996.

Initial searches identified a huge number of articles on the relevant concepts. The OVID database search returned over 2.5 million papers on risk, over 600,000 on safety and over 5,000 on safeguarding. For the CINAHL Plus database, the same keyword searches using the same limiters identified almost 130,000 articles on risk, almost 20,000 on safety, and 73 on safeguarding. To focus the search for this review, we combined the keyword searches using the 'and' function so that only evidence referring to all three concepts - 'safety', 'safeguarding' and 'risk' - and at least one health and/or social care setting was included.

The number of relevant articles identified through the database searches is reported in the findings section below.

Policy searches

We aimed to identify and review all relevant current policy documents on risk, safety and safeguarding in care settings. However, our systematic search strategy combining the three key concepts did not identify some of the key policy and guidance documents referring to safety or safeguarding that we were aware of. In response, we refined our search approach as recommended by Levac *et al.* (2010). As our starting point, we used several recent reports on safety and safeguarding in health and social care settings (including the report on Winterbourne View Hospital (Department of Health 2012d) and the Francis Report (Francis 2010)), in addition to seminal policy and guidance reports (including the Darzi Review (Darzi 2008), 'No Secrets' (Department of Health 2000), and 'An Organisation with a Memory' (Donaldson 2000)). We undertook web-based searches to identify other relevant national and local policy, national and local guidance and case review material. We used the reference lists from relevant material and links from websites to follow cases and identify further literature. This snowballing technique identified several additional relevant sources of evidence that the electronic database searches had not revealed.

The relevant material identified through these snowballing approaches is reported in the findings section below.

Inclusion strategy

Literature was assessed for relevance first by title, then abstract, then by reading the full text. When material was identified as relevant, details of the reference were recorded and the main findings summarised. The data were collated and analysed to understand the conceptualisations of safety, safeguarding and risk used in the material. Thematic analyses of findings and concepts were conducted to allow collation of evidence across different literature sources and types.

For publications falling outside of the research literature we used the same approach but also took into account the author or publisher of the material as part of our effort to assess the relevance of these types of publications. For example, we were aware that publications authored or published by the Office of the Public Guardian might contain relevant material. We assessed material for relevance first by title and author, then by executive summary and then by reading the full text. The conceptualisations of safety, safeguarding and risk and the recommendations for practice set out in the literature were collated and summarised. The policy arena was monitored throughout the research period in an effort to ensure that any relevant new policy was included.

Analysis

In line with scoping review methodology, we summarised the evidence from the different data sources and collated it around the key emergent themes. The findings of the thematic analysis are reported in the findings section below.

6 Findings and discussion

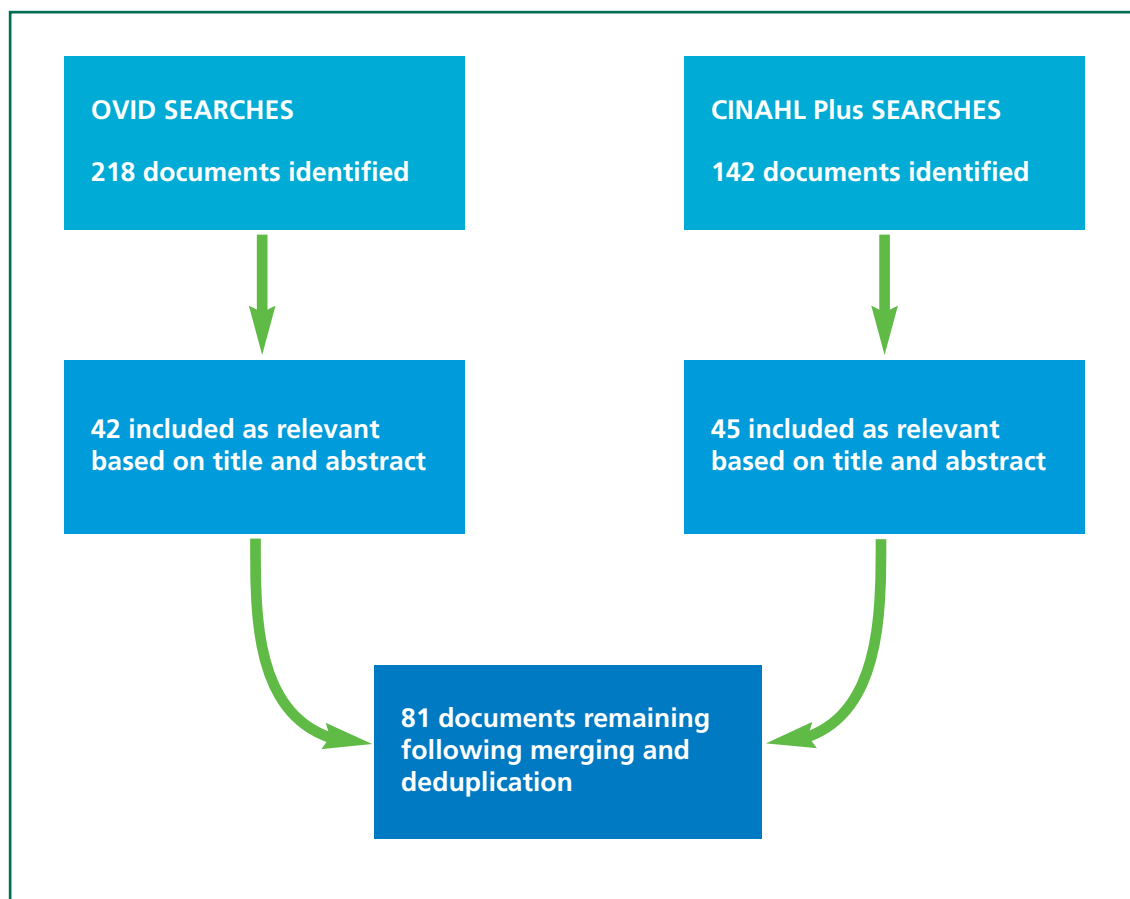
The findings are presented in two sections. The first presents the number of documents reviewed and the second is a thematic discussion of the key concepts and the governance processes identified from the range of literature sources.

Results from the literature searches

Figure 1 shows the number of articles included at each point in the data selection process. When the searches on each database were combined (that is, safety AND safeguarding AND risk) as outlined above, duplicates removed, and documents selected for relevance by reading the title and abstract, we were left with 81 articles (see figure 1).

After searching Social Care Online, using web-based search engines (for example, Google and Google Scholar) and checking the reference lists of included literature, we were able to include some additional literature. In total, we included 116 documents in the review.

Figure 1: Search results



Thematic findings

The findings that emerged from the review of the available literature are presented in three sections: definitions, governance and implications for integrated service provision. We acknowledge that other concepts, such as vulnerability and personalisation are also linked to this discussion. However, as they are outside the immediate scope of his review, we would not be able to do justice to the complexity of debates associated with these related concepts here.

Definitions

The terms safety, safeguarding and risk were rarely explicitly or consistently defined or delineated across the literature included in the review. Thus, identifying a clear and consistent conceptualisation or definition across the evidence from health and social care was not possible. The definitions presented here, therefore, derive from analysing the ways in which these terms were presented and discussed across the reviewed literature.

Risk

As outlined earlier, the purpose of this review was to help to understand the meaning and practice of safety and safeguarding within health and social care organisations. However, it was impossible to do so without considering the concept of risk because of its centrality to governance and the practice of safety and safeguarding; notably the links between risk assessment and its management and safety and safeguarding. This review did not intend to engage critically with the philosophical debates surrounding risk, but rather aimed to explore its meaning articulated through current policy and guidance on safety and safeguarding. Thus, it is important to understand the different ways in which 'risk' might be conceptualised.

Although discussions based on the notion of 'risk' are widespread in modern society (Giddens 1991; Beck 1992), no coherent definition of the concept of risk was presented across the literature we reviewed. Risk is complex and multidimensional, and the way in which it is conceptualised can be determined by cultural values and norms and historical events (Mitchell and Glendinning 2008). Lupton (1999) suggests that there are two broad approaches to conceptualising 'risk': technico-scientific and socio-cultural. In brief, technico-scientific approaches place importance on expert views, consider 'risk' an objective phenomenon and, as a result, assert that risk factors can be identified and risk-probabilities calculated. Socio-cultural approaches, on the other hand, assert that 'risk' is a subjective phenomenon that is influenced by an individual's social, cultural and economic context. These socio-cultural approaches, therefore, emphasise the importance of lay perspectives or of the 'individual' in understanding and responding to risk.

However, the safety and safeguarding literature that we reviewed for this study did not engage with, or indeed acknowledge, these (or other) different approaches to understanding risk. Rather, policy and practice guidance documents appeared to presume a shared understanding of risk and very few research papers, drew on these wider theoretical discourses around risk. An exception to this included work by Macdonald and Lang (2014) who applied risk theory to caregiver safety.

Despite the reviewed literature failing to acknowledge different conceptualisations of risk, employing a thematic analysis meant that we were able to identify tacit assumptions in the literature that linked with the broad conceptualisations outlined above. Generally, policy and practice guidance from social care tended to contextualise risk within the socio-cultural paradigm while that related to health care tended to contextualise risk within the technico-scientific conceptualisation. In the social care literature, for example, discussion about risk tended to be based at the individual level (socio-cultural approach) and in the health care literature it was based at the system level (technico-scientific approach). That these different interpretations of risk appear to be used but not explicitly acknowledged, is likely to have implications for how risk is governed,

particularly where service management and/or provision is integrated. Furthermore, how these different approaches to conceptualising risk play out in community-based health services, residential/in-patient social care settings or integrated services was unclear.

Safety and safeguarding

In the literature included in this review, the authors' understanding of the key concepts of safety and safeguarding were rarely explicitly set out, nor were attempts made to explain how these concepts related to each other. As with the concept of risk outlined above, authors tended to presume a common and general understanding of both concepts across different policy and practice contexts. The literature was clear that safety and safeguarding were both concerned with minimising risks and the harmful effects of taking risks; however, in common with the risk literature, there were inconsistencies in the way that safety and safeguarding were presented within documents and across the literature.

There were few attempts to explore the meaning of these two concepts, and no clear parameters of either concept were outlined. Where efforts were made to provide clear definitions, these tended to be definitions of safeguarding, which often focused on abuse rather than other types of harm, or descriptions of governance and risk management arrangements. In those documents that did present a definition of safeguarding, the precision and the parameters of these definitions often changed across the document.

Safety and safeguarding were used interchangeably within and between some of the documents that we reviewed. For example, in *Caring for Our Future: Reforming Care and Support*, (Department of Health 2012b) the section related to keeping people safe from harm only presented issues related to abuse and neglect and referenced the issues that had occurred at Winterbourne View and the subsequent responses. No references were made to, for example, accidental harm or harm resulting from choices made by service users.

Despite meeting the inclusion criteria (that is, the title and/or abstract indicated that both concepts would be discussed), some of the documents failed to engage with one of the concepts entirely. These documents were not subsequently excluded on this basis as this highlights an important finding: in those cases where only one concept was discussed, social care literature tended to focus on safeguarding, while health care literature focused on safety. Thus, ambiguity remained about the definitions of safety and safeguarding in different service contexts.

Some literature alluded to a hierarchical relationship between safety and safeguarding. Safeguarding was often used as an overarching concept that subsumed the conceptualisation and governance of several different but inter-related themes, including harm, risk, safety and adult protection (Morgan 2010). In this literature, which was mainly concerned with the organisation and provision of health care, safety was situated alongside adult protection as a sub-category of safeguarding. This conceptualisation of the relationship between safety and safeguarding is possibly attributable to the distinct health-based governance structures associated with different types of risk and harm. Throughout much of the literature this broad interpretation of safeguarding – that is, the view that safeguarding concerns all aspects of keeping people safe – was highlighted. In the social care literature, however, there was no evidence of safety and adult protection being distinguished. Indeed, the social care literature we reviewed did not engage with safety as a term per se. The effect that these interpretations might have on governance structures in different settings will be discussed later in this review.

In addition to this broad interpretation of safeguarding, a more nuanced understanding of safeguarding was also used. In this understanding, safeguarding was only mentioned when harm resulted from abuse and/or deliberate acts of harm and little, if any, explicit reference was made to harm that was accidental or resulted from system failures (Bonnerjea 2009). Indeed, the recent

CQC standards, while referring to both safety and safeguarding, only use safeguarding to refer to protecting people from abuse (see CQC (2010), item 7).

Across the literature, safeguarding appeared to be used to describe several distinct issues: risk factors (such as age or infirmity); types of abuse (such as emotional, physical or material abuse); and processes for assessing and managing risks (such as risk assessment processes). The latter of these, for example, was outlined in *Clinical Governance and Adult Safeguarding: an Integrated Process* (Morgan 2010), which maintains that safeguarding is the 'range of activity aimed at upholding an adult's fundamental right to be safe' (Williams 2010; Department of Health 2011c, b; Carr 2013).

The review shows that there appears to be some ambiguity around the conceptualisations of safety, safeguarding and risk. The documents we reviewed rarely included an adequate exposition or definition of these concepts or used them consistently between contexts. Indeed, the primary point of consistency across the literature is around safety, safeguarding and risk being treated as universally understood concepts in need of little or no elaboration. The different ways that these terms are conceived across health and social care policy and guidance, alongside the inconsistency we identified within and across documents, could pose challenges for governance, practice and learning around protecting adults from harm in different care environments. The literature we reviewed suggests that the discourses around risk, safety and safeguarding may not be consistent across health and social care, and given the move towards more integrated approaches to commissioning and provision of support, this might prove problematic for governance of risk and harm.

Governance of services

Managing risk and ensuring good quality service provision is essential if adults are to be protected from harm while under the care of health and social care services. This section outlines the issues related to governance that were highlighted through our review of the relevant practice and policy literature.

Risk management

Although this review focused primarily on safety and safeguarding, the conceptualisation and governance of risk is driven by the need to protect from and mitigate harms which may be as a result of lapses in safety and/or failure to safeguard individuals. The process by which an organisation assesses, monitors and deals with potential or actual risks to both individuals and their organisation is widely known as risk assessment and/or management. There are broadly two levels at which risk management can take place: the individual level and the organisation level.

The individual level requires that risks for a particular individual are assessed and that strategies are developed to help manage those risks. Assessments of individual risk aim to weigh the potential harms and side effects of any service, intervention or treatment against potential positive outcomes for service users. To ensure clients stay safe as they interact with services, organisations undertake such assessments of risk of both the likelihood and the consequence of a hazard being realised. 'The aim of risk assessment is to consider a situation, event or decision and identify where risks fall on the dimensions of 'likely or unlikely' and 'harmful or beneficial'. The aim of risk management is to devise strategies that will help move risk from the likely and harmful category to the unlikely or beneficial categories' (Whittington 2007). Traditionally, health and social care services aim to minimise risk, and pressure is placed on public services to adopt defensive risk management strategies (Power 2004) despite recognising that it is not possible to eliminate risk altogether.

More recently, and in line with the personalisation agenda, person-centred risk assessment has increasingly called for efforts to counter these traditional defensive approaches towards risk management (Titterton 2005). Individuals and organisations will often accept or discuss risk as part

of the process of trying to improve a service user's quality or length of life. This person-centred approach advocates models of assessment and support that are considered to be non-paternalistic. Policies calling on social care services, and more recently health care services, to increase service user choice have been accompanied by increased demands from service users for support so as to enable calculated and positive risk-taking (Department of Health 2005). Despite this, risk assessment and management, at least in health care organisations, seem to remain largely driven by the provider, with limited input from patients – an approach that contrasts with that implemented by social care organisations. In this context more emphasis is placed on an individual's ability to respond to risk and linking risk assessments more explicitly with the Mental Capacity Act (Graham *et al.* 2014).

The second level of risk management involves analyses of incidents across the system and/or organisations. In health care, risk and its management (for example, 'clinical risk', 'non-clinical risk' and the 'health and safety of patients'), is increasingly being replaced by the term 'patient safety' (Emanuel *et al.* 2008). In the health care environment, for example, the governance of patient safety aspires to promote a culture of learning about errors by encouraging transparency and openness in relation to reporting of adverse events and near misses, with the focus on systems failure rather than a single cause. The approach is modelled on other high risk industries (e.g. air travel, rail travel and the nuclear industry). Developing and establishing processes to promote organisational learning when errors occur, following up on incidents and implementing solutions to minimise their recurrence are central components of risk management and governance processes in both health and social care, but systems are not necessarily shared. Mechanisms for national reporting (and learning) are discussed later in this section but include reporting systems such as SARs (previously Abuse of Vulnerable Adults returns) in social care and systems such as the National Reporting and Learning System in health care.

Safety and safeguarding in health and social care

Our analysis of the literature indicated that different governance structures existed within and between health and social care organisations. These could be influenced by type of harm, degree of harm caused and wider contextual issues. This section summarises these different approaches to governance that within- and across-organisational analysis of the literature illustrated. It is important to note here, however, that while existing governance structures in the health care environment were widely described and discussed in the literature we reviewed, the same was not the case for social care. Instead, very little description or exploration was presented across the social care literature and, for that reason, we have had to make assumptions about safety and safeguarding governance structures from our reading and analysis of particular sources, such as legislative summaries, serious case reviews and guidance from overview and scrutiny organisations, such as the CQC.

Types of harm

Across the health and social care literature, three possible mechanisms for harm were reported: harm as a result of neglect or wilful misconduct, harm that occurs as a result of failures within the system, and harm that results from errors made by otherwise well-intentioned people when delivering care.

The clinical governance and adult safeguarding system within health care, particularly within secondary care, makes a clear distinction between two different kinds of harm: acts of deliberate harm or neglect and the more common systems failure and errors. The former is dealt with as a 'safeguarding' issue (Phair and Heath 2012) and the latter as a 'safety' issue. This distinction results in two parallel approaches for examining and dealing with incidents of harm in NHS settings, which may take place alongside each other if the nature of the harm is unclear. While safeguarding procedures are required to work in partnership with local authorities, 'safety' focused investigations are not.

Patient safety in health care is a discipline in its own right; a huge and ever increasing literature contributes to a well-recognised body of knowledge and expertise (Palmieri *et al.* 2008). In health, the terms quality and safety are commonly used and largely fall under the eye of systematic governance procedures that, from our review of the literature, appear not to exist in the world of social care. Frontline health care staff are familiar with descriptions of error, reporting systems for error and protocols and interventions aimed at error prevention and the broader agenda of patient safety. The language of safety in acute health care settings explicitly concentrates on minimising the incidence and impact of, and maximising recovery from, adverse events by encouraging reporting of all adverse events including near misses and attempting to foster a culture that reduces individual blame. This concept of safety is applied to every patient or potential patient in all acute settings. However, there is less evidence about how safety is understood and applied in primary, private and third-sector care settings and patient interpretations of safety and safety culture are not always consistent with those of providers (Entwistle *et al.* 2010; Phair 2011).

The publication of *An Organisation with a Memory* (Donaldson 2000) was instrumental in driving the patient safety movement in the NHS by emphasising the scale and pattern of potentially avoidable patient safety incidents that occur during episodes of care. It acknowledges the devastating consequences that can occur for patients, their families and the healthcare staff involved. However, it is the learning from such incidents that has driven systematic efforts to collect and address these failures in national attempts to improve safety. This movement led to the development of a single system by which incidents are reported, collated and analysed and a high profile research agenda that is not replicated outside health. However, the national consultation that reviewed the 'No Secrets' guidance (Department of Health 2000) highlighted failures of the safeguarding agenda in health. Subsequent guidance for the NHS clinical governance system was produced to clarify the relationship between adverse incident reporting, complaints (Morgan 2010) and safeguarding and to better work with local authorities when adult safeguarding concerns arise. While the process described for health appears to consider whether an incident is also a safeguarding concern, similar differentiation is not clearly described in the social care literature included in our review.

In the social care literature, the term 'safety' is strongly associated with safeguarding (Department of Health 2011c) and thus, distinctions were not drawn between adult protection issues and wider safety issues in the same way as in the literature that focused on health care. Indeed, the social care literature indicated that all incidents or reports of potential harm are dealt with using the same governance structures, irrespective of whether they concern a deliberate act of harm or a systems failure. Thus, the literature we reviewed indicated that issues that would likely be dealt with via safety governance systems in health care, such as medication errors, would likely be dealt with through safeguarding procedures in social care. This has raised concerns for some commentators, with Phair's (2011) research showing that some incidents reported in social care were inappropriately recorded as safeguarding concerns.

Both contexts broadly speaking are subject to the scrutiny of the Care Quality Commission although exceptions to this exist in both health and social care settings (e.g. those using personal budgets, individual user trusts, self-funded personal care, independent midwives) (Care Quality Commission 2015). The CQC is the independent regulator of health and adult social care services in England, whose stated aim is to ensure that agencies meet 'government standards of quality and safety' (Care Quality Commission 2010). The CQC mentions five standards (outcomes 7–11) that specifically fall under the heading of safety and safeguarding:

- Outcome 7: Safeguarding people who use services from abuse
- Outcome 8: Cleanliness and infection control
- Outcome 9: Management of medicines
- Outcome 10: Safety and suitability of premises
- Outcome 11: Safety, availability and suitability of equipment.

In separating deliberate acts of harm or abuse from other factors implicated in threats to an individual's safety during their care, the CQC seem to imply that these different factors might need to be considered, if not governed and managed, in different ways.

National reporting

Local governance structures and recording of safety and safeguarding incidents are affected by national requirements for reporting. Both health and social care organisations are required to record details about all safety and safeguarding incidents.

In 2004, The National Patient Safety Agency (National Patient Safety Agency 2004) acknowledged variability of health care incident reporting structures and processes between localities. However, over the subsequent ten years, a large body of literature that examines support for reporting, and guidance aimed at improving practice around incident reported, has emerged. There is now a well-accepted expectation that any incident, including those which could have (near miss) or did lead to unintended or unexpected harm and/or loss or damage to a patient will be reported via local systems irrespective of how trivial they may seem at the time. These data are fed into the national learning and reporting database via these local systems. This allows individual organisations to determine trends and themes within their own organisation and to target local interventions as well as informing national patient safety alerts.

In social care, reporting to the national systems can be influenced by the level of investigation undertaken. All local authorities are required to return information about safeguarding alerts or referrals via the Safeguarding Adults Return (SAR, formally Abuse of Vulnerable Adults returns) national reporting system. None of the documents included in our review discussed national reporting of safeguarding alerts and referrals. However, there was anecdotal evidence that different local authorities might report safeguarding alerts differently. Some local authorities might report every incident as a safeguarding referral if they took action in response to it, including low level action, such as advice. Others, however, might only report incidents that required multi-professional investigations.

Thus, the way that incidents are defined at a local level can affect whether and how they are reported at a national level. In turn, this can affect the processes that are implemented to reduce the risk of such incidents occurring again and the opportunities for cross sector and national learning. While the emphasis on national reporting and learning in relation to adverse events is strong in acute health care settings, this review found much less evidence about national reporting of incidences of error and harm and the effect that this might have, in the adult social care literature. It is acknowledged that the further health care is removed from acute settings the less clear the discussion of safety and risk becomes. The limited evidence available, coupled with the lack of clarity about what safety and safeguarding means (see the section above on this topic) and the two apparently distinct systems for reporting incidents of harm, may create confusion about what incidents to report via which system in which situation. This might be particularly the case for people working in those care settings that are more organisationally distant from formal statutory provision and those that are integrated across health and social care.

Wider contextual issues

The increased emphasis on integration and the increasingly mixed economy of care has compounded the complexity of health and social care provision. It is likely, therefore, that governance as it concerns safety and safeguarding and the assessment and management of risk is also likely to become more complex.

In the literature we reviewed, this complexity was often explored in the context of agency provided home care and residential care placements, where service providers are distanced from the

structures of governance imposed on in-house provided services. However, following the implementation of the Health and Social Care Act 2012 (HM Government 2012) and the policy of 'any qualified provider', these issues have resonance across the health and social care environment.

The literature discussing safety and safeguarding issues in care homes, for example, indicated that most homes had good local reporting processes and arrangements in place to learn from errors (Care Quality Commission 2012; Quigley 2014) and that there were high levels of compliance with these local reporting structures. However, the reports included in this review also indicated a lack of awareness of wider national reporting systems, and it was unclear how and whether incidents reached the national reporting system. In an environment where regulation is constantly changing (Quigley 2014) and where provision is organisationally distant from statutory services, there may be less opportunity to maintain awareness of national safety and safeguarding governance structures and to learn from national, as well as local, failings.

As outlined in earlier sections, how risk and harm are identified and what constitutes risk or harm can be affected by the context in which care is provided. For example, governance procedures around taking medication may differ depending on whether an individual resides at home, is currently a hospital in-patient, or is resident in a care home. Individuals in their own home, as part of maintaining their right to independent choice, might be encouraged to decide for themselves what risks are acceptable. On the other hand, when a person is receiving care in a hospital setting, more organisational-based or systems-based risk assessments are likely to occur, with the possibility that less emphasis is given to service users' choice in determining acceptability of risk. The ways that the context affects governance in these examples might be related to organisations having to balance risk to the service user and risk to the organisation.

The emphasis placed on the individual with the advent and expansion of 'personalisation' in social care, and more recently health care, can affect approaches to adult protection (Carr 2013). In this context, vulnerability, risk and harm are conceived in an individualised way and require individualised approaches to protecting adults. This approach, where local authorities have to balance choice and control with safeguarding people at risk of harm (Mandelstam 2011), inherently accounts for each person's preferences and situation. However, this approach could have implications for monitoring adverse events and promoting learning across systems, organisations and between local authorities. As outlined earlier, acute health services use a less individualised approach to minimising risks and harm that can promote organisational and professional learning, but these more systems based approaches are unlikely to be able to reflect individual preferences so readily as the more personalised approaches of social care. Nonetheless, as the push towards personalisation within health services continues and the delivery of care in settings outwith acute services develops, it is possible that these individualised understandings of risk and harm will challenge the current predominant patient safety paradigm which dominates the safety agenda in health care.

Limitations of the review

It is important to acknowledge some limitations of this review. First, employing a scoping review methodology requires that eligibility criteria are imposed on the literature; necessarily limiting the range of evidence that is reviewed. We were aware of the extensive literature base that deals with each of our three key concepts of safety, safeguarding and risk as separate constructs but we did not have the resources to review this extensive and disparate literature as part of this project. Instead, we adopted a more refined search strategy so that only evidence that referred to all three concepts was included. However, this approach also resulted in only a subset of the literature about safeguarding, safety and risk being considered for inclusion in this review. This might have implications for our findings and for the conclusions that we draw. For example, evidence from the wider literature, outside the scope of this review might challenge the findings we have reported. Alternatively, however, other literature might strengthen our often tentative conclusions. Focusing on this smaller, though more manageable, literature meant that we were able to undertake in-

depth analyses and identify conceptual variation or ambiguity and to pose robust questions arising from the gaps in the evidence; questions that are also being acknowledged elsewhere (e.g. a recent CQC tender to examine understanding of safety in care homes).

7 Conclusion

This review explored literature that focused on both safeguarding and safety in order to help understand whether there is a shared understanding of safeguarding and safety across care sectors and the degree to which there are shared approaches to their governance across social and health care.

The findings suggest that health and social care may use and understand the terms safety and safeguarding differently. Although, across the literature, there is a sense that the term safeguarding, in its broadest sense, means keeping people safe, safeguarding in health appears to centre on abuse and neglect, while in social care the wider understanding of keeping people safe appears to be held. Acute care health organisations and, to some extent, primary care health organisations also use the well-developed concept of patient safety that emphasises the importance of reporting systems for defined safety events and learning from both adverse events and averted events. However, from the evidence we reviewed, this established national approach does not appear to be replicated in the social care context, which has the potential to make pathways for reporting in any integration of these two sectors unclear. Events such as medication errors, equipment failures and falls, would be dealt with via the patient safety reporting and governance structures and procedures in health care. In social care, it seems that these same events may be covered by safeguarding processes or may fall into a category of quality assurance, but may not be captured consistently or in the same structured way. As such, national patterns may not be identified and, therefore, national learning across and between health and social care contexts might not be realised at scale.

This review also indicated that the location of service provision might impact on reporting and learning. For example, governance mechanisms for collecting data about harm and near misses seem to be widely understood and relatively clear when care and support are provided in acute health services. However, as care moves further away from acute health care settings, certainly in health care services, identification of error and reporting of harm seems to become less clear and systematic (Blais *et al.* 2013). It may be useful to consider the perspective of organisations on risk when thinking about why such challenges may occur. In the acute health sector risk is often managed using a systems approach, often with a less patient-centred approach to risk. Patients are assessed in uniform ways for infection risk, procedural safety, pressure sores etc. However in services delivered in community settings and in particular in the home of an individual risk is often a more negotiated possibility where adverse outcomes while quantifiable may have a less transparent route for responsibility. Given these contextual differences, it is unlikely that shared systems would be an easy solution to capturing events other than abuse and neglect in integrated services. However the issue of where and whether an adverse event or harm is recorded remains unclear in a number of contexts. Perhaps the distinction may be less about differences in health and social care sectors and may be more accurately reflected in a distinction between an organisation-centred versus an individual-centred risk assessment approach.

In the light of these findings, and as organisations and service provision become more integrated, it is essential that:

- clear and shared understandings of 'safety', 'safeguarding' and 'risk' are developed and that these definitions have resonance and can be owned by health and social care organisations and practitioners alike
- more work is undertaken to understand the management and assessment of risk in the context

of integrated service provision

- shared and clear strategies are developed to help apply core principles for professional and organisational learning across different care environments
- the implications for a new agenda of personalisation of care in relation to risk and governance are explored.

By summarising and clarifying what is already known and identifying gaps in the evidence, this scoping review has provided a robust basis for the identification of research questions for future in-depth work exploring what is required to ensure effective shared governance of risk, safety and safeguarding in integrated care. The findings from this work will be of interest to health and social care practitioners and governance managers and to those setting standards and monitoring service quality and safety across social and health care sectors, such as the CQC and NICE. Indeed, the CQC recently announced a tender to examine how safety of care in the adult social care sector is currently defined, measured and monitored, including considerations of reporting and management, learning and the ability to distinguish between safety and safeguarding: making this review timely.

Despite the volume of health and social care literature that discusses safety, safeguarding and risk separately, we found little work that explicitly acknowledged the lack of congruence about how they were understood in different service contexts or that attempted to explore them in the context of integrated care. Our review, therefore, indicates that a more nuanced and focused series of questions needs to be developed to explore if and how these findings play out in practice as well as what could be learned from evidence in different fields, such as mental health, child health and child safeguarding where overlap between issues of safety and safeguarding might be more readily acknowledged.

8 References

- Anderson S, Allen P, Peckham S, Goodwin N (2008) Asking the right questions: scoping studies in the commissioning of research on the organisation and delivery of health services, *Health Research Policy and Systems*, 6, 7, 1–12.
- Arksey H, O'Malley L (2005) Scoping studies: towards a methodological framework, *International Journal of Social Research Methodology*, 8, 1, 19–32.
- Aspinal FJ, Bernard SM, Spiers GF, Parker GM (2014) Outcomes assessment for people with long-term neurological conditions: a qualitative approach to developing and testing a checklist in integrated care, *Health Service Delivery Research*, 2, 9.
- Beck U (1992) *Risk Society: Towards a New Modernity*, Sage, London.
- Blais R, Sears NA, Doran D, Baker GR, Macdonald M, Mitchell L, Thalès S (2013) Assessing adverse events among home care clients in three Canadian provinces using chart review, *BMJ Quality & Safety*, published online first, DOI: 10.1136/bmjqs-2013-002039.
- Bonnerjea L (2009) *Report on the Consultation: the Review of No Secrets. Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse*, Department of Health, London.
- Care Quality Commission (2010) *Guidance About Compliance – Essential Standards of Quality and Safety*, Care Quality Commission, Newcastle upon Tyne.
- Care Quality Commission (2012) *Health Care In Care Homes – A Special Review of the Provision of Health Care to Those in Care Homes*, Care Quality Commission, Newcastle upon Tyne.
- Care Quality Commission (2015) *Registration Under the Health and Social Care Act 2008: the Scope of Registration*, CQC, Newcastle-upon-Tyne.
- Carr S (2013) *Enabling Risk, Ensuring Safety: Self-Directed Support and Personal Budgets*, SCIE report 36, SCIE, London, available at www.scie.org.uk/publications/reports/report36/index.asp.
- Darzi A (2008) *High Quality Care for All: NHS Next Stage Review Final Report*, Cm 7432, Department of Health, London.
- Davis K, Drey N, Gould D (2009) What are scoping studies? A review of the nursing literature, *International Journal of Nursing Studies*, 46, 10, 1386–1400.
- Department of Health (2000) *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse*, Department of Health, London.
- Department of Health (2005) *Independence, Well-Being and Choice: Our Vision for the Future of Social Care for Adults in England*, Cm 6499, The Stationery Office, Norwich.
- Department of Health (2011a) *The Operating Framework for the NHS in England 2012/13*, Department of Health, London.
- Department of Health (2011b) *Statement of Government Policy on Adult Safeguarding*, Gateway reference 16072, Department of Health, London.
- Department of Health (2011c) *Safeguarding Adults: The Role of Health Service Practitioners*, Department of Health, London.
- Department of Health (2012a) *Draft Care and Support Bill*, Department of Health, London.
- Department of Health (2012b) *Caring for Our Future: Reforming Care and Support*, Cm 8378, The Stationery Office, Norwich.

- Department of Health (2012c) *QIPP Long Term Conditions: Supporting the Local Implementation of the Year of Care Funding Model for People with Long-term Conditions*, Department of Health, London, available at www.gov.uk/government/uploads/system/uploads/attachment_data/file/215060/dh_133652.pdf.
- Department of Health (2012d) *Transforming Care: a National Response to Winterbourne View Hospital: Department of Health Review Final Report*, Department of Health, London.
- Donaldson L (2000) *An Organisation with a Memory: Report of an Expert Group on Learning from Adverse Events in the NHS*, The Stationery Office, London.
- Emanuel L, Berwick D, Conway J, Combes J, Hatlie M, Leape L, Reason J, Schyve P, Vincent C, Walton M (2008) What exactly is patient safety?, in Henriksen K, Battles JB, Keyes MA, Grady ML (eds) *Advances in Patient Safety: New Directions and Alternative Approaches*, volume 1, Assessment, Agency for Healthcare Research and Quality, Rockville, Md.
- Entwistle VA, McCaughan D, Watt IS, Birks Y, Hall J, Peat M, Williams B, Wright J (2010) Speaking up about safety concerns: multi-setting qualitative study of patients' views and experiences, *Quality and Safety in Health Care*, 19, 6, e33–e33, DOI: 10.1136/qshc.2009.039743.
- Francis R (2010) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Executive Summary*, HC 947, The Stationery Office, London.
- Giddens A (1991) *Modernity and Self-Identity: Self and Society in the Late Modern Age*, Policy Press, Cambridge.
- Graham K, Norrie C, Stevens M, Moriarty J, Manthorpe J, Hussein S (2014) Models of adult safeguarding in England: A review of the literature, *Journal of Social Work*, DOI: 10.1177/1468017314556205.
- Ham C, Smith J (2010) *Removing the Policy Barriers to Integrated Care in England*, Nuffield Trust, London, available at http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/Removing_the_Policy_Barriers_Integrated_Care.pdf.
- Ham C, Smith J, Eastmure E (2011) *Commissioning Integrated Care in a Liberated NHS*, Nuffield Trust, London, available at www.nuffieldtrust.org.uk/sites/files/nuffield/commissioning-integrated-care-in-a-liberated-nhs-report-sep11.pdf.
- Hardy B, Mur-Veemanu I, Steenbergen M, Wistow G (1999) Inter-agency services in England and the Netherlands: a comparative study of integrated care development and delivery, *Health Policy*, 48, 2, 87–105.
- HM Government (2012) Health and Social Care Act, c.7, available at www.legislation.gov.uk/ukpga/2012/7/contents/enacted.
- Levac D, Colquhoun H, O'Brien KK (2010) Scoping studies: advancing the methodology, *Implementation Science*, 5, 1, 1–9.
- Lewis J (2001) Older people and the health–social care boundary in the UK: half a century of hidden policy conflict, *Social Policy & Administration*, 35, 4, 343–359.
- Lupton D (1999) *Risk*, Routledge, London.
- Macdonald M, Lang A (2014) Applying Risk Society Theory to findings of a scoping review on caregiver safety, *Health and Social Care in the Community*, 22, 2, 124–133.
- Mandelstam M (2011) *Safeguarding Adults at Risk of Harm: A Legal Guide for Practitioners, Adults' Services SCIE report 50*, Social Care Institute for Excellence, London.
- Mitchell W, Glendinning C (2008) Risk and adult social care: Identification, management and new policies. What does UK research evidence tell us?, *Health, Risk and Society*, 10, 3, 297–315.
- Morgan A (2010) *Clinical Governance and Adult Safeguarding: An Integrated Process*, Department of Health, London.

- Mur-Veeman I, Hardy B, Steenbergen M, Wistow G (2003) Development of integrated care in England and the Netherlands: managing across public–private boundaries, *Health Policy*, 65, 3, 227–241.
- National Collaboration for Integrated Care and Support (2013) *Integrated Care and Support: Our Shared Commitment*, Department of Health, London.
- National Patient Safety Agency (2004) *Seven Steps to Patient Safety*, National Patient Safety Agency, London, available at www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/.
- NHS Networks (2015) QIPP workstreams, Long Term Conditions, www.networks.nhs.uk/nhs-networks/qipp-network/ltc, accessed 11 December 2015.
- Palmieri PA, DeLucia PR, Peterson LT, Ott TE, Green A (2008) The anatomy and physiology of error in adverse health care events, *Advances in Health Care Management*, 7, 33–68, DOI: 10.1016/S1474-8231(08)07003-1.
- Phair L (2011) *An Audit of Disciplinary Outcomes and Incident Reporting and the Relationship with the Vetting and Barring Scheme in the NHS*, Social Care Workforce Research Unit, King's College London, London.
- Phair L, Heath H (2012) Safeguarding vulnerable older people in hospital, *Nursing Standard*, 27, 4, 50–55.
- Power M (2004) *The Risk Management of Everything: Rethinking the Politics of Uncertainty*, Demos, London, available at www.demos.co.uk/files/riskmanagementofeverything.pdf, accessed 30 November 2006.
- Quigley L (2014) Policy making, adult safeguarding and public health: a formula for change?, *The Journal of Adult Protection*, 16, 2, 68–86.
- Reid RJ, McKendry R, Haggerty J, Canadian Health Services Research Foundation (2002) *Defusing the Confusion: Concepts and Measures of Continuity of Health Care: Final Report*, Canadian Health Services Research Foundation, Ottawa.
- Titterton M (2005) *Risk and Risk Taking in Health and Social Welfare*, Jessica Kingsley Publishers, London.
- Whittington C (2007) *Assessment in Social Work: a Guide for Learning and Teaching*, SCIE Guide 18, SCIE, London, available at www.scie.org.uk/publications/guides/guide18/index.asp.
- Williams C (2010) *Adult Safeguarding Scrutiny Guide*, Centre for Public Scrutiny / Improvement and Delivery Agency, London, available at www.idea.gov.uk/idk/aio/19170842.