DH Department of Health

Safeguarding Adults

A Consultation on the Review of the 'No Secrets' Guidance

CRIMINAL JUSTICE SYSTEM cjs

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Safeguarding Adults

A Consultation on the Review of the 'No Secrets' Guidance

Foreword




There are frequent reports of abuse of, and crime against, people who have been in vulnerable situations. Some have been living in the community and have been attacked and abused. Others have been living in care homes, in hospitals or in supported housing. This consultation document is about how we empower people to prevent and to stop this happening, with and without the help of government, and how we facilitate greater access to justice when we cannot prevent the abuse.

This consultation paper is about learning. It is about how we as a society learn to empower people – both the public and the professionals – to identify and manage risk. It is about how we empower people to say no to abusive situations and criminal behaviour. It is about locating safeguarding in the wider agenda of choice and control. It is about recognising safeguarding as everyone's business. It is about identifying the tools we need for better safeguarding.

In this consultation we invite a wide range of stakeholders – the general public and members of the public who have witnessed or experienced abuse, and social workers, police officers, NHS staff and lawyers – to consider what role they can all play in the empowerment of people. Empowerment is needed to prevent, respond to and stop abuse; to report, question and challenge abuse; and to work within the criminal justice system to bring to justice those who take advantage of the vulnerability of people to abuse them.

Safeguarding is complex and is not the sole responsibility of a handful of people. Safeguarding will only work if people have the confidence to report harm, whether carried out by unknown people, paid staff or family members. Safeguarding will only work if people who experience crime and abuse understand and trust the process of reporting and responding. Safeguarding will only work if professionals work to empower people who may have all sorts of disabilities to stand up in court. Abuse is not a necessary consequence of disability.

We hope to start a debate on these issues, a debate which will result in our society having much less abuse and much better systems for responding and for accessing justice.

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Introduction

What is the consultation about?

This consultation document is about how society enables adults to be safe from abuse or harm. In particular, it asks how we need to change and develop the *No secrets*[1] guidance – the key piece of policy guidance in this area – and how we combine keeping people safe with three sets of wider Government policy goals. These are the vision of increasing (i) independence, choice and control for users of services; (ii) access to meaningful community empowerment and safer housing in wider society; and (iii) access to criminal justice for all.

The Department of Health and the Home Office issued joint guidance in 2000 on keeping adults safe, called *No secrets*. The guidance is reviewed in chapter 2. The focus of *No secrets* was on 'adult protection'. Since then there has been a move towards using the broader term 'safeguarding adults'.[2] In this review we make no distinctions between the three terms 'adult protection', 'safeguarding' and 'keeping people safe' and we use each to refer to the same activities and outcomes.

Often, in keeping people safe, the focus is on people who may be vulnerable or in vulnerable situations. There are people who are at risk of harm or abuse because they are perceived as easy targets, owing to their age or disabilities; others live with few or no social contacts or in situations where they rely on others for daily support, or they lack the mental capacity to be aware of what may be happening to them. However, keeping people safe is a universal government objective and applies equally to all adults. In this consultation we therefore have a dual focus – on all citizens and also on those groups where practice and research have shown that specific public policy and professional responses may be needed in order to keep them safe.

Why have a consultation?

In the summer of 2007, Ivan Lewis, Minister for Care Services, announced that *No secrets* was to be reviewed. This announcement was made in the context of the publication of the first ever study of the prevalence of abuse in people's own homes.[3] He said:

"Seven years on, and in the light of several serious incidences of adult abuse, it is timely to review this guidance and to consult with other government departments that have an interest in this field. New guidance is necessary to reflect the evidence in today's report and respond to the new demographic realities which are affecting our society. We will also consider the case for legislation as part of the review process."

There are therefore three main reasons for this review. The first is the major changes in the Government's vision of the kind of society it envisages for the future. The policy environment has changed considerably since 2000, when *No secrets* was published, and it is important that policies on safeguarding are fit for this new environment, i.e. that they are fit for purpose and fit for the future. The second reason is that many stakeholders, including researchers on safeguarding, have identified weaknesses in implementation of the *No secrets* guidance and have suggested that various parts of it should be reviewed and strengthened. *No secrets* was a good start but, almost ten years later, it is time to take stock and consider how it might be updated. The third reason is that some people have expressed the view that we need legislative powers in this area. They have drawn attention to the lack of legislative provisions around safeguarding adults and have compared this unfavourably with the legislative provisions around safeguarding children. Equally, other people feel that the top priority should be to change culture and practice rather than to legislate. A specific objective of this consultation is therefore to examine the case for legislative change.

Numerous extensive changes since 2000 have impacted on people's lives and on the systems which are designed to keep us well and safe. There has been much new legislation, such as the Mental Capacity Act 2005 and the Safeguarding Vulnerable Groups Act 2006, which we discuss later. We begin, however, by highlighting three sets of important policy changes. First, there are the Department of Health's initiatives around choice, control and promoting independence. Second, there is Communities and Local Government's focus on creating a new relationship between the Government and its citizens – making community empowerment and lifetime housing a reality for everyone. Third, there are the combined efforts of the Home Office, the police service and the Ministry of Justice to increase access to criminal justice for everyone, including those who are described as vulnerable.

Safeguarding adults is an important and complex area. Before we launched this consultation we felt it was important to listen to people's views on the strengths and weaknesses of the current arrangements. The Department of Health, the Home Office and the Ministry of Justice launched the listening phase of the review of *No secrets* on 20 February 2008. In the subsequent months, we have held 'listening events' across the country to inform us of the specific questions to ask about how to improve safeguarding. We have established an advisory group of about 40 experienced representatives from voluntary organisations, advocacy groups, service providers, professional groups and the social care regulator, and a programme board is steering this work. We have spoken at small and large events to some 600 people – people with experience of regulating, providing and using social care and healthcare services. This consultation incorporates many of the views, questions and debates that we listened to. In this consultation document, we have asked a large number of questions and we invite you to answer some or all of the questions – whichever are most relevant to you.

The consultation document is divided into nine chapters:

Chapter 1 describes the main messages about *No secrets* and sets the scene for mainstreaming safeguarding – making it everyone's business.

Chapter 2 describes the policy background against which this review is taking place, and looks at personalisation, empowerment and access to criminal justice.

Chapter 3 examines three issues which the early consultations events considered important: leadership, prevention and outcomes.

Chapter 4 both reflects, and invites, a debate about what aspects of safeguarding can be built into personalisation and what aspects of choice and control can be built into safeguarding.

Chapter 5 identifies some of the levers which are leading the development of safeguarding in health services and asks what more needs to be done to integrate safeguarding into high-quality healthcare for all.

Chapter 6 asks whether safeguarding, housing responsibilities and community empowerment should be better integrated, and what housing providers should do to enable tenants and residents to live safer lives.

Chapter 7 reflects the questions asked about how safeguarding vulnerable adults can become core police business and what more the courts can do to increase access to justice.

Chapter 8 asks whether we need more guidance and if so what kind, and/or whether we need new legislation, and if so what would make the big difference to making safeguarding more effective.

Chapter 9 raises questions of definitions, eligibility criteria, language and principles.

1. Safeguarding is everyone's business

The *No secrets* guidance

The *No secrets* guidance was issued in 2000, as guidance under section 7 of the Local Authority Social Services Act 1970. This means it is statutory guidance, and local authorities are required to follow it unless they can demonstrate a clear reason why they should not. It created, for the first time, a framework for multi-agency action in response to the risk of abuse or harm. Local authority social services departments were tasked with playing a lead role in developing local policies and procedures for the protection of vulnerable adults from abuse.

No secrets recognised that some forms of abuse were criminal offences and that police investigations were required and appropriate. However, neglect and poor practice are not always criminal offences. *No secrets* listed the main forms of abuse and the main responsible and relevant agencies (20 responsible agencies were identified). It required the identification of roles and responsibilities in each agency, together with clear accountability, mechanisms for monitoring and reviewing, and proposed annual policy and service audits. These audits were to evaluate community understanding of adult protection, how well agencies were working together, the performance and quality of adult protection services, the conduct of investigations, and the development of new services to respond to the needs of adults who had been abused.

No secrets recognised some key guiding principles and made clear the links between training in adult protection and the commissioning of safe services. It provided guidance on investigating, managing and coordinating responses to allegations of abuse.

A prevalence study commissioned jointly by Comic Relief and the Department of Health interviewed a sample of people aged 66 or over living in private households. This found that between 2.6% and 4% of respondents reported that they had experienced mistreatment – the term used for abuse and neglect. This percentage equates to between 227,000 and 342,000 people aged 66 or over in the UK.

In the last few months we have listened carefully to stakeholders' views on the *No secrets* guidance and explored messages from research. Among the messages we have heard, three stand out.

The first message was that *No secrets* has had its successes. The *No secrets* guidance was the first formal government recognition of adult protection as a public duty requiring the formal cooperation of many agencies. As the key guidance document for many people involved in safeguarding, it is seen as a crucial and groundbreaking document. It is held in high regard for identifying most of the issues that remain relevant today; and it is acknowledged as a significant step in the recognition and description of public responsibility for an issue that was hidden or invisible for a long time. In our early consultations we heard examples of staff trying to raise the issue of adult abuse ten years ago but also of some politicians, managers and professionals not wanting to hear the concerns, and not being able to understand the issues. Child abuse was widely recognised in 1999 but, in many places, adult abuse was not. *No secrets* has helped to address that.

Secondly, stakeholders have told us that implementation was slow and inconsistent; joint working was patchy and some partners were unwilling to 'come to the table'. There were no dedicated resources and no specific legislation associated with *No secrets*. While the guidance was an important leap forwards it did not lead to a strong and effective universal system for preventing, recognising and responding to adult protection issues.

Thirdly, stakeholders have told us there needs to be greater clarity about safeguarding being everyone's business. Looking to the future they have asked us to consider how safeguarding fits with unregulated care. They have asked us to consider how safeguarding fits with housing responsibilities. And they have asked us to consider whether the health service should have statutory safeguarding responsibilities and how safeguarding fits with community safety.

These messages suggest the need for a more integrated safeguarding framework, making safeguarding everybody's business. This would need to address safeguarding in both regulated and unregulated care; to define safeguarding roles for housing officers, nurses, advocates, social workers and police officers; and to integrate guidance on hate crime, vulnerable witnesses, community safety, domestic abuse, safeguarding children and forced marriage. The scope would need widening, and the framework would need integrating with the proposed new Single Equality Bill.

The focus may also need widening. *No secrets* set out an expectation of formal 'adult protection' procedures encompassing a single process of alerts, referrals, strategy meetings, investigations and case conferences, which would be largely the same for all types of incidents and all types of harm. But there seems to be a recognition that more flexibility is required. Both locally and nationally, processes have been introduced which are tailored to more specific circumstances, such as self-neglect (Plymouth's procedures describe a parallel but separate process outside safeguarding), poor care practice or neglect (such as those covered by the Bradford pressure area care protocol), or ongoing risk (such as those covered by multi-agency public protection arrangements (MAPPA) and multi-agency risk assessment

conferences (MARAC), described later). Do we need more of this tailoring to particular circumstances?

We may also need to look at safeguarding issues from an equalities perspective. A recent study by Age Concern Scotland reported that 80% of older people from black and ethnic minority (BME) backgrounds who were consulted said they would do nothing if they were being mistreated. The issues involved in not reporting harm need to be looked at in culturally sensitive ways, and the BME voluntary sector and advocacy groups have important roles to play.

Finally, the advent of the Mental Capacity Act 2005 has also changed the legal framework since *No secrets* was published. It has introduced a new criminal offence of ill treatment or wilful neglect of a person who lacks capacity. And, more importantly, it has introduced in law five simple but powerful principles which challenge us to create a new person-centred, empowerment-focused framework in which everyone must operate – and in which to locate safeguarding work.

2. The new policy context: personalisation, community empowerment and access to criminal justice for all

In this section we set the policy context for safeguarding adults. This is important because the context has moved on significantly since *No secrets* was published, and any revision to that guidance must be in harmony with the thrust of current Government policy.

Personalisation: the Department of Health's vision

Consultations on the White Paper *Our health, our care, our say* showed that people want adult social care services to focus on increasing people's independence and promoting inclusion in communities.[4] The Government's ambition is to meet this aspiration through a reform of social care, making personalisation the cornerstone of change. This means every person receiving support in every setting having choice and control over their care and support.

Putting People First is a cross-sector concordat, published in December 2007, which established a collaboration between central and local government, the sector's professional leadership, providers and the regulator.[5] It sets out the shared aims and values that will guide the transformation of adult social care and recognises that the sector will work across agendas with users and carers to transform people's experiences of local support and services. At the same time, the Government announced the new social care reform grant. This £520 million of ringfenced funding will help councils to redesign and reshape their systems.[6]

Part of this commitment is the 'personal budget'. Personal budgets are transparent allocations of social care resources to individuals who are eligible. They may be managed by councils or by another organisation or paid as a direct payment or a mixture of both. The choice of payment mechanism should depend on people's preference. The focus needs to be on the outcome more than the mechanism.

This is an exciting agenda, but in order for it to work for everyone we need to discuss how safeguarding and the management of risks fit in. *Putting People First* makes it clear that a core part of a personalised system is an effective and established way of enabling people to make supported decisions built on appropriate safeguarding arrangements.

Safeguarding policies have resulted in experience and learning that must be built into the transformation process in public services. At the heart of this transformation is the need to recognise that, for the most part, organisations and professionals do not need to make

decisions for people – it is time they had real, informed choices. But with that may come greater risk of harm and abuse. This is discussed in more detail in chapter 4.

Community Empowerment and Lifetime Housing: Communities and Local Government's vision

In July 2008, Communities and Local Government (CLG) published the White Paper *Communities in control: Real people, real power*, which aims to shift power, influence and responsibility away from existing centres of power into the hands of communities and citizens.[7] *Communities in control* presents a range of ideas and policies designed to empower citizens and communities by promoting and revitalising local democracy and encouraging active citizens. The Government is clear that the contributions, experiences and perspectives of all citizens should be recognised and valued.

The Mayor of London published the results of the Disability Capital 2003 Survey in the report *Another planet?*,[8] which recorded the experience of discrimination of disabled Londoners. It was very clear that major changes to housing, support and access were needed in order that people with disabilities could live, work and be housed safely in the capital. A large proportion of the respondents had experienced abuse.

In 2007 the Commission on Integration and Cohesion published its recommendations on how to make the concepts of community cohesion and integration a reality,[9] and CLG responded by publishing its 'cohesion guidance'.[10] While much of this guidance is about the integration of people of different faiths, it also applies to people who are less integrated because of other reasons – such as isolated older people living on their own or people with learning disabilities, who are not always integrated.

Community empowerment and the safety of people in communities need to go hand in hand. Community empowerment that includes all people is the ultimate objective. Community empowerment that ignores – or even works against – the rights of the least socially included people is undemocratic and can be unlawful. Recent research on hate crimes against people with disabilities, for example, makes a very powerful plea for community empowerment to have a safeguarding focus integrated within it.[11]

Equally important is CLG's work on lifetime homes and lifetime neighbourhoods. The cross-governmental strategy document *Lifetime Homes, Lifetime Neighbourhoods* connects housing, communities, health and care within the context of CLG's vision of lifetime neighbourhoods.[12] Again, it is important that housing departments, housing associations and wider local government recognise that keeping adults safe is one of the building blocks of lifetime neighbourhoods.

A third area for consideration is the new Local Performance Framework. Introduced in the 2006 White Paper *Strong and Prosperous Communities*, the Local Performance Framework aims to give more freedom and powers to local government, and to encourage partnership working between local agencies.[13]

One aspect is new Local Area Agreements, which replaced multiple national performance frameworks, reducing the number of targets and reporting systems. These three-year agreements consist of around 35 priority targets for a local area, agreed between local partners and central government (as represented by Government Offices). It is backed up by a new assessment regime, the Comprehensive Area Assessment, which involves less automatic inspection, and more focus on areas where there is risk of under-performance. New approaches on adult safeguarding must be compatible with this framework.

All these policies have important implications for safeguarding adults. They broaden the context for policy on safeguarding adults. Should safeguarding be seen as a community responsibility as well as the responsibility of professionals? This question is discussed in more detail in chapter 6.

Safeguarding adults in the criminal justice system

Crime has been reduced dramatically, by around a third in the last ten years, and the chances of becoming a victim of crime are now at historically low levels. This trend is linked to a significant increase in the number of police officers and the roll-out of neighbourhood policing teams across England and Wales.

Underpinning these changes has been the introduction of arrangements for partnership working. In 1998, the Crime and Disorder Act introduced Crime and Disorder Reduction Partnerships (CDRPs) and Community Safety Partnerships.[14] This made tackling crime a statutory responsibility for a number of agencies, including local authorities.

The Government has worked successfully with delivery partners to draw up a range of policies to tackle different aspects of the criminal behaviours which make people and situations unsafe. Since *No secrets* was published in 2000 many police forces have concentrated all safeguarding issues – whether they involve children, adults, management of dangerous offenders, missing persons or domestic abuse – into single teams generally referred to as Public Protection Units (PPUs). In many police forces the PPU will work together with other key agencies under local multi-agency public protection arrangements (MAPPA), in relation to managing specified sexual and violent offenders, and under the multi-agency risk assessment conferences (MARAC) arrangements, in relation to high risk victims of domestic abuse.

MARAC

Tackling domestic violence has improved. Multi-agency risk assessment conferences (MARAC), which now meet in a large number of areas, respond to high risk victims of domestic violence, aiming to intervene to prevent repeat victimisation. MARAC consists of statutory and voluntary organisations jointly designing a risk management plan. In Bradford good links have been developed between MARAC and the local authority-led safeguarding process.

MAPPA

Multi-agency public protection arrangements (MAPPA) are a system by which police, probation and prison services work together to manage the risks posed by specified sexual and violent offenders in the community. Local authorities and NHS bodies are under a statutory duty to cooperate with MAPPA arrangements. Where there is risk to children, such as with child sex offenders, safeguarding children teams are included in the discussions. Some areas have begun to take specific account of adult safeguarding within MAPPA where adults identified as 'vulnerable' are thought to be at risk.

However, recent reports have confirmed that people with a limiting illness or disability are more likely than those without one to be assaulted.[15] The *No secrets* review offers an opportunity to examine how all the different agencies can best work together to identify, respond to and also to prevent harm to and abuse of the most vulnerable people in society.

Improving access to the courts for those who are vulnerable or intimidated has been a Government objective for some time. The Youth Justice and Criminal Evidence Act 1999 introduced special measures to support the giving of best evidence by vulnerable and intimidated witnesses.[16] Under section 16 of the the Act a witness is classified as vulnerable if they are under 17 years of age at the time of the hearing, if they suffer from a mental disorder within the meaning of the Mental Health Act 1983 or otherwise have a significant impairment of intelligence and social functioning, or have a physical disability or disorder (and the court considers that the disability or illness is likely to affect the quality of their evidence). Under section 17 of the Act, a witness may be eligible for special measures on the grounds that the quality of their evidence is likely to be diminished by reason of fear or distress in connection with testifying in the proceedings.

Special measures include screens (to ensure that the witness does not see the defendant), live links (allowing a witness to give evidence from outside the court room), giving evidence in private (clearing the court), removal of wigs and gowns, video recorded evidence to replace evidence in chief, and the examination of victims and witnesses through an approved intermediary, which has recently been rolled out nationally. The approved intermediary

scheme assists witnesses with communication difficulties in providing their account to the police, legal representatives and the court. The scheme has created a new profession of registered intermediaries, with an official national register, a code of practice and ethics and a system of guidelines and processes. All of these measures are intended to increase the rate of successful prosecutions where a disabled or older victim may not otherwise be viewed as a credible witness in court.

The Government has also made improvements to ensure that court buildings provide a safe environment for vulnerable witnesses, including the provision of separate waiting facilities so that witnesses do not have to come into contact with the defendant and their supporters. Currently 96% of Crown Courts and 97% of magistrates' courts have some type of separate waiting facility. A witness liaison officer has been appointed in all courts who can assist with coordinating the provision of facilities and provide a focal point for other agencies. Additionally, the Witness Service provides support for witnesses while they are at court.

Since April 2008, 98 specialist domestic violence courts (SDVC) have been operating in England and Wales to improve access to justice for victims and witnesses of domestic violence, who receive support from independent domestic violence advisers. This coordinated community response joins criminal justice, statutory and voluntary sector services in the handling of interventions to ensure the safety of victims while holding perpetrators to account.

Much is being done in the criminal justice system to address the harm suffered by many adults. In this consultation we ask what else needs to be done. Having started to tackle the identification of high risk victims of domestic violence through MARAC arrangements, and of convicted sex and dangerous offenders of serious crime through MAPPA arrangements, what is needed to safeguard adults from abuse and harm? We pursue these questions in chapter 8.

3. Leadership, prevention and outcomes

In our listening phase, people talked at length about leadership, prevention and outcomes, which emerged as three vital issues for any review of *No secrets* to address.

Leadership

The *No secrets* guidance created a lead agency for safeguarding and encouraged the collaboration of other agencies. The lead agency with responsibility for coordination became the local social services authority; and 15 other agencies – such as providers of health services and of supported housing, the police, the Crown Prosecution Service and voluntary organisations and many more – were invited (but not required) to work in partnership. The listening events suggested that this resulted in confusion for social services between a leadership role and a coordinating role; and for the other agencies it resulted in confusion between a requirement and an option to participate in the inter-agency framework. This was not helped by the lack of clear national leadership.

At a local level, all local authorities have, since *No secrets* was published, appointed *safeguarding coordinators/adult protection leads.* Their main focus is to establish a multi-agency framework to lead on the development of policies and procedures locally and to set up systems for recording and investigating abuse, harm and neglect and preparing multi-agency responses. These are very varied roles: some are full-time and some part-time, some have budgets and staff and many don't, and some focus on alerts while others focus on investigations, advice, case work or strategy. Some are perceived – and named – as leaders, while others act as coordinators on safeguarding within the local authority and within the local health and social care economy. How effective is their role and how wide do we want it to be?

In the listening phase, one safeguarding coordinator reflected on the complexity of his role:

"I have neither authority nor power. I cannot make a GP, a ward nurse or a police officer come to our strategy meetings if they choose not to. I have no incentives to offer and no sanctions. I run around organising car parking tickets to make it easier for them. I have battles with my police colleagues. The unit dealing with adult abuse is very poorly staffed and cannot investigate all cases; they will only take the ones that they think are both serious and prosecutable – that is about 10%. I have battles with the hospitals, who want to investigate internally, want to deal with everything as employment issues, and have their lawyers hovering. It is a difficult role but a very rewarding one."

Another coordinator observed:

"It is a difficult job – we are always walking on tightropes. My job is both to improve practices in care homes and also to decide when they are too unsafe. It is to protect – but only after the abuse has already taken place. It is to ask questions, to assess situations but not to investigate – because that's what the police do. It is to listen to the service user – but to then act not in her interests but in the wider public interest."

People also commented on the lack of resources 'to lead with' and on the lack of staff to undertake training and to conduct investigations.

Separate from local safeguarding leads in social services is the local authority's *lead of crime and disorder reduction partnerships* as part of the local strategic partnership (LSP). This is not a social services lead – it is a council lead – and the role is to ensure effective partnership on community safety.

There are increasingly also *safeguarding leads in the local NHS*. These are described in greater detail in chapter 5 and are particularly concerned with developing training in safeguarding and procedures for responding to alerts within hospitals.

At a national level, several agencies play important roles. There is a leadership role for the regulator of social care, the *Commission for Social Care Inspection (CSCI)*, in respect of registered care settings, and for the *Healthcare Commission* in respect of the National Health Service and private healthcare.

CSCI has recently started thematic inspections on safeguarding; it works to enforce standards in the regulated care sector, some of which aim to prevent harm and abuse to service users, and it also produces national reports on safeguarding, in line with best practice standards in the safeguarding adults framework of the Association of Directors of Adult Social Services (ADASS).

The Healthcare Commission has been given an explicit power to conduct investigations into the provision of healthcare by and on behalf of NHS bodies. A recent joint investigation with CSCI revealed widespread abuse of people with learning difficulties at an NHS trust in Cornwall. On more than one occasion the Commission has pointed out that there appears to be poor understanding of adult protection procedures among NHS healthcare providers and practitioners.

ADASS has assumed a lead role in safeguarding and, in conjunction with a number of partners, has published a national framework of standards for good practice and outcomes in adult protection work. The framework highlights some excellent practice, describes the key duties and identifies the relevant legal statutes.

There is also a safeguarding role for the *Public Guardian*, based in the Office of the Public Guardian (OPG*)*. The Public Guardian's role includes both preventive and reactive safeguarding. The prevention is achieved through a system of appointments – financial deputies and health and welfare deputies who have legal responsibilities and powers to look after the affairs of people who do not have the mental capacity to look after themselves. The reactive safeguarding is carried out through the Public Guardian's work in the Court of Protection, which makes decisions or orders on financial and welfare matters affecting people who lack the capacity to make such decisions. The OPG describes its vision as: *"Safeguarding rights and enabling and encouraging choice for all who need our services"*.

The *Official Solicitor* also has important safeguarding powers and duties. The Official Solicitor acts for people who, because they lack mental capacity and cannot properly manage their own affairs, are unable to represent themselves and no other suitable person or agency is able and willing to act. The Official Solicitor is a litigation friend of last resort and applications may be made in a wide range of serious healthcare and welfare disputes, when there is a serious judicial issue requiring a decision by the court.

The *Independent Safeguarding Authority (ISA)* is responsible for a new and far-reaching vetting and barring scheme that, from October 2009, will cover some 11 million people working with vulnerable adults and children. It will replace the current barring schemes and will extend to a wider range of services. Staff who want to work with vulnerable adults in health and social care will be required to register with the ISA before they start work.

The *Mental Health Act Commission* has responsibilities for detained patients in mental health settings. Subject to parliamentary agreement, it will soon be merged with CSCI and the Healthcare Commission to form the new *Care Quality Commission.*

Some people have argued that while each of these organisations plays an important role in keeping people safe, the fact that so many organisations are involved blurs the issues of leadership and accountability at the national level. They ask how these agencies should work together to provide national leadership on safeguarding? Should one organisation have a pre-eminent role in adult safeguarding? If so, which one? Or should they work together more?

What could local leadership mean in terms of safeguarding? It could mean having wide-ranging new tasks in the future. It could mean being leaders of systems, working in a collaborative way with leaders of other services. It could involve leadership of the debate about risk management, about acceptable risks or about service user-led assessments of risk. It could mean building user-led assessments into reviews of all health services, housing services, police services and adult services, including commissioning services, provider services, development of training and supervision. Or it could mean working with

stakeholders, the multi-agency workforce and, of course, service users and carers. Do we want coordinators and safeguarding boards to be all of these things?

What is the role of the wider local government? Does the housing department consider safeguarding issues for the increasing numbers of older people – the very old, the ones who hardly leave their homes (both home owners and tenants) living alone? Do public sector landlords effectively address the harassment of their tenants who have physical, mental health or learning disabilities? Should the leadership be in a central place in local government, able to bring together all the different parts of the council? Has the local authority chief executive got an interest in safeguarding, and a relevant part to play?

Where is the leadership for safeguarding issues in the NHS? Should it be with local authorities? With strategic health authorities? With the Department of Health? With the Healthcare Commission? What is the role for the new Care Quality Commission? There is also the local strategic partnership, which brings together local agencies such as the local authority, the primary care trust and the police, to decide local priorities. What should its role be? Where is the leadership for safeguarding issues in the police force? We are interested in views on all of these questions, and in particular:

Leadership

Q1a. Where should leadership for safeguarding adults lie nationally, and how should the various national organisations work together?

Q1b. Where should it lie locally? If within local government, then where in local government?

Q1c. Do we need a template for 'a local safeguarding job description' and national procedures for use locally?

Q1d. How do we know if a safeguarding board is working effectively? To whom should it be accountable?

Q1e. Where should leadership for NHS safeguarding issues lie? Do we want national procedures for the NHS?

Q1f. Where should leadership for safeguarding in the care home sector lie? What can be done to strengthen this?

Q1g. Given that there are multiple 'chains of command', how do we ensure that formal leadership roles are accompanied by appropriate authority levels?

Preventing harm

A large part of the *No secrets* guidance is about reacting after harm has taken place. Many stakeholders were clear that the focus now needed to be about preventing harm from occurring. They argued that government policy has encouraged disabled people, older people, people with learning disabilities and people with mental health problems to live independently in the community. While this is what people want, they also want to be safe. Safeguarding is about learning from adult protection cases, for example about the 'grooming' of people leading to financial abuse or sexual abuse, and deciding what we can do to educate, prevent and alert.

Demographic change also means that in future there will be greater numbers of older people, many with long-term disabilities, and more older people will be living on their own. Some will be very frail and possibly very isolated. There will also be more people with learning disabilities living in the community – though they may be less in touch with care services because they will be making more use of mainstream facilities and services. Research shows that the risk of abuse increases with age, isolation, lack of social networks, cognitive loss, mental health needs and frailty.[17] These are the groups who, according to research, report being subjects of neglect, abuse and harm. These groups may need a particular focus for prevention work. These are some examples of preventive work:

The 'Safe and Secure in Sheffield' project

This project set out to involve service users, carers and older people in designing their services, and to discover what it is that makes them feel safer. With funding from the Home Office and in partnership with Age Concern, the overall aim was to shape and influence adult protection services. There was successful engagement with crime prevention partners, the fire service, the local authority's environment and housing departments, and community safety and neighbourhood teams.

Understanding dementia and abuse

Action on Elder Abuse and the Alzheimer's Society have, with the assistance of Comic Relief, produced a booklet on understanding dementia and abuse. It is aimed at care workers providing services to older people with dementia in their own homes, but is relevant to regulated care settings too. It provides information on spotting abuse, recognising abusive practices, challenging abuse and reporting abuse.

Early warning indicators in residential services

The University of Hull has developed a set of warning indicators and a system for recording concerns for use in residential services. It was developed to try to prevent the abuse of people with learning disabilities living in residential services. It helps 'people who visit homes', whether they are visiting staff, advocates, relatives or friends, to 'reflect on concerns'.

In recent years, the focus has not been on preventive services, although there are some examples of prevention work with older people. The pilot Partnerships for Older People Projects (POPPs), for example, have carried out some interesting work.[18] In Rochdale, a community empowerment model has been used to devolve the commissioning of local activities – older people have been given their own community budgets to spend on services. But most POPPs do not integrate safeguarding issues into older people's projects. As these pilot projects are rolled out, do we need to undertake this more explicitly?

Investigations into cases of abuse invariably lead to calls for the implementation of whistle-blowing policies. Attitudes towards whistle-blowers are changing, but a lot still needs to be done to ensure that workers feel safe enough to air concerns. For organisations there are clear advantages to supporting whistle-blowers – these can include safeguarding staff and the people using the service, as well as protecting the organisation's reputation. If whistle-blowers are protected and viewed in a positive rather than negative light, then more people will be willing to disclose concerns about poor/abusive practice. The consequence of this will undoubtedly be better protection for vulnerable people. Is whistle-blowing an effective part of prevention? Could it be made more so?

Prevention

Q2a. Should we be doing more work on prevention? If so, where should we concentrate our efforts? If you are doing effective preventive work, please tell us what it involves.

Q2b. Should we develop a national prevention strategy for adult safeguarding which includes, for example, links with neighbourhood policing, with a human rights agenda, and with Health and Well-Being?

Q2c. Are whistle-blowing policies effective? What can we do to strengthen them?

Outcomes

Introduction

The public sector now works to performance indicators and outcomes frameworks, and these help set priorities and the use of resources for local government and for other key partners, such as the NHS and the police. In this context, people have asked what are the desired outcomes of safeguarding work?

A better understanding of outcomes could help local agencies to set their local priorities. In the longer term, it could allow the development of an indicator that could be included in the National Indicator Set (for local partnerships) or Vital Signs (for the NHS). This would allow local agencies such as primary care trusts and local authorities to be performance-managed on safeguarding issues by regional and national agencies.

There seems to be little information about outcome measures. Local annual safeguarding reports do not systematically collect or analyse quantifiable outcomes for cases. However, there are examples in many of the local authority reports, in CSCI reports and in the data monitoring and collection project.[19] There are a range of outcomes:

- There are criminal outcomes: i.e. a small number of successful prosecutions for physical assault and sexual abuse, for fraud and for theft.
- There are employment outcomes: where unsuitable workers are placed on the protection of vulnerable adults (POVA) list, which imposes a social care workforce ban.
- There are improved care practice outcomes: where institutionalised practices introduced for the convenience of staff have been stopped.
- There are improved care outcomes even after a death: for example, we heard that deaths as a result of medication errors in a care home were investigated by the police murder team – with valuable lessons learnt.
- There are 'new assessments/new services' outcomes: for example, where a carer is not coping.
- There are financial outcomes: where service users' money is protected by the appointment of deputies by the Court of Protection.
- There are increased physical safety outcomes: either by controlling access to an alleged abuser, or by the removal of a person from a property or service setting.
- There are a small number of prosecutions for institutional negligence/neglect, for example through the use of health and safety legislation.
- There are some 'unwilling to cooperate' outcomes, where for example people with alleged chaotic homes/lives, which may be deemed unsafe, do not wish to change their lifestyle.

- There are 'feeding into service planning/commissioning' outcomes.
- There are regulatory outcomes, such as cancelling the registration of a service or manager.

Would more clarity about the intended outcomes help to raise the profile of safeguarding adults work, and lead to greater priority and resources being dedicated to it?

CSCI's role in adult safeguarding

Safeguarding adults is a priority for CSCI.

CSCI has developed a protocol with ADASS and the Association of Chief Police Officers (ACPO) that clarifies roles and responsibilities with partner agencies:

- CSCI uses its enforcement powers to intervene if a care service is of poor quality and persistently fails.
- CSCI is responsible for producing annual performance assessment ratings for local councils' social care. It has included specific data items relating to safeguarding adults within the self-assessment surveys.
- CSCI looks at council responsibilities for safeguarding adults under the 'maintaining dignity and respect' outcome from the *Our health, our care, our say* outcomes.
- CSCI has agreed a 'limiter' with Department of Health Ministers whereby performance in relationship to this outcome must be 'good' in order to achieve an 'excellent' overall rating and must be, as a minimum, 'adequate' in order to achieve an overall 'good' rating.
- CSCI also undertakes service inspections. Some of the early messages from these service inspections are that, in relation to safeguarding adults, good councils:
  - have up-to-date policies and procedures;
  - provide high-profile professional and public information, and advice in an easily accessible format;
  - involve people who use services and carers in shaping and evaluating safeguarding arrangements;
  - have multi-agency strategic commitment and shared resources;
  - have dedicated safeguarding teams;
  - have safeguarding evidenced in workforce plans and training that is accessible to all agencies;
  - practice good information sharing – prompt action – feedback;
  - have robust systems for acting on alerts from commissioned services;
  - use data gathering to inform priorities and action; and
  - use national reports and inquiries to review local services.

Service user involvement in outcomes

We seem to be at the beginning of public involvement in adult protection processes, particularly concerning the involvement of people with experience of using care services. Some annual safeguarding reports make no reference to such involvement. Others report that this has been recognised as an issue and that service-user involvement in awareness-raising and training has started. Others have gone further and are looking at active ways to involve local people more widely – either from the wider community or the wider family. The use of family group conferences appears to be increasing.

Family group conferences

When older people find themselves in situations involving suspected abuse, they, their extended family and their community can often feel, and indeed may well be, disempowered within the decision-making process. Plans are often made by professionals or by one or two family members in control. There may be limited options to remedy the abuse situation. Sometimes the older person would rather the situation continued (e.g. with a son with an alcohol misuse problem) than risk being isolated from their family or losing control over their life. A family group conference could help them regain control while understanding the level of risk posed to them, and they can then consider the available options.

Family group conferences enable the wider family network and community to come together, to provide high-quality information on options, and to establish a dialogue with the vulnerable older family member at the centre of the discussion. She/he is supported by an advocate of their choice to ensure that their view is central to the process. Family group conferences are sometimes a means of empowering vulnerable adults in domestic violence – and are now starting to be used in adult protection. (Hampshire Social Services)

Accountability to central government, to the Department of Health, to the Department for Communities and Local Government and to strategic health authorities is mainly in relation to performance indicators that are agreed in advance, and for local government these have now moved to a three-year cycle. Currently, the National Indicator Set, on which targets in Local Area Agreements are based, contains 198 indicators. They cover a range of activities carried out by local government by itself or in partnership with others, such as crime prevention, education or community empowerment. There are no indicators in the set directly relating to safeguarding adults. The same applies for indicator sets covering the police and the NHS. In the short/medium term, an outcomes framework could help to explain how safeguarding is a part of wider objectives, showing alignment between safeguarding and wider national Public Service Agreements and indicator sets such as the National Indicator Set and the Vital Signs indicator set. Longer term, a suitable

measure on safeguarding could be specifically developed to include in Vital Signs and the National Indicator Set.

In Wales there are safeguarding indicators, and the first all-Wales report on the indicators shows both the difficulties of getting it right (e.g. is an increase in referrals a positive or a negative indicator?) and the successes of having comparable data.[20] In England, there is currently no regular collection of abuse statistics. However, the Department of Health is working with stakeholders to test the viability of collecting data on abuse. A pilot data collection is planned for late 2008 which, if successful, will subsequently lead to a national data collection. This might raise the possibility of developing safeguarding performance indicators in the next edition of the National Indicator Set, which forms the basis for the Local Performance Framework.

Local annual reports

No secrets set out an inter-agency framework for safeguarding adults. It made proposals for annual audits "to monitor and evaluate the way in which policies, procedures and practices for the protection of vulnerable adults are working". Have we got these right? Do the annual reports evaluate or do they simply describe? How do we learn from safeguarding experience at the local level? How does each multi-agency partnership improve what it is doing?

Training

Training in safeguarding has become increasingly important. Directors of adult social services report that they have, in most authorities, offered free training to their multi-agency partners and have trained several thousand staff each year. Most local authorities are using their public sector resources to train – slowly and often repeatedly – the private and voluntary care sector in adult protection.

It is however not clear what is being achieved through training. Sheer numbers tell us nothing about the outcomes, quality or consistency of the training being provided, or whether the right people are being trained. Data on training are gathered from each local authority area through the annual self-assessment survey, but there is little scope for meaningfully aggregating data nationally because there are no nationally set standards for training. It has been suggested that an educational framework should be introduced across agencies and disciplines, covering both pre- and post-qualification adult protection practice and assessed competence.[21] Would such a framework be helpful? How would it operate in practice?

Service inspections

CSCI, in the current round of 'Independence, wellbeing and choice' inspections, and the Healthcare Commission, in following up abusive practices found in Cornwall and in Sutton and Merton, have both inspected local safeguarding arrangements. How do we regularly review the findings of these inspections and identify the most pressing areas for improvement? How do we identify the key barriers to the effectiveness of the safeguarding systems? The focus of these inspections has primarily been upon local authorities – should inspections in the future be widened to cover the role of other partners, with equal weight given to these areas? What would the costs and benefits be of setting up a joint inspection regime that also includes the police, as is used for inspecting local children's services?

Changes to inspection on safeguarding will need to take place in the context of the new Comprehensive Area Assessment (CAA), developed as part of the Local Performance Framework. The CAA will set out a framework for assessment and inspection in future that is focused on outcomes and areas. This approach places greater emphasis on citizen experiences and perspectives, and takes particular account of the needs of vulnerable and disadvantaged members of the community. It is a joint inspectorate framework, with the approach being designed and implemented by the key local public service inspectorates working together, including CSCI and the Healthcare Commission (ahead of their merger as the Care Quality Commission), and Her Majesty's Inspectorate of Constabulary.

Serious case reviews and other reviews

A number of serious case reviews, other investigations and reviews have been published in recent years, which have highlighted lessons for local safeguarding systems. Some of these have been concerned with the way health or social care services are delivered (e.g. Rowan Ward, North Lakeland Healthcare, Cornwall, Sutton and Merton), and others were concerned with older adults or adults with learning disabilities who have died or been harmed as a result of serious abuse or neglect. Some reviews have been carried out by national regulators, while others have been commissioned by local safeguarding adults boards. However, there appears to be no common understanding of when such reviews should be undertaken, the terms of reference they should be conducted under, or where findings should be reported to. There is, for instance, no national collation and distribution of findings. Nor is it clear whether organisations that are the subject of recommendations in reviews are required to respond formally. Does important learning result from these reviews? Do we need more consistency about how and when these reviews are carried out?

Funding

In the listening phase, some people told us that safeguarding would never achieve the desired outcomes until it is better resourced – in terms of people and money – and its profile was increased. They had been disappointed that *No secrets* did not come with a

dedicated funding stream. The funding of safeguarding varies in different parts of the country. In some areas it is funded entirely from the social services budget. In other areas, the police, the probation service and the local primary care trust also make contributions.

Nowadays, very little of the money going to local councils from central government is ring-fenced and earmarked for a particular purpose. It is therefore for local councils to decide how much to spend, in the light of local priorities. But it is not clear how much should be spent. No data are held centrally on the costs of adult safeguarding, who contributes to it and whether there is evidence that increased funding would result in better outcomes.

We are interested in views on all these questions, but in particular:

Outcomes

Q3a. Would an **outcomes framework** for safeguarding adults be useful? If so, which indicators should we use within the wider responsibilities of local government, the NHS and the police force?

Q3b. Should we encourage **local annual reports** to be more evaluative?

Q3c. How can we **learn from people's experiences** of harm and their experiences of the safeguarding process in order to improve safeguarding?

Q3d. Should we review current arrangements for delivery of safeguarding adults **training?** Should we have national occupational training standards across all agencies?

Q3e. Should we have a national **database of recommendations** from serious case reviews at a national level? Should we review the effectiveness of serious case reviews as learning tools? What should trigger a serious case review, and how should the conclusions be disseminated?

Q3f. Should we develop **joint inspections** to look at safeguarding systems as a whole? Should this include the police (Her Majesty's Inspectorate of Constabulary) – as for inspecting local children's services?

Q3g. What are the desired **outcomes** of safeguarding work?

Q3h. Should there be **national safeguarding adults guidance** that incorporates training, outcomes and multi-agency procedures? How would this be integrated into the personalisation agenda discussed in chapter 4?

Q3i. How much does adult protection **currently cost?** How is it funded? What evidence is there, if any, that increased funding would lead to better outcomes?

4. Personalisation and safeguarding

Personalisation

People have been telling the Department of Health that they want to choose their services and their support. They want to ensure that services are tailored to their needs and that they can respond to individual circumstances. Older people do not want to be taken out of their homes and their community simply because they are frail or dying. They do not want all decisions made for them by staff or their families. People want choice and control over their lives.

There is now a generation of people who expect to make decisions about their services and about the quality of their lives, who previously might have been cared for and had very little choice in long-stay hospitals or homes. Improvements over the last decade across all public services have created challenges. The next phase of public service improvement will require a much more personalised approach, with choice at the heart of it, to meet people's diverse needs.

Choice involves risk, and social care has not got a strong history of managing either choice or risk in a systematic and effective way. Historically, social care was good at providing services that minimised risk; however, personalisation means that in the future, social care has to work towards providing choices rather than services. It needs to educate people about, rather than minimise, risks. This is what was described in *Independence, choice and risk* as the move towards having a joint choice, empowerment and risk policy, which would promote more open and transparent practices.[22]

A joint choice, empowerment and risk policy will, like the rest of personalisation, mean a cultural change, involving working with people rather than doing things for them. It will involve seeing people as active citizens, as service creators rather than service users. It requires a new partnership between professionals and people, which involves informed, adult discussions of risk.

Another reason for the new focus on risk identification and management is that the combination of higher public expectations and demographic changes – the increase in older people and especially in the 85+ age group – means that government resources need to be channelled towards prevention and the early identification of risk and of need. We cannot wait for problems to arise – whether these are falls, chronic illnesses, isolation, neglect or abuse – we must instead invest in prevention.

It is important to try and identify people at risk of experiencing these problems before they happen; and where they cannot be prevented, we need to invest in empowering people to deal with them. For example with a falls service, the aim should be to get people stronger, fitter and moving more confidently, and also to make their environments (e.g. their homes and carpets) safer. Similarly, the aims of a modern safeguarding service should be to invest in empowering individuals and organisations to prevent, avoid, recognise, report and complain about abuse in all its forms. This applies to staff and carers as well as to people using services, to chief executives and practitioners as well as those who are most vulnerable to abuse at some point in their lives.

During the listening events, people expressed concern about the risks that personalisation could open up; this has also been raised in research.[23] Safeguarding professionals were worried about the many different risks that perpetrators of serious abuse cause – especially the targeting and grooming of people who were in vulnerable situations. There was a strong message that risks needed to be identified and carefully managed, so that the benefits of personalisation outweigh the problems. It was thought that some of this could be done through raising the awareness of service users and their representatives; through identifying and tracking persistent 'offenders'; and through making advice, help and continued support available to those employing personal assistants or other staff.

So our task is to link personalisation, prevention and safeguarding. We do not want some staff to work on personalisation in a way that increases serious risks and harm. Neither do we want other staff to focus solely on safeguarding issues to the extent that people's ability to make choices is restricted. Service users need to be seen as active citizens with a right to choose the type of care they receive, together with a right to have a say in the risks they are comfortable with. Both personalisation and safeguarding are everyone's business.

We need to identify risks, assess them and manage them in partnerships with the people who use services. It should be their choice – the informed choice of ordinary people – who they trust with collecting their pensions, or who they pay to help them take a bath or administer their medication, and it should be their choice if they wish to manage the payments for their personal budgets or if they wish someone else to do it for them. Becoming frail or having a disability should not be synonymous with giving up the right to choose your own lifestyle. On the contrary, growing old or having a disability means that we – in central and local government, in the health service and in the police service – must work very hard to ensure that the informed choices, the opportunities, and the range of services are all there.

In order to do this, we need to identify what we have learned about risk assessment and risk management in the last ten years, and we need to apply those lessons to our work on personalisation. We also need to link it with developments in new technology.

Personalisation brings with it many practical challenges for safeguarding, particularly the promotion of a professional and organisational culture that allows and supports appropriate risk-taking. We also need to recognise that employing personal assistants or family members safely requires a level of expertise that will need to be developed. We have begun to explore these issues in *Independence, choice and risk: a guide to best practice in supported decision making.*[24]

In summary, we need to look at what we know about people's wishes for independence, choice and control, and apply this to our work on safeguarding. We need to develop person-centred safeguarding. We should not be making every decision for people. The Mental Capacity Act 2005 has enshrined in law the right to make decisions if a person has capacity to make a specific decision, including those that someone else might think are unwise decisions.[25] Staff or carers who have a great deal of experience of protecting people and making decisions for them are not always confortable with this. But we need to shift the focus to a debate where service users are active citizens who assess risks and make decisions about their quality of life. How do we do this?

Managing risks

Q4. In an environment where an increasing number of people will be taking responsibility for arranging their own support, we need to have a debate on how their interests can be safeguarded. What aspects of safeguarding do we need to build into personalisation? What training, risk assessment and risk management should we use? Please tell us what you are doing locally and what more needs to be done.

Managing choice

Q5. What aspects of personalisation – greater independence, choice and control – can we build into safeguarding? How do we better reflect service users' informed choices? How do we facilitate informed self-determination in risky situations and in the safeguarding process? How can we move forward on this agenda?

5. Health services and safeguarding

There seem to be many reasons for the gradual increase in the NHS engagement with safeguarding.

Twelve reasons why the NHS is increasingly interested in safeguarding:

1. The Safeguarding Vulnerable Groups Act 2006 will introduce the universal vetting and barring of staff into the NHS for the first time. This has substantial implications.
2. The *Good doctors, safer patients* proposals that followed the Shipman Inquiry have moved the issues of safeguarding and medical competence to the fore.
3. The publication of the *Trust, assurance and safety* White Paper.
4. The publication of *Clear sexual boundaries between healthcare professionals and patients*. (Among others, the scandals of the medical practices of consultants Kerr and Haslam have revealed the necessity for complaints to be taken very seriously.)
5. The Mental Capacity Act 2005: the applicability of the code of practice generally, and the offences of wilful neglect and mistreatment in particular, are being considered in light of clinical care.
6. The Mental Capacity Act Deprivation of Liberty safeguards – with its own code of practice – have focused attention on the rights of patients and the duties of staff to be alert to these.
7. *Our NHS, our future* addresses the needs of the most vulnerable and addresses patient safety.
8. *Safeguarding patients*, published by the National Patient Safety Agency (NPSA), focused on improving quality and safety, as well as the need to embed clinical governance, and learn from incidents, from complaints and from audits of commissioned services.
9. The Healthcare Commission published *Learning from Investigations*.
10. The publication of NHS Litigation Authority risk management standards for acute trusts and learning disability and mental health trusts.
11. The existence of the Corporate Manslaughter Act 2007.
12. The high cost of repeated hospital stays that are attributable to abuse and neglect.

No secrets envisaged that each NHS organisation would work actively within an inter-agency framework – that they would carry out joint investigations and actively promote the empowerment and well-being of vulnerable adults.

The listening events suggested that full engagement has been slow to develop. In many areas, safeguarding responsibilities were added on to the responsibilities of already-busy nurse managers, many of whom had no budgets and no staff they could draw upon. Mental health services appeared to be the hardest to engage, with a common perception that safeguarding issues did not apply to these services. We were told that GPs varied from "very helpful" to "very unhelpful".

In our listening events we commonly heard that "the NHS is in denial" and that "primary care trusts don't see safeguarding as a service that needs to be commissioned". There were also comments about the lack of leadership, that there were "no directives" and with "trust boards often unaware". Some thought a common perception was that "abuse is something that happens in care homes and is investigated by social services. It is not an NHS issue'.

However, safeguarding has now begun to be taken seriously in some parts of the NHS. The early reports of NHS staff not attending multi-agency meetings, not sharing information, not putting resources into this work, not reporting alerts and not wanting social care involvement in investigations, are declining. There is increasing recognition within the NHS that it has responsibilities for safeguarding, and some parts of the NHS have begun to appoint quite senior staff to safeguarding and are making it a board responsibility. The Healthcare Commission is also starting to give safeguarding more prominence. The Dignity Challenge encourages everyone to focus on dignity, quality and strengthening the protection of people – and there is also the most recent work on compassion. And the Darzi Report, *High Quality Care For All*, identifies patient safety as an increasing priority for all health services, as an essential component of quality.[26] It identifies a whole range of issues under patient safety and recognises the important role that the NPSA is playing.

An example of safeguarding work in a hospital

"In this hospital we recently had a referral from a care home for a patient who was very malnourished. We initially investigated the nutrition – and then found a whole catalogue of abuse: physical, financial and neglectful. The Department of Work and Pensions and the local authority fraud team were all involved. But it took one nurse – recently trained in safeguarding – to start asking the right questions."

The Monitor contract

"It is the NHS Litigation Authority risk management standards, plus the requirements within the Monitor contract, that are driving changes for the foundation hospital trusts and those seeking foundation status." (NHS safeguarding lead)

Northumbria Healthcare Trust reports

"The NHS Litigation Authority standards section 3 (safe environments) has a new requirement to show engagement with the multi-agency safeguarding process. We have achieved level 2 (engagement) – which is the highest score in the country – and are going for level 3 (embedded in practice). We take this very seriously." (Safeguarding lead)

As noted earlier, the very concerning reviews published on abuse in Cornwall[27] and on abuse in Sutton and Merton[28] both relate (among other things) to healthcare provision for people with learning disabilities, and both recount numerous examples of neglect, ignorance and institutional abuse – as well as failures in the safeguarding process. Similarly, a report by Mencap, *Death by indifference*, charts the stories of six people with learning disabilities and suggests that neglect at various stages of the healthcare system was contributory to their deaths.[29] Mencap argues that the abuse and neglect they suffered should be considered "institutional discrimination". The recently published *Healthcare for all* has investigated, responded and made wide-ranging recommendations.

Whatever the mix of reasons, there appears to be an expansion of safeguarding posts being established in the NHS (although few in London). This expansion is very positive. The immediate focus appears to be on establishing policies, procedures and training. The most common harm they appear to be focusing on is pressure ulcers. CSCI has been asking the NHS to identify which care homes are admitting people to hospitals with serious pressure ulcers – in order for these to be investigated for possible neglect. CSCI has more recently also asked the care home sector to identify which hospitals are discharging people with serious pressure ulcers – in order for these also to be investigated for possible neglect. Several trusts are developing/adopting their own ulcer protocols, such as the one in Bradford.[30]

Other issues include risks of malnutrition on wards, where people are given trays of food but are not helped to eat, and other forms of neglect – where staff, for example, do not know how to make 'best-interests decisions' and may leave patients untreated and in pain because they are 'un-cooperative'. NHS safeguarding leads also work to establish appropriate ways in which staff can respond to disclosures on the wards about abuse in people's own homes or care settings, and are developing local policies, procedures and training about

safeguarding. The Mental Health Act Commission also has an important role in advocating for detained patients, including in incidents of abuse or neglect.

As safeguarding develops further in health organisations, it is important that it builds on and is integrated with the governance systems that already exist in order to promote quality, gather relevant information and maintain oversight right up to board level.[31] The new regulator, the Care Quality Commission, will also regulate the NHS. The Department of Health has recently consulted on the registration requirements that will apply across health and social care, and these include a requirement on safeguarding that all providers (including the NHS) will need to comply with.

A safeguarding manager in the NHS

"My trust recognised the need for adult protection early on and recruited me. I have also had some very good nurse directors behind me. We have very good relationships with social services and also with the police. Training in adult protection is mandatory here. That means everyone from consultants to domestics, and with the turnover of staff that means training continuously. I train on formal induction courses and I have organised a drama-based training event with scenarios all based in hospitals – junior doctors hearing disclosures, nurses seeing abusive family relationships, consultants having concerns about the behaviour of their peers. It is very powerful. Then I back it up by further training that takes place on wards during handover. That way I can get round the hospital and remind everyone of their responsibilities to very vulnerable people."

Another safeguarding manager in the NHS

"I report to the director of nursing quality. I also work with our lawyers, on any allegations against the hospital. We identify independent matrons to carry out investigations. We sometimes have three separate investigations – HR do their own. My biggest headache is getting all the consultants on board. Some are very good, but some think it has nothing to do with them. I work hard with medical students – if I can get the next generation of doctors to take it seriously and be alert to their safeguarding responsibilities, then we have made progress."

North Essex Partnership Foundation Trust

"We were one of the first trusts to create a dedicated safeguarding post. We have developed some good practice, including having a named doctor and a named professional and an internal trust safeguarding working party. We have in excess of 100 teams in the trust, each with a named champion. We have a variety of people (e.g. nurses, social workers, occupational therapists) leading investigations so that everyone owns the agenda – this prevents referrals being batted back and forth between agencies. We work very closely with the local authority safeguards unit and through the Essex safeguarding board we are replicating Part 8 children's reviews (serious case reviews) for adult protection in complex cases. We have effective links between serious untoward incidents (SUIs), risk management and safeguarding, and guidance of the Mental Capacity Act and deprivation of liberty is incorporated into our mandatory two-day training on safeguarding for all clinicians and practitioners."

We are interested in views on all these questions but in particular:

Health services and safeguarding

Q6a. How is the ***No secrets*** **guidance being implemented** and applied to ensure that it enables staff in the NHS to recognise, investigate and act on abuse? Are local arrangements effective? What more should be done?

Q6b. Are health organisations able to work with and adopt multi-agency guidance, or is it essential to **develop operational guidance** that adapts procedures into language, culture and structures appropriate to healthcare?

Q6c. What are the **responsibilities of the NHS safeguarding leads** – are they champions, professional leaders, awareness-raisers, data collectors and reporters? Can one person fulfil all these roles? If not, how should these responsibilities be shared?

Q6d. Is there a need for **regional safeguarding forums** where health organisations can share good practice and learning? If so, what would they look like?

Q6e. How do **procedures for investigating serious untoward incidents** (SUIs) fit into the multi-agency context of safeguarding?

Q6f. Are adult safeguarding **systems within the NHS effective**? If not, what are the specific challenges that need to be addressed?

Q6g. Are **any parts** of the NHS or healthcare sector **less engaged** and more in need of assistance to get on board with safeguarding?

Q6h. Is the **role of GPs** a crucial role for safeguarding in the NHS? Where is the existing good practice and what can be learnt from it?

Q6i. Are there particular issues in relation to safeguarding and **mental health**? If so, how should these be addressed?

Q6j. What **central leadership** role should there be (if any), and what function should it have (Healthcare Commission, Monitor, Department of Health, General Medical Council, Nursing and Midwifery Council, strategic health authorities)?

Q6k. What are the main **drivers for standards** in the NHS that safeguarding should be linked to?

6. Community empowerment, housing and safeguarding

During the listening events people told us that safeguarding issues were frequently coming to the attention of housing providers, but not always being referred on successfully. The recent case of Steven Hoskin showed that adults with moderate disabilities could be subjected to horrific ongoing abuse without housing (or health) staff with whom they were in contact recognising the risks and reporting them for further investigation.[32]

Government policy (as described in chapter 2) is increasingly recognising the relevance of housing and neighbourhood design for improving the well-being and reducing the isolation of older people or people with disabilities or mental health problems, but explicit links with safeguarding policies are often not well made either at national or at local level. The role of public and private sector landlords, of private social landlords and of management organisations all need to be explored. The Steven Hoskin case – Steven was being viewed as a potential candidate for an Anti-Social Behaviour Order (ASBO) instead of someone in need of help and support – illustrates the consequences of failing to make these links.

Like health services, housing services offer scope for early identification of people at risk of abuse, exploitation or self-neglect. However, there is much to be done to ensure that risks are recognised, that appropriate reporting takes place, and that effective intervention follows. Equally, we need to do this in ways that do not prevent people with capacity making what others might see as unwise decisions, if they choose to do so.

Research shows that people who are isolated and people who are socially excluded are more vulnerable to abuse. They are more likely to be targets of anti-social behaviour. They may have few people to talk to about what is happening to them, to help them recognise that they are being abused. They may have no one to help them to get help. So, the communities that people live in are important to safeguarding. The *Together We Can* project showed how communities could be engaged and empowered – ideas like citizens' juries, community kitties and local charters emerged from this work, and the 'Safe and Secure in Sheffield' project showed how this work links to safeguarding.[33]

Safeguarding, Housing and Community Empowerment

Q7a. Do we need stronger policy links between safeguarding and community development and empowerment? How can this be achieved at the national and the local levels?

Q7b. How can housing providers contribute to safeguarding? What could housing departments, housing associations and supported housing/living providers do to enable their tenants and residents to live safer lives?

7. The criminal justice system and safeguarding

The review of *No secrets* raises questions about how safeguarding vulnerable adults might be better integrated into the mainstream criminal justice arena. Some associated definitional issues are addressed in chapter 9. Information sharing and risk assessment, both as part of effective prevention as well as part of investigation, and deciding whether a particular set of circumstances is likely to constitute a crime, are addressed below. The issue of legislation and whether it would help to improve safeguarding practice, and thereby improve the lives of vulnerable adults, is addressed in chapter 8. Somewhat separate, but still linked, is the question of how, once a serious adult abuse incident (involving death, serious injury or serious institutional malpractice) has come to light, lessons can be learnt and serious case review recommendations shared across the country.

The police's role in safeguarding

As part of the listening events we sought views from about 50 police officers of various ranks from five forces, including members of public protection units and other specialist units, and non-specialists.

No secrets gave leadership on safeguarding to social care – rather than to the criminal justice system. However, with the establishment of public protection units, the police has taken a growing role in safeguarding activity.

The work of safeguarding adults has however not always been properly evaluated, as shown by comments at the listening events. These suggested that this area of work may not be well-resourced, despite being recognised as an area of considerable complexity. The view of some people working in social care was that, while police officers are often highly experienced and extremely committed to this area of work, continuity and handover issues were sometimes not effective, leaving gaps in the safeguarding system in the meantime.

More recently, a number of forces have identified adult protection specialists who can coordinate work across the force and provide advice to other partner agencies. As a result, there is an increasing element of mainstreaming of the work within the criminal investigation department (CID) field.

Another recent development has been the work by the Association of Chief Police Officers (ACPO) and others on hate crimes. Disability hate crime, for example, where people with disabilities are being targeted and abused, has been formally recognised and now needs to be linked into safeguarding. Some very good work has taken place in relation to this area,

involving the cooperation of people with disabilities, criminal justice agencies, non-governmental organisations and local councils.

The listening events suggested that staffing the police end of safeguarding work was a problem in many places. There were some examples of good practice: West Midlands Police has developed a specialist expertise and a special interest in 'vulnerable adults' work, and the Salford unit appears to be particularly active and focused on delivering effective access to the criminal justice system for people who have experienced harm and abuse. A number of forces, including the Metropolitan Police Service, have developed a 'vulnerable adults' policy.

Information sharing, risk assessment and deciding whether a crime has been committed

Information sharing

Critical to any safeguarding process are rigorous systems to handle information exchange and to assess what intelligence the information provides about a particular set of circumstances. This can be used to determine the level of risk posed to a vulnerable adult and to inform a decision about whether and by whom a crime may have been committed.

Intelligence gathering and risk assessment perfom best if all the available information is shared. Relevant information may be collected in the first instance by non-criminal justice agencies, for example the ambulance service is often the first responder to calls about incidents involving vulnerable adults, either in the home or an institutional setting. Should information from the ambulance service be shared with the police service even if it is not obviously crime-related? There is some concern in the police service that the decision as to whether something is a crime or not is being undertaken by non-police/criminal justice professionals, and there is a significant concern that in doing so, relevant information is not being considered.

We are also aware of issues that can make information sharing and risk assessment more problematic. For example, when care home staff are from the same extended family, poor practice is less likely to be challenged or questioned. All institutional settings should have procedures in place that ensure that incidents are reported to the relevant authorities.

If procedures for reporting incidents are not followed, then inspection and oversight are needed to identify areas of bad practice. But to do so, information is needed from a variety of sources including emergency call logs, the Commission for Social Care Inspection (CSCI), the placing/host local authorities, GPs and other health professionals, families, the public and employees.

Information, once gathered and assessed, provides a basis for deciding whether further action is necessary. We need to decide how the initial analysis should take place. One option would be similar to 'rich picture' analysis, which gathers intelligence about a particular area and in relation to particular issues. We also need to decide what cultural and situational factors need to be borne in mind.

Risk assessment/information evaluation/action

Information, which includes complaints and concerns, needs to be evaluated. At the moment this is done in a variety of ways, mostly by bringing different professionals together when needed, occasionally by bringing together teams involving police, social work/health professionals and probation in co-located, multi-disciplinary arrangements. We need to be clear on the benefits and resources (both in terms of public protection and resources) of each of these options. The focus needs to be on the most effective response/investigation/action, and the quickest way of responding effectively to serious concerns and complaints about people at risk.

If risk assessments identify risks to a vulnerable adult, then action is needed, supported by agreed local arrangements for reporting and investigation. Options include immediate supportive measures, working with local adult safeguarding arrangements and then, if a substantial criminal investigation is required, strategy meetings and case conferences.

Financial abuse of vulnerable adults is a growing problem, with many offences going unreported. Often committed by family members or informal carers and due to the sometimes vulnerable mental or physical condition of the victim, difficulties arise in obtaining admissible evidence. Financial institutions are raising concerns informally with the police about unusual financial transactions on vulnerable people's accounts. This may in fact be the 'tip of the iceberg' and financial abuse may be more widespread than reported incidence suggests.

Access to the courts

In cases referred by the police to the Crown Prosecution Service for a charging decision, the prosecutor reviewing the evidence makes an early assessment of vulnerability and whether any additional information is required. The prosecutor also considers whether special measures are appropriate, and with the police, whether an intermediary is required.

The introduction of special measures has been phased in over a considerable time and has been evaluated by the Home Office. Its impact in the adult safeguarding arena will take a little longer to establish. Disappointingly low levels of prosecution were reported from a national data collection exercise [34] but recent work by the Crown Prosecution Service on crimes against older people and on hate crime [35] highlights the potential for increasing

prosecution rates, including greater use of special measures. One practical problem to be overcome, however, is the difficulty that police officers have in successfully identifying vulnerable witnesses to enable the witness to receive the support and assistance they need to secure access to justice.

The intermediary special measure for vulnerable witnesses with communication difficulties has now been rolled out to 40 of 42 local criminal justice areas and is expected to be completed later this year. Intermediaries carry out an assessment of a witness's capability at the investigative stage and can assist with communication during police interviews. Also a witness may give evidence at the trial through an intermediary to ensure that they understand the questions put during examination and cross-examination. An early 'witness profiling' scheme in Liverpool reported significantly improved rates of successful prosecutions involving victims with learning disabilities.[36]

As part of the effort to improve identification and treatment by the criminal justice system of vulnerable people, the Office for Criminal Justice Reform (OCJR) is engaged in the process of relaunching a suite of guidance for criminal justice practitioners dealing with vulnerable witnesses. In October last year, the OCJR launched an updated version of *Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses, and Using Special Measures.*[37] This document provides practitioners with good practice guidance for interviews with vulnerable people and identifying their support needs. It is cross-referenced with the *No secrets* guidance. Other guidance that is in the process of being updated by the OCJR and criminal justice system partners includes pre-trial therapy for children and adults and guidance for frontline police officers to help them identify vulnerable witnesses.

In December last year, the OCJR held a conference for frontline police officers focusing on identification of vulnerable and intimidated witnesses, helping police officers to identify and share best practice.

To improve the way in which victims access support and to ensure that support services are more accessible and more tailored to the individual, the Victim Support Plus model is being rolled out across England and Wales.[38] Victim Support Plus is a radical move away from the traditional practice of writing to all victims of crime and a major opportunity to expand and improve the way in which support services are accessed by victims.

Victim Support Plus introduces a process of support that means victims receive a telephone call from a fully trained victim care officer within 48 hours of referral from the police. Using a new toolkit, victims will have their needs assessed before arrangements are made to provide the necessary support services. Services will take the form of practical advice and support, and emotional support from volunteers with specialist training in supporting victims of serious and violent crime; the model makes support services for victims faster and

easier to access, more consistent and practical, and tailored to victims' needs. The national charity, Victim Support, received a grant of £5.6 million in 2007/08 and a further £7 million this year to roll out and run the Victim Support Plus model.

The Ministry of Justice Disability Equality Scheme (DES) makes accessibility (to court estates and information), including access to justice, one of its key priorities. A draft copy of the DES was sent to Mind as part of the consultation process. The DES is available on the Ministry of Justice website.[39]

Work is also now under way on the Justice Secretary's report on disability, due for publication on 1 December 2008. This report will look at the services the Ministry delivers, including areas of shared responsibility with other government departments and, through consultation and involvement of interested stakeholder groups, will take a holistic approach to identifying any barriers to using these services and what actions can address these.

Access to the criminal justice system

Q8a. How can safeguarding vulnerable adults be **better integrated** into the mainstream criminal justice arena?

Q8b. Are **police units adequately staffed** to respond to the increased reporting of adult protection issues? If not, what changes are needed?

Q8c. Is there a **need to develop a more formal system**, as in MAPPA and MARAC, with regular police-led safeguarding meetings for serious cases?

Q8d. Is there support for **multi-disciplinary teams/joint investigation teams** working together at the same location to assess intelligence, risk assess situations, take decisions on immediate action to safeguard vulnerable adults, decide whether a crime has been committed and whether the allegations should enter the safeguarding adults process? What are the advantages and disadvantages of joint investigations or joint investigation teams? What helps a joint investigation to work well?

Q8e. Police officers have considerable experience **of risk assessment and risk management**. Has that been sufficiently integrated into adult protection work and shared with the multi-agency partners, or should that be further developed? How should this be taken further?

Q8f. Should **information** about the safety of a person **be passed between** health and social care organisations, the ambulance service, GPs, the CSCI and the police? If so, can it happen now or does it need legislation? Should such information include incidents not amounting to abuse, but which may provide early indicators of the likelihood of abuse?

Q8g. Should we have **guidance on** if and when information should be shared, even when the victim expresses a wish that it is not shared?

Q8h. Should we look at ways of making it easier for people who may be vulnerable to **report abuse**?

Q8i. Would the proposal to have an **annual analysis/review** of all information held on each care/nursing home by all relevant agencies be likely to gain support from agencies, the public and the independent sector providers?

Q8j. **Financial abuse** appears to have increased steadily and to have diversified. Is there a need to explore the most common types and most effective responses? Should this include preventive strategies in consultation with the Financial Services Authority and the British Bankers' Association? Should banks, building societies and the Financial Services Authority be encouraged to share information that suggests financial abuse of vulnerable adults?

Q8k. What **strategic links** should there be between homicide reduction strategies, crime reduction partnerships, children's safeguarding boards, adult safeguarding boards, domestic violence forums and disability hate crime?

Q8l. **What else** is needed to increase the ability of the **police** to participate fully in adult protection/safeguarding?

Q8m. What can be done to **improve identification** of vulnerable adults by criminal justice practitioners? For example, could local arrangements be made to provide the police with local groups who might be able to offer advice?

Q8n. What more can be done to raise awareness in local areas of the **availability of intermediaries** to assist vulnerable adults with communication difficulties in criminal investigations and trials?

Q8o. **What else do you think would make a difference?**

8. The roles of guidance and legislation

We have, in this document, attempted to identify some of the main issues that safeguarding needs to address in the future. There are many more, which the forthcoming public consultation will identify and add. The question then becomes: what are the best ways of improving safeguarding? There will be many ways of doing this: raising practitioners' awareness, better training, better partnerships, more effective data sharing and better case management systems all might help. In this chapter we look at two specific options: new guidance, or new legislation together with new guidance.

New guidance

Do we want or need an updated, refreshed *No secrets* guidance document? Guidance has the advantage of being able to be broad and flexible. We can review and add to guidance every few years. In Wales, guidance on financial abuse was created as a separate and very useful addition to this country's *In Safe Hands* document.[40] We can change guidance as we learn lessons from our experience with personalisation, our experience with community empowerment and our experience with the use of special measures in the criminal justice system.

Guidance is more immediately applicable; it is more up to date and is more integrated to wider policy. An updated additional guidance document could be prepared for all multi-agency partners in safeguarding, or we might prefer to have more targeted guidance separately for police officers, possibly for the health sector and for local authorities.

However, a new guidance document on its own may not be sufficient to prioritise a focus on safeguarding. For example, it may not help improve the staffing levels at the police end of safeguarding and it may not necessarily get more prosecutions in the courts. Also, if we have new guidance, the question arises of what additional measures we need for each of the sectors.

New legislation

There has been a great deal of legislation and implementation of legislation since *No secrets*: the implementation of the Crime and Disorder Act 1998; the Data Protection Act 1998; the Youth Justice and Criminal Evidence Act 1999; the Care Standards Act 2000; the Sexual Offences Act 2003; the Domestic Violence Crime and Victims Act 2004; the Mental Capacity Act 2005 (including the deprivation of liberty additions and the new offences of wilful neglect and mistreatment), the Safeguarding Vulnerable Groups Act 2006; the Fraud

Act 2006; and the Corporate Manslaughter and Corporate Homicide Act 2007. We are also anticipating the new Equalities Act. Each of these places requirements on practitioners and organisations concerned with safeguarding.

Do we need more new legislation? The Government has to consider carefully the benefits of any new legislation and make sure that there is the right balance of laws, policies and freedoms in society. We need to consider how any new legislation would fit with other laws, for example, with the Human Rights Act 1998. We need to consider whether there is a case for making existing laws more visible, better used and more useful, rather than creating new law. The Law Commission will be carrying out a broad review of existing social care legislation and this consultation will feed into it.

Laws can be inflexible: they do not move easily with new policies. This means that any new legal duty in primary legislation must be carefully considered and there has to be certainty that the benefits of a new Act and new legal powers would substantially outweigh the disbenefits. Neither are laws a quick solution. Parliamentary time is limited and it is unlikely that new primary legislation could be commenced for at least two years after the decision to legislate is made.

In the listening events, the first response from our stakeholders was often that new safeguarding legislation is necessary. However, the second response was often that it would be difficult to identify what exactly would make the big difference that everyone wanted. Can we ensure through legislation that abuse and harm are prevented, or reduced, or tackled better? How much harm can we prevent through new legislation and how much freedom do we need to give up in order to do it? We need a thoughtful and considered public debate on these issues.

The calls for legislation address many different issues. We have selected four key areas under which to start the debate. The first is the role of the safeguarding adults boards and whether to make them statutory. The second is the duty of cooperation and information sharing. The third is clarification of terminology and duties. The fourth concerns new powers for police, or social workers or nurses to enter people's homes in the community if there is suspicion of abuse, and a duty to respond to complaints of possible abuse. We look at each of these in turn, and pose some questions.

Adult safeguarding boards

It has been argued that adult safeguarding boards should be placed on a statutory footing and that there should be a duty to contribute to serious case reviews. The safeguarding board could commission such reviews. Before a serious case review is commissioned, information from all available sources should be considered. Recommendations made during all serious case reviews could be placed on a national

database, to inform practice. Do we want these boards to be statutory? What would this allow them to do that they cannot do at the moment?

The duty to cooperate

Everyone would agree that multi-agency cooperation is very important; and safeguarding cannot take place without it. It is also generally agreed that it took a long time to begin to establish this cooperation in each of the local areas, and that it is still a problem in some areas, especially in relation to some partner agencies. We are part of the way there on cooperation. Broadly, the message seems to be that cooperation in some areas and with some partners is now perhaps better than it has been but that there are still significant problems.

What would a duty to cooperate add? How would it be enforced? Would we need to develop sanctions in response to non-cooperation or poor coordination? Does placing a legal duty on an organisation ensure that effective practice will result?

Sharing information is part of cooperation and is also crucial to its success. It is increasingly recognised that information sharing is one of the keys to prevention and early response. We saw some very good practice in information sharing in West Lothian – where not only were police, health and social work staff co-located and managed in one unit, but the police database recorded a large variety of incidents from different sources and was able to identify trends and patterns at an early stage. Do we need legislation or more good practice guidance on information sharing? Different databases in partner agencies may make this difficult and we do not know if the public will agree to this sharing of data about suspicions and allegations.

And the duty to cooperate is also linked to the role of adult protection/safeguarding committees or boards. Are these properly constituted; who are they accountable to; and should there be a stronger role for members? Should they be made statutory?

Clarification of duties and powers and of definitions

At the listening events we were told it is not always clear what the duties and powers of the different agencies in the multi-agency framework are, although the Commission for Social Care Inspection/Association of Directors of Adult Social Services/Association of Chief Police Officers protocol addresses this. Do they need to be spelt out more clearly – and also discussed publicly? Does an ambulance trust have a duty to identify properties where people with mental health needs are calling ambulances frequently – and to share this information? This is a key issue in Cornwall at the moment – and the answer may well be 'yes'. But does it require legislation to bring that about?

Regarding clarity of definitions: 'safeguarding', 'vulnerability', 'people at risk' – all these need defining and understanding. We need useful working definitions but do we need another piece of legislation? What does enshrining definitions, powers and duties in law add?

New social work, police or other powers

a) Powers to enter private homes

Currently social workers do not have the power to enter a private home when there are grounds to suspect that an adult is being abused. They need to persuade a police officer that an adult is being harmed – they can then accompany them "to save life or limb". The question is whether police, social workers, nurses or occupational therapists should be given the legal power to enter private homes in response to concerns. If yes, should they have these powers for assessment or removal or barring, or for all these purposes?

There are two types of situation where this may be an issue. First, there may be concerns about 'self-neglect' involving a small number of people who are perhaps not coping well living independently in the community and who may live in chaotic homes and not look after themselves well. Should police or social workers or nurses have the right to forcibly enter a home if these individuals are very clear that they do not want social work help? If yes, should there also be a right to remove people against their wishes? Is the National Assistance Act 1948 (as amended) not working in this respect? How does the Mental Capacity Act 2005 work in such circumstances?

The second situation is where a family or other person is preventing a person from having access to social workers or to other forms of assistance. Should social workers rely on negotiations – or should they be given a right of entry and the right to remove people who say that they do not wish to be removed?

These questions are central to the Human Rights Act 1998, under which individuals have both the right to family life and the right to be safe from abuse and harm. How do we balance these two imperatives? With a legal power to enter, and remove people, there will be situations where people's right to family life, privacy and self-determination may be violated. But there will also be occasions where people will be protected from harm and helped to leave situations where they are at risk.

There is a separate, but related, question about whether police need additional powers to enter people's homes. Police officers are able to enter premises under section 17 of the Police and Criminal Evidence Act (PACE) 1984 to save life or limb. However, the majority of adult protection concerns do not amount to immediate fears about danger to the life of a vulnerable adult, and the use of these powers may not be reasonable in more than a few cases.

If there is a need for changes, we need to decide how to make them. One suggestion is that legislation should be introduced to amend section 17 of PACE to allow entry where there are reasons to believe that a vulnerable adult is being subjected to abuse. There are two possible options here. The first is that a police officer of the rank of inspector or above must authorise entry. The second is that entry must be authorised by a magistrate. We would also need to decide whether the power of entry should just be for police officers or whether it should include social workers and other professionals.

Once inside a person's home, what action should be permitted? We need to consider the person; if they should be removed with or without their consent, where to and for how long. Who, if anyone, should accompany the police officers?

b) Duty to act on alerts of the need for adult protection; duty of care; duty to investigate

Some people have argued for the need to have a legal duty to act on alerts of possible harm. This duty could apply only to social workers – or to a much wider range of professionals – and would make it mandatory to take appropriate action when they have reason to suspect that a vulnerable adult is being abused. At present, no such specific legal duty exists (apart from the one vested in *No secrets*), although a recent judgment about a case in Hounslow suggests that local authorities may already have such a public duty as part of their other housing and social care responsibilities. Other suggestions have included a duty of care (raising the question of which organisations this would apply to) and a duty to investigate – possibly also a duty to whistle-blow and to cooperate with the investigation afterwards.

We have posed questions here about whether new legislation is thought to be necessary and, if so, specifically about which issues. It is important to remember that all legislation has benefits and dis-benefits and is not always the best way to change custom and practice. Equally, there are times when bringing to bear the force of law is a very powerful lever. The Government is open-minded on the question of legislation and would welcome views.

Guidance and legislation

Q9a. Do we need an updated and refreshed ***No secrets*** **guidance**? If so, should it be one document for all multi-agency partners, or should there be separate documents for: the criminal justice system; the health sector; and local authorities, to include social care, housing and community safety?

Q9b. Is new **legislation** necessary and how would it help?

Q9c. Should legislation placing **safeguarding adults boards** on a statutory footing be introduced? Should it include a duty to commission and contribute information to serious case reviews?

Q9d. Should we introduce a **wider duty to cooperate** in relation to safeguarding? Who would this apply to, how would it improve outcomes and how would it be enforced?

Q9e. Should there be a **power to enter premises** where it is suspected that a vulnerable adult is being abused? Should this power apply to: the police only; or social workers and other professionals as well?

Q9f. Should such a **power apply when an adult has mental capacity** and may be self-neglecting or self-harming?

Q9g. If a power of entry is supported, which **means to obtain entry** should be introduced (e.g. authorisation by a senior police officer or magistrate or other means)?

Q9h. Should an **offence of ill-treating or neglecting a vulnerable adult with capacity** be introduced?

Q9i. Should there be a **power to remove an adult** who does have capacity and who does not consent, but who is thought to be being subjected to harm?

Q9j. Should **force** be used to remove a person who is self-neglecting or self-harming?

Q9k. If a person is **removed, where** should they be taken, for what purpose and for how long?

Q9l. Is current **care standards legislation sufficient** for closing down poorly performing care homes in a timely and effective manner?

9. The definition problem

No secrets set out, for the first time, national definitions for the terms 'vulnerable adult' and 'abuse'. A vulnerable adult was defined as a person aged 18 or over who is or who may be in need of community care services by reason of mental or other disability, age or illness; and who is or who may be unable to take care of himself or herself, or unable to protect himself or herself against significant harm or exploitation. There is a broad belief that the definition does need revision, but no clear agreement on how this revision may take place.

The lack of agreement reflects the several different definitions of 'vulnerable' or 'vulnerable adult' that now exist in legislation. The definitions in the Care Standards Act 2000, the Youth Justice and Criminal Evidence Act 1999 and the Safeguarding Vulnerable Groups Act 2006 differ significantly from each other, making it difficult for operational staff to identify who should be referred (or accepted) into safeguarding services. To add to the potential confusion, Scotland has abandoned the use of the term 'vulnerable adult' in its new legislation, and uses instead 'adult at risk'. Importantly, the term 'vulnerable' has been seen by some groups as patronising and dis-empowering to the individuals concerned.

To develop an appropriate definition, we have first to be clear what we want the successor to the *No secrets* guidance to achieve. We begin by suggesting that we want the definition to enable practitioners and others to decide which groups of people we believe require special help to deal with abuse, in order to 'signpost' them towards some sort of special support. To achieve this, the definition will need to do two things:

- to clarify what 'wrongs' we want the new *No secrets* to put right, i.e. to define what is 'abuse'; and
- to define how bad the 'wrong' has to be to warrant a response, i.e. to define the threshold needed to justify a response.

A definition that can do these two things will give a general starting point. But before we can finalise a definition, we will also need to make some more difficult choices:

- whether (and how) the definition should refer to the vulnerable adult being unlikely to be able to self-care or protect himself or herself from harm or exploitation;
- whether it is right, or indeed possible, to separate a situation where a person lacks the mental capacity to recognise what is happening to them as abuse from one where the person does have the capacity but chooses to ignore, condone or accept the abuse;

- whether (and how) the definition should seek to distinguish between abuse carried out by a person in a position of trust or power in relation to the victim and that committed by a stranger;
- whether there should be a test (as in the paramountcy principle used in children's services) to ensure that everything we do is in the best interests of the individual who is the focus of concern; and
- whether we should limit the range of people to whom we are prepared to offer assistance. There is a need for clarity about the implications of definitional changes. A wide definition may lead to homeless people, drug addicts, alcoholics and others being regarded as vulnerable adults. We need to be aware of the risks of a wide definition which include diluting the strength of this review and also placing a great strain on limited resources for central and local government. But if we have a narrow definition, then should we also have a duty to at least offer some help – information, signposting, advice – to those who fall outside the definition?

Despite the lack of overall agreement, some themes do seem to be emerging. The reference in *No secrets* to "eligible for community care", which in 2000 was a positive and inclusive definition, is now increasingly felt to discriminate against adults with low-level needs. It has also been used to limit eligibility (inappropriately) for protection to those who are already receiving community care services.

Views and comments on all of these issues would be welcomed.

Definitions

Q10a. Should the *No secrets* definition of vulnerable adult be revised? If so, should the revised definition do the following, and if so, how?

Should it:

- enable practitioners to decide which groups of people they believe require special support?
- provide clarity on what 'wrongs' we want the new *No secrets* guidance to put right?
- clarify how bad the 'wrong' has to be to warrant a response, i.e. define the threshold needed to justify a response?
- take into account those vulnerable by reason of a temporary physical or mental condition?

- distinguish between abuses carried out by a person in a position of trust or power in relation to the victim and those committed by a stranger?
- make reference to an adult being unlikely to be able to protect himself or herself from harm or exploitation?

Q10b. What language should we use? Is 'abuse' always useful or should we change to 'harm' and 'crime'? Is 'perpetrator' always useful (i.e. for neglect within families)?

Q10c. How do we enshrine within safeguarding the principles contained within the Mental Capacity Act 2005 and the Human Rights Act 1998?

Summary of consultation questions

1. Leadership

Q1a. Where should leadership for safeguarding adults lie nationally, and how should the various national organisations work together?

Q1b. Where should it lie locally? If within local government, then where in local government?

Q1c. Do we need a template for 'a local safeguarding job description' and national procedures for use locally?

Q1d. How do we know if a safeguarding board is working effectively? To whom should it be accountable?

Q1e. Where should leadership for NHS safeguarding issues lie? Do we want national procedures for the NHS?

Q1f. Where should leadership for safeguarding in the care home sector lie? What can be done to strengthen this?

Q1g. Given that there are multiple 'chains of command', how do we ensure that formal leadership roles are accompanied by appropriate authority levels?

2. Prevention

Q2a. Should we be doing more work on prevention? If so, where should we concentrate our efforts? If you are doing effective preventive work, please tell us what it involves.

Q2b. Should we develop a national prevention strategy for adult safeguarding which includes, for example, links with neighbourhood policing, with a human rights agenda, and with Health and Well-Being?

Q2c. Are whistle-blowing policies effective? What can we do to strengthen them?

3. Outcomes

Q3a. Would an **outcomes framework** for safeguarding adults be useful? If so, which indicators should we use within the wider responsibilities of local government, the NHS and the police force?

Q3b. Should we encourage **local annual reports** to be more evaluative?

Q3c. How can we **learn from people's experiences of harm** and their experiences of the safeguarding process in order to improve safeguarding?

Q3d. Should we review current arrangements for delivery of safeguarding adults **training**? Should we have national occupational training standards across all agencies?

Q3e. Should we have a national **database of recommendations** from serious case reviews at a national level? Should we review the effectiveness of serious case reviews as learning tools? What should trigger a serious case review, and how should the conclusions be disseminated?

Q3f. Should we develop **joint inspections** to look at safeguarding systems as a whole? Should this include the police (Her Majesty's Inspectorate of Constabulary) – as for inspecting local children's services?

Q3g. What are the desired **outcomes** of safeguarding work?

Q3h. Should there be **national safeguarding adults guidance** that incorporates training, outcomes and multi-agency procedures? How would this be integrated into the personalisation agenda discussed in chapter 4?

Q3i. How much does adult protection **currently cost**? How is it funded? What evidence is there, if any, that increased funding would lead to better outcomes?

4. Managing risks

Q4. In an environment where an increasing number of people will be taking responsibility for arranging their own support, we need to have a debate on how their interests can be safeguarded. What aspects of safeguarding do we need to build into personalisation? What training, risk assessment and risk management should we use? Please tell us what you are doing locally and what more needs to be done.

5. Managing choice

Q5. What aspects of personalisation – greater independence, choice and control – can we build into safeguarding? How do we better reflect service users' informed choices? How do we facilitate informed self-determination in risky situations and in the safeguarding process? How can we move forward on this agenda?

6. Health services and safeguarding

Q6a. How is the ***No secrets*** **guidance being implemented** and applied to ensure that it enables staff in the NHS to recognise, investigate and act on abuse? Are local arrangements effective? What more should be done?

Q6b. Are health organisations able to work with and adopt multi-agency guidance, or is it essential to **develop operational guidance** that adapts procedures into language, culture and structures appropriate to healthcare?

Q6c. What are the **responsibilities of the NHS safeguarding leads** – are they champions, professional leaders, awareness-raisers, data collectors and reporters? Can one person fulfil all these roles? If not, how should these responsibilities be shared?

Q6d. Is there a need for **regional safeguarding forums** where health organisations can share good practice and learning? If so, what would they look like?

Q6e. How do **procedures for investigating serious untoward incidents** (SUIs) fit into the multi-agency context of safeguarding?

Q6f. Are adult safeguarding **systems within the NHS effective**? If not, what are the specific challenges that need to be addressed?

Q6g. Are any parts of the NHS or healthcare sector **less engaged** and more in need of assistance to get on board with safeguarding?

Q6h. Is the **role of GPs** a crucial role for safeguarding in the NHS? Where is the existing good practice and what can be learnt from it?

Q6i. Are there particular issues in relation to safeguarding and **mental health**? If so, how should these be addressed?

Q6j. What **central leadership** role should there be (if any), and what function should it have (Healthcare Commission, Monitor, Department of Health, General Medical Council, Nursing and Midwifery Council, strategic health authorities)?

Q6k. What are the main **drivers for standards** in the NHS that safeguarding should be linked to?

7. Safeguarding, Housing and Community Empowerment

Q7a. Do we need stronger policy links between safeguarding and community development and empowerment? How can this be achieved at the national and the local levels?

Q7b. How can housing providers contribute to safeguarding? What could housing departments, housing associations and supported housing/living providers do to enable their tenants and residents to live safer lives?

8. Access to the criminal justice system

Q8a. How can safeguarding vulnerable adults be **better integrated** into the mainstream criminal justice arena?

Q8b. Are **police units adequately staffed** to respond to the increased reporting of adult protection issues? If not, what changes are needed?

Q8c. Is there a **need to develop a more formal system**, as in MAPPA and MARAC, with regular police-led safeguarding meetings for serious cases?

Q8d. Is there support for **multi-disciplinary teams/joint investigation teams** working together at the same location to assess intelligence, risk assess situations, take decisions on immediate action to safeguard vulnerable adults, decide whether a crime has been committed and whether the allegations should enter the safeguarding adults process? What are the advantages and disadvantages of joint investigations or joint investigation teams? What helps a joint investigation to work well?

Q8e. Police officers have considerable experience of **risk assessment and risk management**. Has that been sufficiently integrated into adult protection work and shared with the multi-agency partners, or should that be further developed? How should this be taken further?

Q8f. Should **information** about the safety of a person **be passed between** health and social care organisations, the ambulance service, GPs, the CSCI and the police? If so, can it happen now or does it need legislation? Should such information include incidents not amounting to abuse, but which may provide early indicators of the likelihood of abuse?

Q8g. Should we have **guidance on** if and when information should be shared, even when the victim expresses a wish that it is not shared?

Q8h. Should we look at ways of making it easier for people who may be vulnerable to **report abuse**?

Q8i. Would the proposal to have an **annual analysis/review** of all information held on each care/nursing home by all relevant agencies be likely to gain support from agencies, the public and the independent sector providers?

Q8j. **Financial abuse** appears to have increased steadily and to have diversified. Is there a need to explore the most common types and most effective responses? Should this include preventive strategies in consultation with the Financial Services Authority and the British Bankers' Association? Should banks, building societies and the Financial Services Authority be encouraged to share information that suggests financial abuse of vulnerable adults?

Q8k. What **strategic links** should there be between homicide reduction strategies, crime reduction partnerships, children's safeguarding boards, adult safeguarding boards, domestic violence forums and disability hate crime?

Q8l. **What else** is needed to increase the ability of the **police** to participate fully in adult protection/safeguarding?

Q8m. What can be done to **improve identification** of vulnerable adults by criminal justice practitioners? For example, could local arrangements be made to provide the police with local groups who might be able to offer advice?

Q8n. What more can be done to raise awareness in local areas of the **availability of intermediaries** to assist vulnerable adults with communication difficulties in criminal investigations and trials?

Q8o. **What else do you think would make a difference?**

9. Guidance and legislation

Q9a. Do we need an updated and refreshed ***No secrets*** **guidance**? If so, should it be one document for all multi-agency partners, or should there be separate documents for: the criminal justice system; the health sector; and local authorities, to include social care, housing and community safety?

Q9b. Is new **legislation** necessary and how would it help?

Q9c. Should legislation place **safeguarding adults boards** on a statutory footing be introduced? Should it include a duty to commission and contribute information to serious case reviews?

Q9d. Should we introduce a **wider duty to cooperate** in relation to safeguarding? Who would this apply to, how would it improve outcomes and how would it be enforced?

Q9e. Should there be a **power to enter premises** where it is suspected that a vulnerable adult is being abused? Should this power apply to: the police only; or social workers and other professionals as well?

Q9f. Should such a **power apply when an adult has mental capacity** and may be self-neglecting or self-harming?

Q9g. If a power of entry is supported, which **means to obtain entry** should be introduced (e.g. authorisation by a senior police officer or magistrate or other means)?

Q9h. Should an **offence of ill-treating or neglecting a vulnerable adult with capacity** be introduced?

Q9i. Should there be a **power to remove an adult** who does have capacity and who does not consent, but who is thought to be being subjected to harm?

Q9j. Should **force** be used to remove a person who is self-neglecting or self-harming?

Q9k. If a person is **removed, where** should they be taken, for what purpose and for how long?

Q9l. Is current **care standards legislation sufficient** for closing down poorly performing care homes in a timely and effective manner?

10. Definitions

Q10a. Should the *No secrets* definition of a vulnerable adult be revised? If so should the revised definition do the following, and if so, how?

Should it:

- enable practitioners to decide which groups of people they believe require special support?
- provide clarity on what 'wrongs' we want the new *No secrets* guidance to put right?
- clarify how bad the 'wrong' has to be to warrant a response, i.e. define the threshold needed to justify a response?
- take into account those vulnerable by reason of a temporary physical or mental condition?
- distinguish between abuses carried out by a person in a position of trust or power in relation to the victim and those committed by a stranger?
- make reference to an adult being unlikely to be able to protect himself or herself from harm or exploitation?

Q10b. What language should we use? Is 'abuse' always useful or should we change to 'harm' and 'crime'? Is 'perpetrator' always useful (i.e. for neglect within families)?

Q10c. How do we enshrine within safeguarding the principles contained within the Mental Capacity Act 2005 and the Human Rights Act 1998?

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Appendix 1: The consultation process

This consultation seeks views on the questions identified in the scoping stage of the review of the *No secrets* guidance. The consultation questions are included in each chapter. An easy read version is also available. We are inviting you to choose which of the many questions you wish to reply to.

How to respond

The consultation begins on 13 October 2008 and closes on 31 January 2009. As well as inviting written responses to the questions, there will be a series of regional and national events, workshops and meetings organised by the Care Services Improvement Partnership for people to give their views. Details will be available on the Department of Health (DH) website (www.dh.gov.uk). We are also consulting directly with service users. If you would like further copies of this document, you can download it from the DH website and a limited number of hard copies can be obtained by emailing nosecretsreview@dh.gsi.gov.uk.

Please send consultation responses by email to:

nosecretsreview@dh.gsi.gov.uk

or by post to:

Lucy Bonnerjea
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Wellington House
133 Waterloo Road
London
SE1 8UG

The Department of Health, together with the Home Office and the Ministry of Justice, will use the responses in the development of further guidance and other measures to improve the safeguarding process. We appreciate the time taken to respond, and hope that you will choose those questions which you are most interested in and which are most relevant to you.

When responding, please state whether you are responding as an individual or representing the views of an organisation. If you are representing the views of others, please tell us how their views were assembled.

Criteria for consultation

This consultation follows the Cabinet Office *Code of Practice on Consultation* (2005). In particular, we aim to:

- consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy;
- be clear about what our proposals are, who may be affected, what questions we want to ask and the timescale for responses;
- ensure that our consultation is clear and widely accessible;
- ensure that we provide feedback regarding the responses received and how the consultation process influenced the development of the policy;
- monitor our effectiveness at consultation, including through the use of a designated consultation coordinator; and
- ensure that our consultation follows better regulation best practice, including carrying out a regulatory impact assessment if appropriate.

The full text of the code of practice is on the Better Regulation website at:

www.berr.gov.uk/files/file44364.pdf

Comments on the consultation process itself

If you have concerns or comments that you would like to make relating specifically to the consultation process itself, please contact:

Consultations Coordinator
Department of Health
3E58, Quarry House
Leeds
LS2 7UE

email: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department of Health.

The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary of the consultation

A summary of the response to this consultation will be made available within three months of the end of the live consultation period and will be placed on the Consultations website at www.dh.gov.uk/en/Consultations/Responsestoconsultations/index.htm

Appendix 2: Acknowledgements

The Department of Health would like to thank the following people who participated in the scoping of this review.

The Department of Health

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The Programme Board

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Jill Manthorpe	King's College London
Leo Quigley	Department of Health/Sheffield Council
Gary Rooney	Association of Chief Police Officers

The Advisory Group

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