

Safeguarding Adults

*Report on the consultation on the
review of 'No Secrets'*



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Safeguarding Adults – Report on the Consultation on the Review of “No secrets:

Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse”

Foreword



We launched a consultation on Safeguarding Adults in October 2008 and we are now very pleased to publish the results of the consultation. Our aim was to learn from a wide range of stakeholders the best way to empower people, whose situation makes them vulnerable, to keep themselves safe. We want to enable self-determination and choice, whilst at the same time, where there is a risk of harm or abuse, to identify the systems, structures and tools that will enable effective safeguarding for all.

We are delighted that 12,000 people were able to take part in the consultation and give their views as to the best way forward. The consultation has identified the main issues that we need to consider and the Government will publish its response when we have examined them in more detail.

17th July 2009

Handwritten signature of Phil Hope in black ink.

Phil Hope
Parliamentary Under Secretary
of State, Department of Health

Handwritten signature of Claire Ward in black ink.

Claire Ward
Justice Minister

Handwritten signature of Vera Baird in black ink.

Vera Baird QC, MP
Solicitor General

Handwritten signature of Alan Campbell in black ink.

Alan Campbell
Parliamentary Under Secretary of State
for Crime Reduction

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Executive Summary

1. This is the report on the consultation, *Safeguarding Adults: The review of "No secrets Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse"*. The consultation was carried out by four government departments: the Department of Health (DH), the Home Office (HO), the Ministry of Justice (MoJ) and the Attorney General's Office (AGO) and ran from 16th October 2008 to 31st January 2009. It involved 12,000 participants, including 3,000 members of the public, many of whom were adults to whom this guidance applied, or their carers. The remaining 9,000 participants were professionals working in the field. We received nearly 500 long and detailed written responses.
2. The Welsh equivalent of *No secrets*, entitled "*In Safe Hands – Implementing Adult Protection Procedures In Wales, July 2000*" is also under review by the Welsh Assembly Government. The review is being conducted by the University of Glamorgan and their report is due in Autumn 2009. Policing in Wales remains the responsibility of the Home Office so Welsh police forces have also contributed to the *No secrets* consultation and the Home Office is liaising with the Welsh Assembly Government over the review.
3. The Government is aware that there are concerns about the *No secrets* definition and the term "vulnerable adult." This consultation therefore asked the question "Should the *No secrets* definition be revised?" and the review is examining both this issue and the terminology (Q10a/b). Therefore, for the purposes of this report, we have used the term "adult" to describe those who fall within the parameters of this guidance.
4. Key messages from the participation of older people, adults with learning or other disabilities and people with mental health needs included:
 - a) Safeguarding must be built on empowerment – or listening to the victim's voice. Without this, safeguarding is experienced as safety at the expense of other qualities of life, such as self determination and the right to family life.
 - b) Everyone must help to empower individuals but safeguarding decisions should be taken by the individual concerned. People wanted help with options, information and support. However, they wanted to retain control and make their own choices.

- c) Safeguarding adults is not like child protection. Adults do not want to be treated like children and do not want a system that was designed for children.
 - d) The participation/representation of people who lack capacity is also important.
5. Stakeholders from professional and voluntary organisations wanted better leadership from central government, local government, the NHS, the Care Quality Commission, the Police Service and housing leaders. There was strong support for making Safeguarding Adults Boards statutory; for developing prevention work, having joint inspections and identifying workable outcomes.
6. There was great interest in establishing the appropriate balance between safeguarding and personalisation. It was argued that this balance, of choice and risk, had not yet been determined, and that there had been little leadership. Despite this some professionals reported they had made good progress and built bridges to deliver both safeguarding and personalisation. These included various measures around informed choice; support systems for direct payments; and looking at the way reviews are carried out. Further work was needed to develop financial safeguarding in the light of developments on personalisation.
7. Professionals across the NHS reported that the NHS was struggling to ‘own’ the concept of safeguarding, with greater reliance on internal parallel systems of investigations. This was despite a number of important policy and practice initiatives which could be harnessed. There were pockets of good practice – for example, where PCTs were commissioning services that explicitly addressed safeguarding. There was also a growth in NHS staff with formal safeguarding responsibilities. However, there was little NHS leadership and safeguarding remained an undeveloped area. There were particular concerns about the participation of GPs and Mental Health Trusts in safeguarding meetings.
8. Housing providers wanted to play a part in safeguarding and were seeking leadership from within the housing sector in defining their role within safeguarding. Some good work had been done around customer profiling and developing vulnerability policies; and there was a clear understanding that the focus needed to be on ‘empowering tenants to keep themselves safe’. The Supporting People’s Quality Assessment Framework (QAF) was regarded as a helpful framework for working with adults.

9. The Association of Chief Police Officers (ACPO) led an extensive consultation across the Police Service in England and Wales. Police forces and individual officers participated actively and showed their commitment to the safeguarding adults agenda. The Police Service believed that national leadership should lie with Adult Social Care and the Department of Health and, on a local level, that responsibility should sit with Safeguarding Adult Boards. They supported legislation to make Safeguarding Adult Boards statutory and to oblige partners to cooperate, share information, report suspected abuse and work together to reduce harm and safeguard those at risk. They wanted a national guidance document supported by an inspection framework, a national database of recommendations from serious case reviews and argued that improving information sharing was the key to improving the effectiveness of prevention work. Probation Areas/Trusts were also involved in the consultation and wanted to be better linked into the safeguarding of adults. The voluntary sector organisations working with adults under this guidance in the criminal justice system wanted crimes against them taken seriously and dealt with as crimes; to be able to support and advocate for them in the criminal justice system; and to be involved with police and Crown Prosecution Service training in this area.
10. There were reportedly few successful prosecutions in relation to safeguarding.
11. There was widespread support for safeguarding legislation at the consultation events. The majority – 68% – of respondents to the written consultation supported legislation. The following reasons were given: a) safeguarding adults should mirror child protection; b) legislation would make safeguarding a priority; c) Scotland had the new Adult Support and Protection Act 2007 that made their adult protection statutory; d) the Government's choice agenda needed to be balanced with a safeguarding agenda.
12. Reasons given for not needing legislation included: a) much had been achieved in adult safeguarding without legislation and improvements were likely to continue; b) legislation would not necessarily lead to adult safeguarding becoming a priority; c) the experience in Scotland ought to be studied over some years before conclusions were drawn; and some of the possible new legislative powers would extend the Government's power over people's lives in a dangerous way; d) the most effective safeguarding was when it became part of mainstream activity and was effectively part of the choice agenda.

13. 90% of respondents wanted the *No secrets* definition of a ‘vulnerable adult’ revised and there was much support for replacing the term ‘vulnerable adult’ with ‘person at risk.’ Other terminology of concern to some respondents was the use of ‘abuse’ and ‘perpetrator’ when referring to the spouses of older people with dementia when what was required was more support for the carers. The consultation identified that people from black and minority ethnic (BME) backgrounds, particularly the older generations, had less understanding of what abuse meant or how to get help; and some had significant concerns about being able to get help in ways that were respectful and might help to keep their family honour intact.
14. This report sets out the main issues raised. The Government is now looking at all the evidence and working to develop a response, taking into account what we have learned from the consultation. The Government considers all forms of abuse to be unacceptable but the abuse of those in situations that make them vulnerable, and who do not have the capacity to safeguard themselves from harm, to be particularly abhorrent.
15. This Government has a vision of an inclusive society with opportunities and justice for all. It has a vision of a future for the safeguarding of those at risk of harm which is empowering and person centred, preventative and wide-ranging. This vision extends to the whole criminal justice system, whether the vulnerable adult is a victim or has committed a crime themselves. Most importantly, the delivery of this vision will require strong multi-agency and inclusive partnership working.

1. Introduction

The aims of the consultation

1.1 The Government Consultation on 'Safeguarding Adults' closed on January 31st 2009. It was led by four government Ministers – Phil Hope from the Department of Health, Maria Eagle from the Ministry of Justice, Vera Baird – the Solicitor General, and Vernon Coaker from the Home Office. The aim of the consultation was to listen to, and to learn about, views and experiences of adult safeguarding. The main question posed by the consultation was whether and how the *No secrets* guidance needed to change to enable society to keep adults safe from abuse or harm. This included whether new legislation was necessary.

1.2 The existing Government policy, as set out in *No secrets*, asked the question "Which adults are vulnerable?" and stated:

"In this guidance 'adult' means a person aged 18 years or over. The broad definition of a 'vulnerable adult' referred to in the 1997 Consultation Paper 'Who decides?', issued by the Lord Chancellor's Department, is a person:

"who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

For the purposes of this guidance 'community care services' will be taken to include all care services provided in any setting or context." (*Section 2.2 of "No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse."*)

1.3 The Government is aware that there are concerns about this definition and the term "vulnerable adult" and this consultation asked the question "Should the *No secrets* definition be revised?". The review is examining both this issue and the terminology. For the purposes of this report, we have mainly used the term "adult" to describe those who fall within the parameters of this guidance.

- 1.4 The Government invited a wide range of stakeholders – the general public and people who had witnessed or experienced abuse, social workers, police officers, NHS staff, lawyers, voluntary organisations and others – all to consider what role policy, guidance and legislation could play in the future of safeguarding adults and the empowerment of people.
- 1.5 The Government wanted to listen to what was going well and was not going well. We wanted to find out what was needed to prevent, to respond to and to stop harm – to report, to question and to challenge abuse, and to work within the criminal justice system to bring to justice those who commit criminal offences against those in situations that make them vulnerable.
- 1.6 This consultation process was essentially about learning. It was about how society – both the public and professionals – could learn to safeguard adults, and to identify and manage risk. It was about how people can be empowered to say no to abusive situations and stop criminal behaviour. It was about locating safeguarding in the wider policy goals of choice and control. It set out to recognise safeguarding as everyone’s business. It was also about identifying what is needed for better safeguarding, whether people were police officers working in neighbourhood policing, housing officers carrying out tenancy verification, social workers reviewing care and support packages, health staff faced with a disabled person with unexplained bruises or a member of the Crown Prosecution Service considering how the evidence of a disabled person with communication difficulties should be heard in court.

The consultation process

- 1.7 An engagement strategy was developed to stimulate a wide debate about the future of adult safeguarding with large and diverse groups of stakeholders. The engagement strategy benefited greatly from input from both the *No secrets* programme board and the advisory group. This strategy was characterised by:
 - a) A focus on multi-agency safeguarding partnerships and their role in adult safeguarding as effective local partnerships; this included professionals from health, local authority, criminal justice, voluntary and other organisations, and others all working together to discuss and debate the way forward; and
 - b) Separate events for members of the public, whether or not they had experienced old age, learning or other disability, mental health

problems or other possible forms of 'vulnerability', to articulate their views and experiences.

1.8 This engagement strategy delivered:

- a) 16 large multi-agency consultation events supported by the Government, across the country from Newcastle to Exeter, many with several hundred people participating in each. This was in addition to the discussions within most of the local Adult Safeguarding Partnerships.
- b) Targeted consultation events involving the criminal justice sector; the NHS; housing staff and key voluntary organisations.
- c) A survey of police forces in England and Wales by the Association of Chief Police Officers (ACPO) in addition to the participation of police officers in many of the multi-agency events. (Although health matters are devolved in Wales, policing in Wales remains the responsibility of the Home Office so Welsh police forces have also contributed to the *No secrets* consultation and the Home Office is liaising with the Welsh Assembly Government over the review.)
- d) Separate consultation events for over 300 people with learning disability organised through Valuing People and the National Forum, and separate events for older people.
- e) Through an advert in a national newspaper, organisations were funded to run 11 consultations with hard to reach groups. These included 900 people with mental health needs and many people from BME communities. A total of 2,000 people were consulted by this method.
- f) Appendix A provides the quantitative analysis; Appendix B is a list of respondents; Appendix C is a report on the consultation process; while Appendix D is a list of the small local projects funded in e) above.

1.9 12,000 people participated in this consultation and 3,000 of them were people who participated and contributed as adults to whom the *No secrets* guidance might apply.

Box 1: Number of participants

- 12,000 people participated in this consultation in 228 events.
- 3,000 members of the public participated: adults to whom the *No secrets* guidance might apply.

The analysis of the responses

- 1.10 The analysis of the consultation responses has been complex. This is partly because the issues are complicated and the 64 questions (plus sub-questions) asked in the consultation report reflect the many aspects of adult safeguarding that people wished to discuss. The analysis was also complex because there were essentially three types of response. There were 12,000 participants in events; and some 500 written responses including 108 very detailed Safeguarding Partnership responses.
- 1.11 At the events, many people discussed what they thought worked for them and what did not work for them in adult safeguarding; they shared their personal views and their experiences. They told us what they wanted to change.
- 1.12 The written responses were much more detailed, but also quite diverse. They included responses which clearly reflected the views of a large organisation, such as the Care Quality Commission (CQC) or the Police Service. They included responses which reflected the views of NHS Trusts, small voluntary organisations, umbrella organisations representing many other organisations, the views of individuals – some of whom shared their personal views as safeguarding coordinators and some as individuals who had experienced the safeguarding process.
- 1.13 Finally, there were long and detailed responses from 108 Safeguarding Partnerships. These were expressions of years of experience and depth of feeling, of professional engagement and personal experience as safeguarding champions and of years of multi-agency cooperation. Again the views, suggestions, examples, policies and exhortations are a vital contribution to an understanding of the history and future of adult safeguarding.
- 1.14 All this material was rich in detail and importance: it was immensely valuable and relevant – and immensely difficult to compare and analyse. Some reflect the views of individual coordinators, others have been signed off, and some possibly written by, Directors of Adult Social Care. Some were apparently painfully arrived at partnership views, reflecting the different and equally valid views of each of the partnership organisations, while others were much less debated and discussed position statements. The language of social care, the NHS and criminal justice are markedly different – their aims however are the same.

2. Key Messages

- A. Safeguarding requires empowerment/the 'victim's' voice needs to be heard.
 - B. Empowerment is everybody's business, but safeguarding decisions are not.
 - C. Safeguarding Adults is not like Child Protection.
 - D. The participation/representation of people who lack capacity is also important.
- 2.1 An important objective of the engagement strategy was to hear from the people who might be regarded as in need of safeguarding. We begin this report with a summary of their views, together with the views of people working in the voluntary sector.
- 2.2 We listened to some 3,000 members of the public in this consultation. This included hundreds of people who had learning disabilities, hundreds who had experience of having been detained or sectioned under the Mental Health Act 1983, and some very elderly and frail people. But it did not include people who lacked capacity to consider these issues and to communicate their views. Some reflections on this limitation to the consultation are set out in the final paragraphs of this section of the report.
- 2.3 There were four strong messages from the respondents about safeguarding. The first was the importance of linking empowerment to safeguarding. The second was that safeguarding decisions were seen as personal while empowerment was seen as everybody's business. The third was about the important differences between safeguarding adults and children. A fourth message is a reminder about the participation/representation of people who lack capacity.

A. Safeguarding requires empowerment/the 'victim's' voice.

- 2.4 One of the strongest messages from the engagement with non-professionals was that safeguarding must be built on empowerment – on listening very carefully to the voices of individuals who are at risk, and those who have been harmed. Without empowerment, without people's voices, safeguarding did not work (see Box 2).

- 2.5 This message applied equally to the criminal justice system. The voice of victims, whether in pre-recorded witness statements, in victim’s accounts, in video evidence was said to be very important, so is a witness profile and a victim impact assessment. In a criminal justice context there are increasingly numerous ways that a victim’s voice can, and should be heard, and people were very concerned that this should be central to the criminal justice system. They called for this to be rolled out nationally and consistently.

Box 2: Voices for Empowerment/Victims’ Voices

Quotes from the consultation responses

- VOICE 1: *What was clear from one group of respondents was that the safeguarding system had failed them.... People said they seemed to get lost in the process and the bureaucracy....outcomes seemed to be in the best interests of the care home.. or the hospital, or the local authority.... None of the people interviewed (by AEA for this consultation) attributed any positive resolution of the problem to the safeguarding process itself.*
- VOICE 2: *People continually returned to the importance of ‘listening’ to the victim – both in terms of the alleged abuse and in terms of what resolution they wanted. People felt it was important to ‘truly empower’ older people in the community. Access to the criminal justice system had not been successful.... Arduous investigation and emotional ups and downs for the victims and their families came to nothing.*
- VOICE 3: *People with dementia must be empowered to express a view about their services and more must be done to take the fear out of making a report... Open forums and websites for service users are needed.*
- VOICE 4: *Members of our disability forum argued strongly that “the abused person must be the one who agrees all decisions about what measures are taken to prevent their abuse.”...” being ignored, side lined, passed from pillar to post by squabbling public body officers is just another form of abuse...”*
- VOICE 5: *I am not sure I would have the confidence to report my own family for stealing from me.. public services tend to have their own agendas.. I would be the one who would want to be in control and decide how far to go...*

- VOICE 6: *One of the best ways of preventing abuse is by instilling in vulnerable people that they can report their concerns discreetly. At the moment the public have no confidence in public bodies being able to hold onto confidential information.*
- VOICE 7: *The vulnerable community want abusers punished by courts or through the workplace... but they often want reconciliation if family members are involved.*
- VOICE 8: *When are the views of the patient to be heard? Who seeks and records patients' views? Is there an established alleged abuse reporting line within each NHS site? Is the first duty of the NHS system to protect the NHS from adverse publicity?*
- VOICE 9: *Anti-Social Behaviour policies could be used as early warnings of abuse.... but instead people are passed from housing to police and back again – there is no empowerment in any of this.*
- VOICE 10: *Let the police know how we need to be talked to. Give them help to help us.*
- VOICE 11: *The experience of being kept 'safe' has left some people unwilling to share their safety concerns in case it compromises their hard won independence.*

2.6 There were many examples of how people could be empowered and listened to in the community. These for example included the 'Keep me Safe' SMART Agreements, which were suggested as good practice by people with learning disabilities who worked with the Eastern Region Forum Coordinators. These were described as a clear and formal understanding of who is responsible for an individual's health, safety and well-being in a range of circumstances and environments. They detailed when, how and in what circumstances decisions could be made for and in the safety interests of each person. These were supplemented by 'Keep Safe SMART Plans', detailing specific and general risks an individual is taking, how they are working to address the risk, what support agencies or technology or training is needed and when the plan will be reviewed.

2.7 A recurring message from respondents was that it is not government's role "to keep people totally safe." For example, a group of people with learning disabilities said, "Abuse can happen anywhere, like when I'm walking down the street. You can't be kept totally safe from abuse. But I need to know what to do or who can help."

- 2.8 This was echoed by several older people who commented on care home regimes: *“They tell you what to do all the time, and most importantly what you can and can’t do. They say it is for your own safety. But it is my choice and my risk and my life.”* Some of the strongest voices against the idea that “keeping people totally safe” should be a government aim, came from older people who were living in their own homes. Very large numbers stressed the importance of confidentiality as a key component of their quality of life. A large number commented that *“I don’t want everyone knowing my business.”* This was particularly strongly felt about relationships with family: *“If keeping me totally safe means moving me away from here, where I know that my family and neighbours visit me, then I don’t want it.”* And *“If keeping safe means going into one of those homes, then that’s not for me.”*
- 2.9 These messages will of course depend on people’s individual circumstances, their health, their quality of life, the extent to which they feel at risk, and the choices open to them. These are not blanket statements, suggesting that people are choosing lack of safety over safety. But there was a very clear message from people that they wanted to be able to choose what they thought was right for them. Many reported they were offered ‘safety’ often at the expense of other qualities of life, such as dignity, autonomy, independence, family life and self determination – and many older people and people with learning disabilities said this was a very high price to pay.

B. Empowerment is everybody’s business; but safeguarding decisions are not

- 2.10 Many respondents did not know what the words ‘safeguarding’ or ‘adult protection’ meant, or that there were people responsible for safeguarding in local authorities, in the NHS and in the Police Service. Nor did many people use the word ‘empowerment’. The words they tended to use were ‘safety’ and ‘choice’.
- 2.11 When asked whose responsibility it was to ‘keep people safe’, many people said it was their own responsibility. They explained that no-one else could do it, because understanding what made them safe required understanding them as people – understanding their personalities, their experiences, their family relationships, their wishes for the future and their past histories of choices. Safeguarding could not be an activity that was delegated to anyone else – although it could be a shared or supported activity.
- 2.12 For older people the most frequent organisation they expected to share it with was the police. Older people saw the police as having a safeguarding

role in many different ways – catching criminals, telling off unruly youths, talking to older people about locks and chains on their front doors and about the law.

- 2.13 For people with learning disabilities who had support workers there was a perception of shared responsibility with their support workers. Good support workers were often described as those who explained things and gave them choices. Bad support workers were those who made decisions, did not explain anything and *'went on and on about not being able to do things'*.
- 2.14 Most people with mental health needs did not report having a shared responsibility with any specific professionals. They reported that sometimes health workers worked with them on safety issues, but they also thought they *'worked against'* them. There were also mixed feelings about police, who were rarely seen as *'safeguarders'* of people with mental health needs.
- 2.15 There was a strong feeling that *'communities'* needed a larger role. *'People have to take responsibility for other people, basically. We should be more vigilant – be a good member of the community and try to be knowledgeable about the procedures you should follow'*.
- 2.16 A common challenge that professionals and members of the public might face was what to do when they thought that someone was being abused. When people understood what was happening and could choose to leave, but they didn't want to leave, should they be forced to leave? This was discussed at many of the consultation events and most citizens who took part in the consultation concluded – sometimes after lively discussions – that it was important to respect the person's wishes even if that meant they would remain at risk of further abuse:
- Mrs A: 'I think this is so difficult because you are taking away the older person's rights. If they say 'I want to stay here', it smacks of a police state if they are going to take you anyway and put you somewhere else and I think you have to respect the wishes of the older person..... I don't see a situation where the police should be allowed to take an older person out of their home'*.
- 2.17 However, when asked whether there was a safety/safeguarding role amongst the services people were in contact with, people said they recognised many hazards and some responsibilities in relation to these. Examples mentioned included – holes in pavements they could trip over, *'drunks'* who called them names, people who befriended them for their money, youths who were

after their handbags, partners who were abusive, adult children who mainly visited because they wanted to inherit the house. Some people wanted help with these and some did not. But all those that did want help, wanted help to deal with the problems in their own way. They wanted to do their own safeguarding, they wanted help with information, options, alternatives, suggestions, mediation, ‘talking to’ and so on. It has already been made clear that the people who took part in the consultation ‘had capacity’ to engage with the issues – and amongst these, none wanted decisions made for them.

C. Safeguarding Adults is not like Child Protection

- 2.18 Many professionals who contributed to the consultation drew comparisons during the consultation, between child protection and adult protection/ safeguarding. They highlighted that much of the language is the same and that many of the professional processes are the same. In both there are alerts, referrals, case conferences, strategy meetings and safeguarding plans. Both are multi-agency, built on years of experience of joint working and joint approaches between local authority social workers, staff in the NHS and the police – as well as other agencies.
- 2.19 Some of these professionals argued that adult safeguarding should follow and ‘catch up’ with safeguarding children. Notwithstanding the recent attention to the death of ‘Baby P’, safeguarding children was seen as better developed than safeguarding adults; better resourced; regarded with greater priority by each of the three main partner agencies; and with a greater body of knowledge, a tradition of influential serious case reviews, more research and evidence and more status as a statutory activity and as a professional activity.
- 2.20 Nevertheless, many respondents involved in the consultation reported wanting very different solutions from those used with children. Many spontaneously said things like *“I do not want to be treated as a child”* *“Social services make decisions for you as if you were a child.”* *“Staff have too much power over adults.”* *“They do not listen to you”* *“Sometimes staff do not believe you”* and *“They find it hard to work with you as equals; they do not listen like lawyers.”*
- 2.21 The theme of the child vs adult perspective was explored further in some consultation events, where professionals were able to identify similarities and differences, and thought there was a lot to learn in both directions. But the comment was made that issues around consent were completely different. Child protection had been designed for younger children – often

babies and toddlers, who are the most dependent and most vulnerable. Adult protection/safeguarding in contrast has two very different client groups: people who have capacity to make decisions and who need to be asked for their consent – and those who do not have capacity to give consent and who need to be approached in the context of the Mental Capacity Act principles. The professionals in this workshop thought this dual focus made safeguarding adults more complex.

2.22 Further differences between safeguarding children and safeguarding adults were identified:

1. A different contextual vision: A 'good childhood' as opposed to a fulfilling and productive adult life. Very young children are nurtured and protected by adults and cannot be expected to contribute significantly to protecting themselves or to take part in decisions on protection plans. Adults with capacity, however, do have a fundamental right to choose their own actions and their own safeguarding plans, though they may need to be assisted and empowered to make their own informed choices. This impacts on the values underpinning service design, procedures for intervention, prevention strategies and staff competencies and training.
2. Different policy direction: For children the policy is early assessment followed (if decided by Courts) by removal of a child and attempted adoption, if possible, or long term fostering or family support. For adults the policy is self-directed support, increased choices, and assistance to live in the community as long as possible.
3. Different legislation: There is widely different core and supporting legislation. The Children Act 1989, supplemented by the Children Act 2004, set down a holistic approach to safeguarding in the wider context of the well-being of children. There is no comparable legislation for adults in England. The Human Rights Act would support intervention in family life to protect children in ways where intervention in the life of adults would not be supported e.g. where intervention is opposed by the affected child/adult.
4. Parents' rights and responsibilities are different from rights and responsibilities of carers (family and friends) supporting adults. Parental rights and responsibility (and culpability) are not at all the same thing as family carers' 'responsibilities' in supporting disabled adults, so a different approach is needed for carers from that needed for parents.
5. Different mainstream services: There is very little similarity between

mainstream services for children (schools) and mainstream services for adults (health and care services), so it would be difficult (but not impossible) to develop overarching legislation/systems to build safeguarding into services for both children and adults.

6. There is a different approach to mental capacity – there is a presumption of capacity in adults, and a presumption of incapacity in children. This is very important in relation to decision making and not always acknowledged.
7. There are different court systems – Family Courts who can make decisions for children, and a new Court of Protection who can make decisions for adults who lack capacity.
8. There are mostly separate policy, leadership and delivery mechanisms – different central government departments, different local government departments and different regulators. However, the police and GPs have overlapping responsibilities for adults and children.
9. The nature of abuse in relation to adults is different, possibly wider. Financial and institutional abuse adds additional dimensions to the physical and sexual abuse that are the most common types of abuse of children. This is further complicated by other kinds of abuse which rarely apply to children – such as the inappropriate prescribing of anti-psychotic drugs to people with dementia; the over sedation of many vulnerable people in care homes and hospitals; and the susceptibility to abuse from fellow patients for people in hospitals for people with mental illness. Neglect of an adult who has capacity is not a crime while neglect of a child is.

2.23 Many consultation respondents thought it might not be impossible to bring together the safeguarding approaches to children and to adults at some time in the future. Safeguarding processes – such as Boards and Coordinators were similar. However, present policy locates them in different contexts and is driving them in very different directions. It was thought important to recognise that safeguarding adults could not and should not implicitly follow the children’s approach, not even when the adult lacks capacity. We should not treat adults as though they were children.

D. The participation/representation – of people who lack capacity is also important

2.24 The above messages came from respondents who had the capacity to reflect on the consultation and to express their views. Some of them, particularly

mental health service users, had fluctuating capacity and were able to reflect on the way they were supported when their capacity was impaired. However, many of the citizens who are the subject of safeguarding enquiries do lack capacity to make their safeguarding decisions, and it is important that their views are taken into account in this consultation.

- 2.25 Although adults who lack capacity may not have the same ability to make informed choices, the principles of the Mental Capacity Act (MCA) must be followed. These make it clear that a person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken, and that no one should be deemed to lack capacity merely because their decisions appear unwise.
- 2.26 The MCA therefore has important implications for how people's capacity is assessed, how people with limited capacity are helped to make decisions wherever possible, and how decisions are taken on their behalf. Respondents articulated some of these implications, for instance that review and monitoring processes for people who lacked capacity to consent to their care plans, should be fundamentally different from reviews carried out with people who could understand their options and communicate their choices.
- 2.27 Respondents were clear that safeguarding processes for those who can make their choices and those who cannot, have to be different in significant respects. These differences have to be explicitly addressed.

Consultation Questions:

3. Leadership, Prevention and Outcomes

A. Leadership

- 3.1 There was widespread agreement amongst stakeholders from the large numbers of safeguarding partnerships who replied to this consultation, and from professional and voluntary organisations that there needed to be stronger national leadership on safeguarding issues.
- 3.2 Many respondents wanted to see safeguarding leadership being part of a wider aim such as 'health and well-being' or 'community safety.'
- 3.3 There was not complete agreement about where this national leadership role should lie. While 60% of the respondents wanted it to be with the Department of Health (Chart Q1a), there was a wide variety of other views held simultaneously. Some respondents wanted the Home Office to provide leadership in the way they were thought to have provided leadership for domestic violence.
- 3.4 The most common suggestions included:
- a government department (Department of Health was the most frequently named Department, or the Department for Communities and Local Government) or
 - two government departments jointly (Department of Health with the Home Office) or
 - the Care Quality Commission, or
 - the Independent Safeguarding Authority, or
 - an independent person/body i.e. a Tsar, or
 - it should lie with a Minister, or
 - a national advisory/steering group be set up.
- 3.5 Quite a large number of responses indicated that where leadership is situated was unimportant as long as there was leadership and it was effective.
- 3.6 Examples of the responsibilities of a national leadership role included:
- to ensure that different agencies work together at the top;
 - to ensure that these different agencies are strategically accountable;
 - to ensure that legislation and guidance are coordinated;

- to ensure that different agencies are all working to the same goals;
- to ensure that a shared social and criminal policy is developed;
- to ensure that a focus on an empowering framework is developed;
- to oversee the development of a 'Working Together' type of document (as exists in children's services).

3.7 It was argued by many respondents that a national leadership role should lead to a strengthened partnership role, strengthening the collective and shared responsibility of all partners. National leadership should develop a coherent national framework, as well as carry out periodic reviews in areas such as:

- an adult at risk framework
- training
- outcomes for adults
- local safeguarding boards
- impact assessments

3.8 The vast majority of respondents thought that elected councils were best placed to take overall local responsibility for safeguarding adults, given their accountability for the well-being of local citizens in the local area. Seventy-four per cent of respondents chose this option (Chart Q1b). Many supported 'a local package' having:

- a lead elected member;
- the Director of Adult Social Services (or equivalent) as the lead officer with statutory responsibility for coordinating safeguarding;
- links with the Local Strategic Partnerships, particularly Health and Well Being and Community Safety; also the Crime and Disorder Reduction Partnerships;
- all NHS organisations to have an executive lead and an operational lead;
- joint adult social care and PCT involvement to ensure that safeguarding responsibilities are carried out in both commissioning and providing roles;
- police forces also to have an executive lead and an operational lead.

3.9 As part of the local leadership role there was much support for strengthening Safeguarding Adults Boards by:

- making Safeguarding Adults Boards statutory;
- ensuring participation by partners with decision making powers;
- having an independent chair;
- quality assuring 'adult protection' functions;
- quality assuring risk management in self directed support (eg Direct Payments);

- facilitate strategic and operational links to all adult risk prevention, management and response systems (MAPPA, MARAC, Community Safety, Environmental Services);
 - delegating responsibility to local NHS services where necessary, for an enhanced patient safety role;
 - delegating responsibility to police forces where necessary, for an enhanced public protection role.
- 3.10 There was widespread support for the introduction of national procedures from: most of the police forces; most of the NHS partners; the housing partners and about three quarters of the social care responses. All of the partners who worked across geographical boundaries (e.g. across two or more local authorities) reported very strongly that local differences in procedures were obstacles to joint working; that they resulted in delays in responses and confusion and sometimes lead to further harm to people.
- 3.11 Many safeguarding partnerships also wanted national procedures. They too argued strongly that local variations in procedures created obstacles to joint working, created dangerous delays, and built up barriers between those who had written the procedures and those who were struggling to use them. They questioned whether effective local and regional partnerships were in fact possible if local (social care) ownership was more important than all partners across all regions working to a single document. They also questioned how support for national legislation, which would require working to national standards, could sit easily alongside a call for local procedures.
- 3.12 Those organisations/individuals who did not want national procedures, said that their local procedures had recently been reviewed and were thought to be working well. However, most respondents acknowledged that while there was much local attachment to local procedures, they were aware of the high level of frustration of partner organisations who worked across local authority boundaries – such as care home providers, supported housing agencies, NHS Trusts and some police forces.
- 3.13 There was broad support for a template for a local safeguarding coordinators post, as long as there was scope for local adaptation.
- 3.14 There was a great deal of interest in ensuring that Safeguarding Adults Boards (SABs) were effective. There was widespread support for:
- (1) national standards/a performance framework for SABs;
 - (2) scrutiny by independent and multi-agency inspectorates;

- (3) proper accountability to all the partners – and many thought that financial and accountability arrangements should mirror children’s boards;
- (4) a requirement to have annual reports to be submitted through elected members to the CQC and/or the Local Area Agreement/Public Services Board.

3.15 The Department of Health was the preferred national organisation with leadership responsibility for safeguarding in the NHS in the majority of responses, but often with enhanced roles for PCTs in their commissioning functions and that, SHAs should link with PCTs on this. All Trusts were thought to need safeguarding adults leads and safeguarding governance structures, which should cover all professional groups, such as GPs, nurses, therapists, managers, and many people thought Serious Untoward Incident procedures and safeguarding should be linked together. While most people wanted one set of national multi-agency procedures for all agencies, there was also thought to be a need for NHS-specific guidance.

3.16 It was thought leadership within the NHS should lie at executive board level (Chart Q1e). However, there was also strong support for PCTs to demonstrate safeguarding leadership in their commissioning role and for SHAs to have regional responsibility and oversight.

3.17 More than half the respondents (55%) thought the Care Quality Commission (CQC), should be the lead on safeguarding in the care home sector. Other respondents (18%) thought this leadership should lie with commissioners of the services. Some thought both should share leadership – and develop a protocol to recognise this shared role nationally. And eight per cent said leadership should lie with the care home providers themselves (Chart Q1f).

3.18 There were many suggestions as to how to attach appropriate authority to formal leadership roles. These included: making safeguarding statutory and prescribing at what level it should operate; job descriptions at all levels to include safeguarding responsibilities; relating job descriptions to safeguarding competencies at different levels; making attendance at boards and other meetings ‘mandatory’; and clarity of accountability and monitoring – including publishing information on how leadership duties are undertaken.

B. Prevention

3.19 Almost everyone (97%) agreed that prevention was key to the development of safeguarding (Chart Q2a). There was widespread agreement that the

current safeguarding system was designed around responding to problems rather than preventing them, and that time and effort were currently invested disproportionately in individualised responses. Most respondents wanted a move from a re-active to a pro-active safeguarding system. There was an almost universal call to develop a national prevention strategy based on a multi-agency pro-active approach (Chart Q2b).

- 3.20 To prevent abuse in the care home sector, respondents wanted commissioners and regulators to work together and in a synchronised approach to improve high quality services. There were many calls for ‘Quality in Care’ kinds of projects, which involve working with care providers assessed as poor, to improve the care they were providing. A small number of respondents wanted a different approach and asked for a ‘zero tolerance’ approach, which moved rapidly to home closures irrespective of the consequences for residents.
- 3.21 With respect to people in any kind of risky situation, respondents wanted a much stronger emphasis on empowering adults to challenge abuse, to know how to get help and to be confident they will be listened to. There were strong messages about people in receipt of personal budgets of all types needing preventive/safeguarding information and assistance as well as the personal budget. Respondents said that the role of ‘reviews’ was particularly important because many people would find themselves in risky situations and needed to be offered help to get them out, before the risk became too high. Prevention needed to focus not on eliminating problems or risk, but on preventing the escalation of problems or risks to the level of ‘significant harm’.
- 3.22 Respondents said there was much to learn about prevention from best practice in other areas – such as community safety and domestic violence; from some of the most experienced housing providers and from community development practice. They felt that much of this work had not been applied to safeguarding, and that it would be good to bring this together in a national and local prevention strategy. It may need to develop a common and possibly new language; to link to the work of various committees and boards; and would need to build on existing local priorities, while also only being effective if based on high level organisational commitment. The main views of those working in the criminal justice system are set out in chapter 7. However, Police Forces also replied as part of partnership responses. They said that they felt that information sharing was key to prevention work. West Midlands Police, and several other forces, suggested that the police should be adopting some of the very successful strategies employed to prevent repeat

victimisation in domestic abuse cases, for example, involving neighbourhood watch coordinators and initiatives in setting up 'cocoon watch' for those at risk, installation of personal attack alarms and disruption visits.

- 3.23 There were mixed responses to the question about whistle-blowing. Some respondents thought whistle-blowing was important and should be written into contracts for all staff. Many others thought whistle-blowing was not particularly effective – that it was difficult to prevent whistleblowers from being victimised and it was 'practically useless' in small organisations. Some respondents said that we should be working more towards a culture of openness and this was at odds with whistle-blowing. If we encouraged open staff meetings where issues of quality of care and quality of work could be openly discussed there would be no need for whistle-blowing.

C. Outcomes

- 3.24 There was strong support for the introduction of an **outcomes framework**. Eighty-eight per cent of respondents said that this would be useful (Chart Q3a). Respondents wanted a framework that would include both indicators and performance measures; that could be applied to individual safeguarding partners; and that could be applied to Safeguarding Boards as well. Police Forces thought outcomes were important in that they focused agencies on their objectives and NHS staff thought they would be able to give more priority to safeguarding if there were indicators or performance measures. Staff in social care thought that the overall partnership would be stronger if the work of each of the partners was linked to their respective performance frameworks.
- 3.25 Some respondents wanted high level indicators, which linked safeguarding to **high level outcomes** relating to health and well-being, to the dignity and privacy policies, and to risk management standards; and to the level of investment, by police and the CPS for example, in prevention.
- 3.26 Others wanted more immediate indicators, such as timeliness of multi-agency responses; safer recruitment; more and better training, a reduction in incidents of abuse reported; increased numbers of protection plans created and closed; timescales; the percentage of cases taken to court by the CPS; and the number of strategy meetings that the police attended. Many respondents wanted a performance indicator around individuals' experiences, including a demonstrated improvement in the quality of life for a person who had been 'safeguarded'; and a quantifiably better understanding of abuse issues in the local community.

- 3.27 There were many different ‘desirable outcomes’ proposed, including: the right to risks; being safe from significant harm; reduced risks; people empowered; people able to protect themselves; people able to raise alerts; better awareness of safeguarding; better awareness of ‘self-safeguarding’; clear outcomes of investigations; improved quality of care; more Independent Safeguarding Authority registrations of staff who are barred from working with vulnerable adults; improved service planning; more effective training; more resources for safeguarding; safer environments; feeling safe; zero tolerance; prevention; redress; better partnership.
- 3.28 Most respondents wanted local annual reports on safeguarding, to address wider safeguarding outcomes as well as the narrower case work statistics and examples. Many thought that these reports should have a minimum common format, which could be added to optionally.
- 3.29 Many respondents wanted a document similar to ‘Working Together to Safeguard Children’ to drive and structure outcomes, a document that:
- clarifies and quantifies the roles and contributions for each partner agency;
 - ensures that national training competencies exist for all partner agencies; and
 - ensures that service user/carer feedback is collected systematically and informs policy and practice.

All respondents wanted to learn from people’s experiences and many had suggestions on how this could be done. This included listening to users on a more regular basis, possibly with the use of advocates, and evaluating the process from their perspective; having annual ‘audits’ of experiences, and feeding experiences into training, into events and into policy making; carrying out research, measuring the extent to which all contact with the public services is empowering; providing and evaluating support following abuse; carrying out exit interviews; developing a set of customer standards or a tool to capture self defined outcomes (being developed in Sutton).

D. Training

- 3.30 Respondents also wanted much more consistency in training, and there were frequent references to the lack of knowledge about whether current training courses and methods were effective. Chart Q3d shows that 97% of respondents wanted training reviewed with a view to developing national occupational standards across agencies. But many also wanted much more: development within social work programmes, greater prominence within

nursing and medicine programmes, and mandatory training on safeguarding, on working with vulnerable people and on the Mental Capacity Act for all frontline police officers. A few respondents reflected further and asked for Mental Capacity Act training, Deprivation of Liberty Safeguards training and Safeguarding training to all be integrated. Some Police Forces responding through partnerships explained that they were developing their own training courses, such as West Midlands Police who were developing training for both frontline officers and specialist training for their 'Vulnerable Persons Officers'.

- 3.31 Many respondents wanted guidance on when serious case reviews should be undertaken to promote learning from experience. Some suggested it should be when there was a death or serious harm – others thought additionally it needed to be when there were problems in the partnership working. Some respondents wanted guidelines about what could be published; some wanted a more 'no blame' NHS type of approach to learning; others commented that serious case reviews get all the attention, whereas the starting point should be 'to get the majority of the lower level cases right'.

E. Other drivers for good outcomes

- 3.32 Interestingly, 91% of respondents wanted joint inspections, by CQC and Her Majesty's Inspectorate of Constabulary (HMIC) to be developed as a driver for better outcomes (Chart Q3f). Respondents felt that safeguarding is a multi-agency process and needs to be inspected as a multi-agency process. Looking at *'only one aspect of a multi-agency partnership is inadequate'*. Others thought it would be 'methodologically too complicated', 'hard to coordinate' or that it would need resources.
- 3.33 Most respondents did want more guidance – *"but not great long reams of it"*. Some wanted it to mirror children's guidance. Some wanted the ADASS guidance integrated into a wider document which focused on risk and personalisation – *"Yes it should look at positive risk assessment and monitoring and safeguarding and empowerment all in one. Do not separate them, because each is only part of the picture."* Some wanted legislation backed by a code of practice *'like the MCA Code'*.
- 3.34 Most respondents did not identify the current costs of safeguarding work and so could not indicate what the relationship was between expenditure and outcomes. Many said that the activity had not been costed in a systematic way. Those few who did, suggested that *'a specialist safeguarding adult team might cost £100,000 to £200,000'* but that the *'investigation by front line services might be ten times as much'*. In many places the investigations are subsumed in mainstream activity.

4. Personalisation and Safeguarding

Transforming social care

- 4.1 Respondents from the safeguarding partnerships put much time into answering the two questions on the relationship between safeguarding and personalisation (choice and control in services and support). There was unanimous agreement that these two policy goals needed to be looked at together and this journey had – to varying degrees – begun.

Box 3: Reflections on the Interface between Empowerment and Safeguarding

Observations from various Safeguarding Partnerships

A balance needs to be established between empowerment and protection and between the rights for self-determination and the duty to ensure safety of people and safety of public money

We want to support people to be citizens and take risks that they understand

Empowerment in all aspects of life is a protective factor against abuse

We are looking for new approaches to safeguarding

The interface issues have not been sufficiently addressed as yet

We firmly believe that personalisation and safeguarding can work together in a complementary way

We are developing empowering risk frameworks

We have evidence that shifting the power balance within families and between service users and professionals can have very positive safeguarding outcomes.....

- 4.2 Most respondents from local authorities reported on their achievements in this area. Many said they had made huge progress in two relatively new areas of social care: person centred risk assessment and person centred risk management. Many had begun to identify potential risks and vulnerability to abuse during the assessment process and had begun to develop risk management strategies and safeguarding processes as part of the personal budget and support plan.

- 4.3 The concepts of empowerment and of self-determining adulthood, of ensuring that the individual is at the centre at every stage, of risk assessment and risk management **with** (not **for**) service users were stressed by many respondents. Care management processes and workforce skills, we were told, needed to be refocused on communication, empowerment and enabling people to take considered risks. Respondents in Hampshire and Wirral reported that empowering practice, engaging with service users all the way, underlines the important distinction between adult and child safeguarding.
- 4.4 The Bradford response, for example, reported that people choosing self directed support had to have access to: good risk assessments, person centred planning, independent advocacy; the safeguard of a named individual to turn to; agreed review dates; further safeguards where the risk assessment suggested a person may not be able to exercise choice – i.e. undue influence may exist. In Coventry staff are developing an outcome focused approach, based on partnership working around a person's aspirations. Many respondents stressed the importance of reviews. They pointed out that people change their aspirations and their views. Different kinds of support were needed at different times, and reviews enabled change and improvements to take place.
- 4.5 Many respondents identified person centred risk assessment as a key area of new work – *'and conversations about risks have not been explicit enough.'* The Westminster response reported that they were building explicit questions on risk into self assessment and supported assessment tools, and several respondents said that what was needed was building safeguarding into mainstream assessment, rather than designing a specific safeguarding risk assessment. Some reported that thinking-about-risk was better developed amongst staff who worked with people with learning disabilities than with older people.
- 4.6 Staff in Haringey had developed a 'Vulnerable Adults protocol for people below the Fair Access to Care threshold'; staff in West Sussex had a risk assessment tool that could be applied in care settings for older people; staff in Wirral had developed self-directed assessments, which identified both what individuals and professionals considered to be risks. Staff in Kent were developing a safeguarding training programme for users and carers, training people to write their own support plans, answering *'How will I stay in control?'* and staff in Manchester were using 'person centred safety plans' built into standardised risk assessment processes. Overall, an immense amount of important and creative work appears to be taking place.

- 4.7 However, many respondents also expressed the view that the balance between choice and risk had not yet been established, either nationally or locally. Several respondents reported feeling that national messages about personalisation had not really addressed safeguarding and messages about safeguarding had until very recently not looked at the interface with personalisation.
- 4.8 Similarly at local level, many reported the two areas as not yet integrated and not fully engaged with each other. There were exceptions – and foremost of those were local authority areas where the two reported to the same person, such as the Isle of Wight where the lead professional on safeguarding was also the lead for personalisation.

Choice and Risk

- 4.9 Where people were struggling with the balance between choice and risk, two main areas of concern were identified. First, there were the risks for opportunistic and predatory abuse; and second the risks that once money for support was handed over, local authorities might no longer have the authority to question or ‘police’ its use.
- 4.10 Opportunistic financial abuse was described as carried out both by low paid support staff and unpaid family members, often with financial difficulties in their own personal lives, making use of a service user’s bank card, their savings in a tin, or their weekly pension or direct payments money. ‘Helping themselves to a little’ (often the perception of the person doing it) was theft and was fraud – but would be hard to notice and prevent.
- 4.11 The more predatory abuse was described as the deliberate grooming of people by pretending friendship in order to access their income, savings or homes. Concerns were raised about self directed care ‘opening the door’ to this kind of abuse.
- 4.12 In the consultation workshops, most professionals agreed that these were the most common types of abuse that needed to be prevented and addressed. What people differed on was the way to prevent and to stop them. Some thought it was important *‘to empower staff to exercise their professional skills and knowledge’* while others thought the challenge was *‘to empower service users by greater awareness, more informed choices and the confidence to ask for help if things go wrong.’* The other main difference was between those who thought the local authority ‘could do nothing’ if public money was misused in these ways, while others thought that local

policies could and should be developed to address what the local authority could do, and that monitoring, reviews and discussions could and should take place.

- 4.13 Many local authorities mentioned the ability to undertake mandatory Criminal Records Bureau (CRB) checks as an important tool in the vigilance against predatory and sometimes also opportunistic abuse. There was considerable anxiety about the idea of promoting and trusting employment practices for service users that did not use CRB checks; many did not think this should be a matter of choice for service users, and certainly not in relation to people who lacked capacity to weigh up risks.
- 4.14 Several of the respondents had strong views on the regulation of personal assistants (PAs) (who are not covered by vetting and barring, registration or inspection systems) and wanted 'parity of protection'. Some thought local authorities should pay for these CRB checks, some thought PAs should register with the ISA or on a 'voluntary register' of PAs.
- 4.15 Others however commented that as a society we had become too complacent in relying on CRB checks as a symbol of safety, that a CRB check was neither a necessary nor sufficient indicator of safe or high quality care and while it was useful, it was no more than one of the means of choosing appropriate care and support. These respondents were comfortable about leaving this to the 'informed choice' of people designing their own care and support.
- 4.16 At a broader level, questions were posed about the limits and boundaries of 'duty to care'. It was pointed out that *'if a blanket duty of care means making all the decisions then it is extremely disempowering'* but *'walking away from public responsibility will lead to harm and institutional neglect.'* People were searching for the right balance.

Informed Choices

- 4.17 There was unanimous agreement that informed choice was the key objective to aim for. There was also agreement that much more needed to be done to make informed choices a reality. Respondents wanted information packs and other guidance, for example (see Box 4).

Box 4: Informed Choice

Informed Choice for people using self-directed support needs:

Safeguarding information pack; information on CRBs; information on employing staff; information on employing family or friends; lists of accredited organisations and people (i.e. for domiciliary care); examples of individual and costed support plans; user-friendly safeguarding website; awareness raising about people who target and manipulate and groom; information on reporting concerns, abuse indicators; ‘survivor toolkit’ for victims of abuse; legal advice; buddying system for those who are embarking on self directed support.

- 4.18 There was also unanimous agreement that people needed support systems:
- a) generally when they began thinking about self directed support; and
 - b) if things go wrong. The latter may or may not include abuse; the support it was argued should be offered irrespective of whether abuse was suspected or whether it was related to some other breakdown in support or working relationship (see Box 5). Importantly, respondents wanted clear policies about what should happen when safeguarding issues arise and self directed care may be terminated abruptly.

Box 5: Support Systems

Examples of Support Systems

It was reported that the need for support systems could not be emphasized enough. These were about prevention and response, but also about healing, as was mentioned in some of the public responses.

Support could and should come in different forms, including advocacy; brokerage (and some respondents wanted brokerage systems to be regulated); Independent Mental Capacity Advocates (IMCAs) being more widely available; mentors and buddying programmes; organisations linking people, organisations vetting people; support with employment issues such as recruitment and dismissal; mediation services and legal advice.

Support should include money management support (*“How much of the general population is good at managing money? We should not expect the impossible”*).

Support should include emotional support when things go wrong. (In Salford a local user group gives support and advice and their representative sits on the Safeguarding Group)’. a help line; advice on insurance services; advice on training – both on staying safe and accessing help; on employment law and employer responsibilities and small business management and keeping financial records.

Reviews of social care

- 4.19 Respondents thought reviews were very important. They were important as a means of assisting people who wanted to change their minds, change their support plans, and change their choices. Some people could change their plans and their support without any professional help. However, others needed support to do this, especially when they were vulnerable due to changing needs, for example increased confusion arising from dementia.
- 4.20 Respondents thought reviews of support were very important for people who lacked capacity to make their own choices and specifically lacked the capacity to communicate that they were not happy or did not feel safe. Respondents reported that reviews for people who lacked capacity to consent to their care plans should be fundamentally different from reviews carried out with people who could understand their options and communicate their choices. Reviews should never be done by phone; they should be carried out more frequently; they should routinely have specialist communication staff or IMCAs or other 'disinterested parties' present. They should be based on a 'life story' approach to the individual – acknowledging and recording their past life, their past preferences and choices and linking the present best interests choices to it. They should be much more risk focused and should try 'by all reasonable means' to give the person a voice in the review.

Financial safeguarding

- 4.21 The consultation reported an increasing interest in and awareness of financial safeguarding. Police forces, social care professionals and housing providers all stated that financial abuse had greatly increased, was difficult to deal with and that 'financial safeguarding' needed to be much better developed and understood.
- 4.22 Respondents thought that financial safeguarding was regarded as a relatively new professional area, one that might be built on the probity and safety of finance staff and accountants in local authorities and in the private sector, in what are commonly known as the 'Receivership Groups' or similar. When people could no longer look after their own financial affairs, then these professionals might be asked, by the courts to manage the affairs of those who could not. What was new was that these staff were now expected to adapt their working to the principles of the Mental Capacity Act, to the values underlying personalisation and to the new partnership methods expected of all the new public sector – and the private sector deputies. It was

reported that this transformation in role was often without any training or any policy that explained the challenges of the new role.

4.23 Respondents reported they were struggling to bring together the recognition ‘that there is a right for individuals to make unwise decisions’ while ‘public money has to be wisely used and properly accounted for.’ The West Sussex Financial Safeguarding Team (renamed from its previous role as the Receivership Unit) reported, as did many others, an increase in numbers and complexity of cases. They added that financial professionals and institutions are essential partners in financial safeguarding but many have limited awareness, training or involvement in these matters.

4.24 It is clear that much more work is needed in the area of financial safeguarding, and that this area will need particular attention.

5. Safeguarding and the NHS

- 5.1 Health professionals contributed to this consultation in two ways. First, many took part in the formal written response from the safeguarding partnerships and second, 67 health organisations submitted specific responses. The majority of responses came from committed specialist practitioners, who were already well aware of the complexities presented within NHS clinical areas where people experience safeguarding concerns. These include PCT Commissioners, Provider Arms, Acute and Mental Health Trusts, Ambulance Trusts, Strategic Health Authorities (SHA), Teaching PCTs and the *No secrets* NHS Advisory Group. There were also 13 responses from professional and regulatory bodies with NHS responsibility such as the Royal Colleges (Nurses, GPs, and Psychiatrists), British Medical Association, NHS Alliance, NHS Confederation, and the Healthcare and Mental Health Act Commissions.
- 5.2 During the listening events, it was alleged that full engagement with adult safeguarding across the NHS and particularly at Board level was limited. Representation at a senior level at the consultation events was similarly limited and reflected perhaps the low levels of awareness and priority given to safeguarding issues in the NHS.
- 5.3 There were **three main messages** from the health responses:
- The NHS is struggling to 'own' safeguarding as a concept
 - Leadership needs to be clarified
 - Engagement of all parts of the NHS is vital

Ownership of the concept

- 5.4 NHS respondents widely believed that implementation of the *No secrets* guidance has been, at best, slow, patchy and inconsistent and recognised that much more needs to be done. They argued that "*individuals are engaged but the NHS is not*". Perhaps the most important reason given for the slow engagement with safeguarding is that the NHS appears to be "*struggling to see, to understand and to own safeguarding*" as a concept. Many respondents said that although the majority of Trusts have signed up to local procedures, there is a distinct lack of knowledge of the issues at an operational level and lack of requirement to comply with the procedures

at strategic level. Many of the respondents indicated that the majority of safeguarding concerns raised within an organisation are typically around examples of patients arriving at A&E departments with pressure ulcers *‘and are rarely about poor practice or abuse that occurs within health organisations themselves’*. Box 6 below illustrates some of the points made at both the events and within the responses.

Box 6: Safeguarding and the NHS

Emerging issues for consideration

- *The NPSA does not require safeguarding alerts to be registered with them, and their descriptors of harm are focused on mechanical errors only; However, the NPSA is now looking at a growing number of incidents related to **poor transfers of care** both ‘to’ and ‘from’ hospital where patients have suffered potential harm, actual harm and death.*
- *In my hospital I am aware that staff are failing to meet the basics, for example an older person can be left in a soiled bed for long periods of time before they receive the assistance they require, **is this poor practice or abuse?***
- *Training should include education about safeguarding issues within the practices and culture of the NHS as well as being able to spot concerns elsewhere.*
- *Pre-registration training and education on safeguarding adults should be mandatory, not only to ensure professionals can raise alerts about others but also so that they understand, how their **own practice can be seen as neglectful**.*
- *The issue of corporate neglect, whereby the impact an organisation has had on the neglect of a person should also be defined. Currently there is no differential between **‘neglect’** and **‘abuse of power’** because of professional responsibility or accountability and the neglect or abuse caused by intentional acts or omissions which have a more sinister intent.*
- *Currently a large proportion of referrals to the **NMC (Nursing and Midwifery Council)** is from care homes, yet the type of concern (e.g. neglect) occurs in the NHS yet does not necessarily get referred as the organisation has other ways of dealing with the problem.*
- *We had a patient who was terminally ill and in terrible pain, the doctor would not prescribe effective pain relief, he is reluctant to prescribe morphine because of **‘Shipman’**.*

- *Uncomfortable, painful, invasive interventions should be considered and **only** used as a last resort and **strictly regulated** by formal 'best interests' procedures.*
- *...the number of complaints upheld which are on the neglect-abuse continuum e.g. adults with dementia discharged from hospital in the early hours.*
- *...in our experience the NHS in all its forms has yet to move beyond the 'see and treat' response and mindset.*

- 5.5 Health respondents said there was a widely held perception that care provided by healthcare professionals was 'safe'. This assumption of safety and good-will and the assumption that everyone was doing their best – it was argued – meant it was difficult for staff at all levels to engage with the questions of abuse and safeguarding. Additionally, respondents thought the hierarchical culture in the NHS meant it was difficult to question staff practices, staff attitudes and patient outcomes. The result was a resistance to engage with safeguarding issues.
- 5.6 However, respondents identified an increasing level of awareness that health organisations should not be complacent as *'there is the potential for abuse of vulnerable adults in an NHS setting, specifically, some complications of care, such as falls and pressure ulcers, need to be challenged rather than accepted as a recognised complication of treatment.* Some responses felt that *'a culture of complacency and indifference is sometimes tolerated within institutions'*. Other responses also highlight that safeguarding in the NHS is largely associated with nursing care rather than the whole spectrum of issues from vulnerability to abuse.
- 5.7 Many of the NHS responses revealed a feeling that the current culture within the NHS did not facilitate the positive acknowledgement of safeguarding as a concept and did not demonstrate how it should translate into current practice. Some respondents discussed the idea that abuse is often passed off as poor practice and that sometimes *'this is accepted as a consequence of staff shortages'* and *'knowledge about adult safeguarding in practice is low'*. Many of the responses spoke about the need to develop a culture across organisations where staff feel able to challenge and question as the 'norm' and use whistle blowing only as a last resort when things go very wrong. There was a belief that much more needs to be done to develop such an open culture. *'This means developing a leadership culture that is facilitative*

and listens to the views and concerns of staff. Improving inter-agency working, including better sharing of both formal and informal information’.

- 5.8 Although awareness of adult safeguarding varied among NHS organisations the challenges stated were similar. Respondents said that the main challenges were thought to be: acknowledgement of the concept/issue of adult safeguarding, limited resources, a lack of integration of reporting systems with safeguarding systems, inadequate education and training and low levels of understanding.
- 5.9 Respondents sought NHS specific guidance and clarification of ‘safeguarding’ and ‘vulnerable adults’. Most health respondents agreed that the *No secrets* definition needs to be revised and terminology such as ‘neglect’ should also be clarified to capture the type and degree of neglect particularly to determine between individual and organisational responsibilities and between acts that are passive, intentional, wilful and by omission. *‘The NHS as a whole does struggle fundamentally with the use of the words ‘abuse’ and ‘neglect’.* Therefore, an approach must be adopted based on the best change management principles to support a better understanding of the language’.
- 5.10 Health practitioners want more training and education to improve awareness, along with the development of clear roles and responsibilities for safeguarding. There was unanimous support for multiagency training and for detailed operational procedures and practice guidance to be available to all staff.

Integrating systems

- 5.11 Respondents argued that safeguarding systems had, on the whole, neither been properly set up, nor been embedded in the NHS and 44% (Chart Q6f) of the respondents stated more needs to be done. As an illustration, NHS respondents drew attention to the systems for responding to clinical incidents, serious untoward incidents (SUIs) and complaints. There was a perception across all agencies that these were largely dealt with ‘in-house’ through clinical governance systems and were rarely thought of in the wider safeguarding context. There was resistance to taking it ‘out’ of the NHS: *‘Investigation of serious safeguarding incidents are protracted, there appears to be no formal reporting system, and whether “lessons are learnt” is dependent upon the priorities of individual organisations and their willingness to engage in the process’.*
- 5.12 Many of the respondents said that it would be possible to integrate these systems. However, at present it is confusing and unclear as to which incidents

would fit into the multiagency context of safeguarding. Some organisations said they were already making such links and developing their own range of guidance to support this. *'We have referenced safeguarding procedures in Trust policies and procedures for serious untoward incidents. We have tried to make clear the distinction between the two processes and to avoid duplication of effort-for example, where one investigative process can meet the requirements of both sets of procedures. There remains some scope for confusion for staff and we are developing flow charts to make things clearer'*.

- 5.13 Adverse incidents may involve a wide range of issues which are not necessarily related to adult safeguarding. However, some respondents thought there were opportunities to be gained from streamlining and integrating systems where investigations could be undertaken in parallel and the learning from both could be informative and help to develop communication between safeguarding teams and health agencies. The overwhelming majority of respondents 90% (Chart Q6d) agreed that the NHS would benefit from regional safeguarding forums where health organisations can share good practice and learning. Some respondents were already using a Memorandum of Understanding (MOU) to cooperate fully between agencies during investigations, and one organisation has a multiagency critical incident review protocol in place, which is in use by the adult safeguarding board. A mental health Trust has a named safeguarding member of staff who receives all Serious Untoward Incidents (SUIs), notifications and complaints to consider within the safeguarding arena. Where an incident, complaint or SUI is also a safeguarding concern, the processes are dovetailed so that investigations are well coordinated and not duplicated. This requires a high level of communication, openness, trust, expertise and where possible an underpinning policy or agreement.
- 5.14 There was concern about the potential high level of adverse incidents that would be reportable as safeguarding concerns if the two processes came together and the potential effects on staff. It was argued that balancing the positive benefits from wider reporting and managing "the blame or guilt" associated with serious cases *"will need strong leadership"*. Some responses debated whether value is added to improving patient care by reporting SUIs as safeguarding. *"The added value will be external scrutiny and transparency by the local safeguarding system"*. Others echo the outcomes of the Healthcare Commission 2007 report 'Is anyone listening?', which recommended that the NHS needs to be transparent, not be adversarial and to implement changes as a result of investigations. The report concludes that 'Fundamentally, the two systems can be made to work together once the barriers of language and process are examined in a positive way'.

5.15 Overall, there was support for the NHS to operate within this multiagency context of safeguarding from health respondents and safeguarding partners including the police. There was also a clear request from NHS respondents that guidance is needed to clarify the relationship between adverse incident reporting, complaints and governance structures and safeguarding, to clarify language and terminology and to encourage reporting in a way that supports the investigation and empowers staff in the process.

Drivers for change

5.16 Development of systems for adult safeguarding within the NHS has mainly been in response to the requirements of regulation and monitoring. Many health respondents suggested that there were already many positive drivers for change in existence. Examples included Standards for Better Health, (as noted by 23% of the respondents see Chart Q6k) which sets out the level of quality all organisations providing NHS care are expected to meet. The NHS Litigation Authority (NHSLA) (mentioned by 14% of the responses) establishes measures to raise standards of care and reduce risks in the care delivery process. Many health respondents wanted dignity to be part of the new drivers for safeguarding and to see the inclusion of more specific ‘service delivery’ quality metrics. Some managers were aware of these standards and could see opportunities to develop them further for safeguarding; however, there was a little understanding of how these standards may affect the way NHS services are designed. The lack of resources dedicated to safeguarding was highlighted and many respondents said that little work had been undertaken to understand the true costs of achieving safety, dignity and safeguarding within the NHS.

5.17 ‘Essence of Care’ (EoC) was another set of standards that was mentioned by many of the respondents. EoC was first launched by the DH in 2001 and was designed to support the measures to improve quality set out in ‘A First Class Service’ and to contribute to clinical governance at a local level. The benchmarking process set out in EoC was a tool which was developed to support practitioners to measure practice and develop action plans to improve poor practice and to celebrate, share and compare best practice. Health respondents in this consultation considered that the EoC standards fitted well with safeguarding principles in the NHS as they focused on ensuring that patients receive the basic fundamentals of care such as, pressure ulcer care, nutrition, continence, personal care, privacy and dignity, self-care, record keeping and safety for clients with mental health needs in general hospital settings.

- 5.18 Respondents thought that one of the key success factors with EoC, was that it allowed the practitioner to elicit a patient's experience of the topic chosen for auditing and for the patient and their carer to be part of the action-planning group for change thereby empowering frontline staff and patients to become dynamic change agents in the care process. Although in many organisations the momentum and enthusiasm for EoC seemed to have been lost in the sea of competing priorities, responses suggested that now was the time to strengthen the links with EoC to achieve the standards, to reduce the risks of neglect or abuse and ensure that NHS patients receive safe and competent care. *'The Essence of Care provides a toolkit to help practitioners to take a structured approach to sharing and comparing practice. Safeguarding Adults needs to be incorporated into each area. This should enable health care professionals to ensure that care is offered to a high standard, and where this does not occur changes are made to improve the service and that issues relating to abuse are identified and actioned. Health care teams need to be able to evidence changes in practice'*.
- 5.19 Respondents identified other drivers for change as CQC regulations (currently out for consultation), World Class Commissioning, Lord Darzi's Quality Accounts, and Professional Codes and Standards. Many of the health responses identified clear links with service standards and professional standards, *'Safeguarding Adults is an essential part of professional practice and its principles are conducive to the standards established by professional organisations including Nursing & Midwifery Council, Allied Health Professionals, GMC and BMA'*.
- 5.20 Training in safeguarding was identified throughout the health responses as an area that people felt needed development. Although many NHS organisations have incorporated safeguarding awareness training into their induction programme, in response to the consultation question 'should we review current arrangements for delivery of safeguarding adults training?' All health respondents replied it should be reviewed and increased. It was described by many as ' cursory'. Most respondents supported the need for multiagency training and saw the benefits in sharing expertise and building relationships as well as addressing differences in language and culture across different organisations.
- 5.21 Health respondents wanted the following training:
- Safeguarding Adults training to be a priority across all services

- Regular updates to be available to staff and delivered in a way that meets staff needs around different clinical and non-clinical environments and shift patterns
- Guidance on raising concerns particularly if the concern refers to a colleague
- Training needs to deal with the integration of incidents and complaints into safeguarding
- Whether, when and how to share information about safeguarding concerns between one area and another
- Training to be tailored to meet different levels of roles and responsibilities
- Standards for safeguarding training.

5.22 Health respondents wanted the following systems:

- Providing services that respect privacy and dignity so that the “starting point” is that people using those services feel safe
- Involving people who use services in developing local safeguarding policies and procedures – listening to the voices of experience
- Providing staff with the knowledge, confidence and support required to take action/make alerts
- Inter-agency communication, providing a common understanding when there are differences in language
- Providing feedback to the service user.

5.23 In summary, to develop effective systems within the NHS, respondents reported a need for a greater acknowledgement and ownership of the concept of safeguarding in the NHS. Many opportunities to use current and new drivers for change already existed to influence the development of systems to support safeguarding practice. However, these were neither recognised as mandatory nor subject to regular review.

Leadership

5.24 A large number of health respondents stated that the majority of NHS organisations did not have a leadership structure for safeguarding adults at Board level, and that there were significant gaps at an operational and strategic level in both Commissioning and Provider organisations. *‘There is often a real lack of awareness at a very senior level of the implications*

of safeguarding. This then makes it difficult to gain support to embed it throughout the organisation. It was reported that most NHS Trust Boards considered that 'patient safety' was paramount and integral to the business of health, however the respondents also reported that both the Healthcare Commission and the Health Services Ombudsman had revealed poor accountability in respect of abusive 'institutional practices'. To illustrate this point, responses have referred to incidents in the Cornwall Partnership Trust, and Maidstone and Tunbridge Wells NHS Trust.

- 5.25 There was wide agreement from NHS responses that the DH should be the strategic leader for health and responsible for setting national priorities and standards. They also acknowledged the good work already achieved by local authorities for adult safeguarding, for the considerable knowledge and expertise gained in developing safeguarding systems within the localities, and there was support for this work to continue. However, there were also requests that there should be explicit links to partnerships with health through the local Health and Well-being Partnerships and to local overview and scrutiny.
- 5.26 With regard to the question 'where should leadership for NHS safeguarding issues lie?', two thirds of the health respondents voiced a preference for safeguarding to have an 'Executive Board' focus within the NHS with a 'Designated' Director with board responsibility. There was also support for leadership coming from the PCT as the commissioner of services with overall responsibility for the performance of its providers and a third of the responses also said that the SHA should have leadership responsibility.
- 5.27 Almost all respondents commented (without being asked) that there was now good leadership and good practice in relation to children's safeguarding in the NHS. They argued that the only way to make safeguarding for adults a priority was to implement a robust leadership structure that is held to account. *'The Department of Health and the Strategic Health Authority need to lead with Safeguarding Adults across the NHS to ensure there is a central leadership role. Leadership needs to be developed within all organisations at a senior level to ensure that Safeguarding Adults is an essential requirement in the delivery of quality healthcare. Each agency should ensure compliance and good practice in this area. Safeguarding Adults needs to be everyone's responsibility. There needs to be a Trust wide understanding that Safeguarding Adults matters'*. Health responses also wanted leadership responsibility to be statutory and to stand up to scrutiny. *'Each NHS organisation (including the SHA and Monitor) should have a statutory responsibility to have executive and dedicated operational*

leads for safeguarding. The quality of this should be monitored by the SHA/ Monitor through the CQC monitoring standards’.

5.28 Health respondents wanted ‘*explicit responsibilities defined within Job Descriptions of key staff that can be applied nationally’*. Roles and responsibilities for safeguarding needed to be part of the employment contract for all staff in addition to the professional duties for safeguarding detailed within professional codes and standards. ‘*Professional organisations have a duty to take the lead in this agenda. They have an educational role to play and should take the lead in investigating allegations and applying appropriate sanctions to individuals or organisations that are reported to them for professional misconduct of any kind.*’ Only one or two health respondents made any reference to the new Independent Safeguarding Authority (ISA). There appeared to be little understanding about how the ISA will affect the NHS.

Safeguarding Leads

5.29 There was unanimous agreement that safeguarding in a Trust or a hospital could not be the responsibility of only one person; they could not be the champion, professional leader, awareness raiser, data collector and reporter and have all safeguarding roles. A team approach to safeguarding within the NHS was thought necessary by many respondents. ‘*NHS Safeguarding leads need to do a whole range of activities. Essentially their role will be to provide leadership and a central point of expertise within the organisation at a senior level’*.

5.30 Both ‘Commissioner’ and ‘Provider’ organisations reported that they wanted and needed clear service models with clear roles and responsibilities for each part of the NHS. ‘*The PCT commissioning arm has a service specification, which each NHS Provider Trust completes setting out the arrangements within their organisation. Safe Systems are important and cover arrangements in place’*. Some respondents refer to innovative commissioning PCTs, for example, one PCT has commissioned a substantial delivery model for safeguarding in partnership with its provider arm. ‘*Safeguarding Adults needs to be reflected within both the commissioning and provider role and at a strategic and operational level. As the role of the safeguarding lead develops within the health service it is important that safeguarding issues are sufficiently recognised and developed to ensure that there is an integrated approach and response in the locality where health services are commissioned and delivered’*.

- 5.31 The responses clearly argue that no 'one' person can effectively manage the NHS safeguarding role and that organisations must develop a sustainable structure with a team approach. *'NHS safeguarding leads are best placed to lead specialist teams, which provide support, awareness raising, data collection etc. It is a 'co-ordinating' leadership role'*. Health respondents thought that it was important that 'safeguarding leads' should be professional leaders with operational responsibilities or have a good understanding of operational issues. They need organisational support to ensure they were empowered, training programmes that raise awareness, provide an understanding of procedures, roles and responsibilities, and systems of collating and using data that is reported at Board level. *'Safeguarding should be seen as creating a safe environment (prevention) as well as being able to respond effectively to incidents. Giving attention to safety, privacy and dignity for all patients increases both the perception and experience of safety for service users, who will feel particularly vulnerable when leaving the ward is not an option available to them.'*
- 5.32 One Mental Health Trust reported: *'We have just appointed a Trust lead for Safeguarding Vulnerable Adult. The post holder will link with local safeguarding boards and be a point of expert advice for Trust staff. We think that this post mirrors the process we went through some years ago around safeguarding children, where we now have a team of local leads and a corporate lead. We also expect that this post will help ensure consistency across the Trust and help us work across four separate local procedures, strategies and local operational arrangements'*.
- 5.33 In summary, the key responses about leadership in health want each NHS organisation to have an executive lead with board accountability, designated operational leads and dedicated teams for safeguarding with clear roles and responsibilities built into employment contracts, job descriptions and professional standards. In addition, the PCTs should be commissioning organisations to provide safeguarding services for adults.

Engagement

- 5.34 The consultation asked health organisations to consider whether any parts of the NHS were less engaged in safeguarding than others. A general perception emerged that GPs are seen as the least engaged (37% of the respondents see Chart Q6g); followed by acute hospitals and A&E departments (18% of the respondents). Other parts of the 'less engaged' health economy were thought to be independent providers, dentists, optometrists, commissioners, secure units, and drug and alcohol services.

- 5.35 The question of the role of the GP seemed to provoke the most detailed responses from health staff, because most felt that the role of the GP was crucial to safeguarding. Many of the responses highlighted the positive role that GPs can play because they are in an ideal position to identify safeguarding concerns with their knowledge of patients, their families and situations. Many of the responses pointed to the very small percentage of all the adult safeguarding referrals that originate from a GP, which they find surprising considering the amount of contact that primary care services has with vulnerable adults. *‘GPs are the single biggest problem for adult safeguarding in the NHS. Less than 1% of safeguarding referrals made are from GPs and yet they are the health professionals that have the closest contact with the vulnerable adults within their communities’.*
- 5.36 The responses suggest that GPs should be asked how they might develop their role around safeguarding, exploring skills development or training so that they can work within local procedures and this should extend to practice staff. It was also suggested that quality measures for safeguarding be introduced through the Quality and Outcomes Framework and that the contract process might be enhanced to make adult safeguarding explicit within it.
- 5.37 There are particular issues of concern for GPs about a reluctance to share information or to break confidentiality and this may put a barrier in the way of effective reporting. Sharing information and breaching confidentiality is reportedly difficult particularly in situations when both people involved are their patients. Health staff have indicated that guidance on sharing information would help to clarify what is possible and ultimately will have a more positive effect on confidence to engage in the process.
- 5.38 The Royal College of GPs has already worked to ensure that safeguarding children responsibilities are fulfilled including the development of a toolkit for Safeguarding Children and Young People. This toolkit provides effective guidance for GPs and their practice teams and some respondents suggested that a similar toolkit be developed to support GPs with adult safeguarding practices.
- 5.39 Some respondents were quite critical of GPs’ contribution to adult safeguarding. Some said that GPs would not engage unless they were offered an incentive or were forced in some way. However, some good areas of practice were also identified particularly with regard to care homes, *‘I know that GPs have flagged up areas of concern such as inappropriate dressings or management of pressure ulcers, but this does not seem to*

come through the referral process and may need more work to make them confident to use the system'. It is also suggested that 'a nominated Doctor on the highest Strategic Board will encourage medical staff to take this subject and their responsibilities seriously'.

5.40 GPs were also thought to play an important role in relation to identifying and preventing carer 'burnout'. *"It should be statutory requirement that every GP practice has a Safeguarding lead'...It is crucial because primary care is the most accessible part of the NHS, and where patients who may be reluctant to involve the police or social services may chose to confide', 'the role of screening using health checks and the single assessment process is potentially valuable providing that the appropriate level of analysis is applied to the data collected', 'GPs are struggling with sharing information and confidentiality', 'GPs may be the first health professionals to observe signs of neglect and should be expected to have the skills to differentiate between this and health deterioration and acute illness effects'. Health responses also noted the presence of concerns and safeguarding alerts raised by patients about a lack of care from their GP, especially in care homes.*

5.41 There are some further challenges highlighted with regard to engagement **with mental health services**. Health responses suggest that people with mental health problems have been under-represented in safeguarding referrals and that the amount of abuse of people with mental health problems may be underestimated. There were significant concerns raised about a possible lack of implementation and understanding of the Mental Capacity Act across the NHS and limited support for the assessment of capacity and application of best interests decision making. There was also anxiety about how the Deprivation of Liberty Standards were being considered particularly within Acute Trusts.

5.42 Many people with a mental health problem receive services from organisations other than Mental Health Trusts and one suggestion was made that *'Safeguarding Boards need to establish clear protocols on who is responsible for managing individual safeguarding concerns'*. This area poses significant difficulties for staff with little mental health expertise. *'There can be situations where people disclose real abuse during episodes of mental illness that they then retract when their mental health improves. We consider that this needs to be understood and worked with. Other areas are in relation to staff attitudes when handling issues from vulnerable, disadvantaged and marginalised groups. Over-weave this with issues around ethnicity, language, age, gender, sexual orientation and disability, and it has the potential to become even more complex and voices even less heard'.*

5.43 Some health responses reported a view that Mental Health is a separate discipline and that adult safeguarding is nothing to do with them, or alternatively, the view is that *‘everything we do is about adult safeguarding and keeping people safe...so we don't need these policies and procedures because we are doing it already’*. Some responses state that some healthcare workers, particularly in the emergency sector, have a tendency to see people with a mental health issue as a risk to the worker, rather than as a vulnerable adult. The inclusion of mental health trusts on Safeguarding Boards and other multi-disciplinary forums might provide useful links with other agencies and valuable expert input into discussions. Probation staff were very concerned about the number of their clients who were turned away from the NHS on the grounds of their history of violent offending. They asked why health staff could refuse to work with offenders, when probation staff continued to do so.

5.44 The particular issues reported for mental health services were as follows;

- The effects of stigma
- Not being believed or taken seriously (complaints interpreted as symptoms)
- Differentials in power, a sense of powerlessness and a lack of choice/ involvement in care planning
- Safety, privacy and dignity as an inpatient, particularly on mixed gender wards (a major issue for women)
- Staff attitudes and responses to concerns
- Use of physical restraint in hospital and care settings
- Environments that feel threatening and unsafe
- Fear of complaining when you are detained and may suffer reprisals

5.45 Responses from the ambulance services reported that they are often excluded from investigations and reviews. *‘It can be that ambulance services have valuable information contained within their records relating to safeguarding cases’*. It was also observed that the nature of emergency care provision placed limitations on the availability of ambulance staff to participate in Serious Case Reviews. This was also thought to be the case for emergency departments in hospitals. It was argued that improved multi agency working was needed to be addressed to ensure that processes were in place to identify repeat attendances or calls by people who were vulnerable so that appropriate action is taken.

5.46 Offender management reported serious problems about the interface between offender management and access to mental health services. This was an area identified as needing greater attention, to enable offenders to better access mental health services in the community.

Conclusions

5.47 Professionals who participated in the consultation identified the need for the following:

NHS Systems

- To acknowledge safeguarding within NHS settings and improve systems
- To implement fully integrated clinical governance systems, include reporting of Serious Untoward Incidents, Complaints and Significant Events into Safeguarding
- To develop commissioning plans that include good safeguarding practices and services
- To create a culture of openness towards safeguarding concerns, and promote organisational learning from incidents.

Leadership

- To implement clear organisational leadership structures that identify PCT Board Level expectations, an Executive Board lead for safeguarding, an operational lead, and safeguarding coordinators linked to the wider multiagency safeguarding team
- To implement clear lines of accountability from frontline NHS staff to the DH
- To identify individual roles and levels of responsibility for safeguarding
- To empower frontline staff to understand professional and employment obligations and the level of conduct required to safeguard patients within their care.

Engagement

- To ensure that all parts of the NHS are engaged in adult safeguarding practices and developments
- To clarify the safeguarding role of the SHA and Commissioning PCT
- To clarify the role of the Medical Practitioner in adult safeguarding

- To consider if there is a need to develop GP guidance for safeguarding adults
- To clarify information sharing protocols to enhance safeguarding practice and level of engagement.

6. Housing, Safeguarding and Community Empowerment

- 6.1 The consultation included eight housing events, where about 500 housing organisations were represented. Some also sent written responses addressing specific questions. Participants included senior managers in local authority housing services, managers from registered social landlords (RSLs), supported housing organisations, sheltered housing, housing consultants and others. Participants fell into three groups: those who were only just beginning to address safeguarding as an issue, those who were already doing some training and some awareness raising on safeguarding, and some who had developed specialist expertise. Many of the written responses were from those who had not only developed their own safeguarding policies and practices but had thought hard about how to make them relevant, useful and meaningful for their tenants and owners.
- 6.2 Perhaps the strongest message from housing organisations in general was that they wanted leadership. They wanted leadership from ‘the government’ and from ‘Ministers’; but more than that **they wanted leadership within the housing profession**. The government, they thought, should provide the overall framework and the vision and the direction. But they wanted their own professional lead organisations to clarify what this would mean for housing, what their strategic responsibilities would be, and what ‘duty of care’ meant for housing organisations and housing professionals. They wanted leadership from each of the Tenant Service Authority, the Homes and Communities Agency and the Department of Communities and Local Government.
- 6.3 Housing staff in local authority housing departments reported lack of clarity in policy and management around vulnerability and safeguarding. The term vulnerability had a specific meaning in relation to housing law and had another meaning in relation to ‘duty of care’. Whether or not individuals were ‘statutorily vulnerable’ affected their housing rights and housing options – but how did it fit with their right to safety and safeguarding? Housing professionals acknowledged substantial confusion and reported that negotiating these issues was getting in the way of safeguarding: *“We spend a lot of time working out and arguing whether someone is statutorily vulnerable rather than focusing on what measures could be put in place to enable a person to keep themselves safe”*.

- 6.4 The main message from supported living providers was that, because *No secrets* was published prior to the Supporting People reforms, there was little clarity about the role of supported housing in relation to safeguarding. A revised *No secrets* needed to ensure that housing related support services were fully included in any new arrangements for safeguarding. Respondents commented that much had been achieved by the Valuing People reforms in learning disability services, which resulted in many residential care services moving to a supported living model. This model involved working with large numbers of people who traditionally had been seen as vulnerable but nevertheless were now seen as able to live independently with the right support. New expertise was emerging in this field, but safeguarding was key to the ability to live independently with support.
- 6.5 Supported living providers reported that awareness of safeguarding issues was increasing in part due to its inclusion within the Supporting People **Quality Assessment Framework (QAF)**. This framework has been in operation since 2003 and has recently been updated, with the strengthening of providers’ responsibility for safeguarding and protection (revised QAF, April 2009).
- 6.6 The language used by housing professionals was markedly different from that used by the main safeguarding partners. Housing professionals spoke of policies/measures/training *“to enable a person to keep themselves safe”*. The role of the professional was seen as an enabler, and the main ‘actor’ in the safeguarding process was the person themselves rather than others.
- 6.7 Housing professionals made important ‘structural’ links between safeguarding and Local Strategic Partnerships (LSPs) and Crime and Disorder Reduction Partnerships (CDRPs). Many said these were the obvious places where safeguarding needed to feed into and be owned and recognised.
- 6.8 Housing respondents were very clear that they wanted national safeguarding procedures. Most RSLs and supported housing providers worked across local authority boundaries and reported immense frustration at the differences in procedures. *“We must have national procedures. Different procedures and policies are not an acceptable response to a universal issue.” “We are hampered by the varied criteria” “There is massive variation in the approach and application of safeguarding guidance and procedures – yet they all expect instant understanding and compliance with the processes each has chosen ... and they keep changing.” “We monitor safeguarding issues across our services and need to keep up with the changes in nineteen procedures – does this make sense?”*

6.9 Housing providers wanted the following from **Safeguarding Boards**:

- A clear remit which is communicated widely and available on the internet.
- Stakeholders should be able to contact the Board with questions and concerns and expect a response within an agreed timeframe.
- Each Board should establish a starting point or benchmark: how safe are people in this area? How safe do they feel? Do they know who to talk to?
- To set targets and measures for improvements and check whether these have been achieved.
- To have a 'clear no blame, no shame' approach – for all referrals, investigations and outcomes.
- To build a strong partnership model of working.
- To offer a way of raising concerns about investigations which can be looked at independently.
- Accountability in different ways to a) people with experience of harm and the organisations that support them; b) local authority, local NHS and local police scrutiny and c) through their annual reports to central government and CQC.

6.10 Housing providers wanted the NHS to be firmly integrated into multi-agency safeguarding systems and also thought all care homes should have safeguarding policies and QAF equivalents.

6.11 Housing professionals also raised questions about how the Independent Safeguarding Authority, the General Social Care Council and the Local Government Ombudsman all fitted together. They understood that both the ISA and the GSCC would be looking at what was acceptable conduct in the workforce, but how would they link to the complaints system and as a result to the local government ombudsman?

6.12 Housing professionals wanted much more prevention and some of them were already doing much in this area. This included:

- Looking at risk indicators (isolation, alcohol/substance misuse, mental illness) and working up a prevention of abuse/keeping people safe strategy.

- Conceptualising prevention as empowering tenants and making them more connected.
- Informing people/equipping people with information and plans to safeguard themselves.
- Having named people to make referrals to and named people who support tenants while investigations are taking place.
- Working with tenants “whose behaviour poses risks to the wider community.”
- Holding community meetings, developing advocacy and intermediary services, working with police liaison officers, and with neighbourhood safety initiatives.

6.13 A few housing organisations had developed quite sophisticated safeguarding policies through what they called ‘customer profiling/tenant profiling’. Boxes 7 and 8 show how such customer information was being used. They said much of the information for this has always been collected as part of housing needs assessments, and this is simply making use of the information.

Box 7: Customer Profiling and Vulnerability Policy

Customer Profiling and Vulnerability policy

- *We are improving the information held on customers in relation to their vulnerability through customer profiling... triggers relating to age, severe illness and disability are entered onto our database.*
- *We have a Vulnerability Policy.*
- *We have Vulnerability Review Visits, and where concerns are identified, we call and make further visits and people can be signposted on.*
- *We also have systems in place for monitoring problems/progress on safeguarding alerts and vulnerability alerts.*

Box 8: Vulnerability concerns

What would we do if we had vulnerability concerns?

- *We ask all our tenants when they move in if they want us to notify anyone if for example they got very ill or if we had serious concerns about their well-being. We keep that information on our database.*
- *We then notify these chosen people if necessary. They are usually family and close friends.*
- *We look to see if supportive technology would help (i.e. personal alarms).*
- *We can provide a small amount of floating support (care worker visits) where necessary.*
- *We will make safeguarding referrals but we do it preferably with the permission, or at the very least with the knowledge of the tenant. The latter if we consider the situation very serious.*

6.14 Some housing providers were also very aware of the advantages and disadvantages of Anti Social Behaviour Policies. Some had used these to address the safety of tenants with learning disabilities where there had been general harassment on the estate and/or by neighbouring tenants. They commented that Anti-Social Behaviour Orders (ASBOs) could be used as part of safeguarding policies. But others commented that they were often used against vulnerable tenants as well, and that sometimes organisations “jumped to ASBOs when mediation and support to vulnerable tenants would be more appropriate.”

6.15 Other aspects of good practice included: having safeguarding leads in all housing organisations; developing policies, procedures and training; establishing a team of dementia experts; learning about triggers and signs – including ‘threats to independence’. Housing professionals spoke about the need for respecting confidentiality in most situations where no one else was at risk and working with tenants for support them to make their own referrals rather than doing this for them.

6.16 Housing professionals noted that if fewer people met the local authority’s interpretation of the Fair Access in Care Services (FACS) criteria – (establishing the threshold for receipt of publicly funded social care), fewer would receive services in the community. The conclusion drawn from this was that landlords had to work with tenants on ‘Being a good and vigilant neighbour.’

- 6.17 Some housing organisations wanted the government to make prevention a legal responsibility; to make it part of the Local Strategic Partnership; to recognise the limitations of certain kinds of commissioning – i.e. *‘very short episodes of care, like 15 minutes are themselves abusive’*; and to raise public awareness.
- 6.18 Many housing organisations commented that the changing institutional framework within the housing sector meant that there was now an opportunity for the new regulator, the Tenant Services Authority (TSA), to provide new guidance on the duty of care of landlords for the future. While many housing providers were interested in the revision of *No secrets*, they were as, if not more, interested in whether the TSA would provide leadership on this issue.
- 6.19 Some housing professionals expressed concern about some aspects of safeguarding practice in their areas. Their concerns were about bringing the police in too early; about having safeguarding meetings about tenants without them; about not recognising their rights. *“We need to put limits on the powers of intervention that social services have or where will it end? It is not good if social services acts like a second tier police service.”*
- 6.20 A marked difference between housing responses and other responses was the approach taken to **‘perpetrators’**. For many housing officers perpetrators were just one of the categories of people who needed housing, and they had the same housing rights as anyone else. The landlord responsibility was to try and help keep them safe in the community and to keep the other tenants safe from any of their offending behaviour. Other supported housing organisations went further and said it was important to work with them. *“Unless work takes place with abusers, they will continue to abuse”*.
- 6.21 Housing organisations wanted a **clear national indicator**, and they wanted it to be one that recognised tenants’ rights to self determination. They commented that in the housing world, confidentiality and consent were important in all interaction with tenants and very rarely would they want to breach that. Any indicator or national outcome framework should be built on tenants’ rights.
- 6.22 The Quality Assessment Framework for supporting people services (QAF) was put forward as possibly a better, more relevant, framework for developing a new framework for adults than the framework of children’s social services safeguarding.

Housing and Risks

- 6.23 Housing providers in supported housing were clear that their tenants needed to identify their own safety plans, with support from professionals. They wanted risk management plans to be developed with the person at risk, and also to include other people who know or care about the person. *“Where possible, ensure that people have people who love them involved in their lives.”*
- 6.24 Housing staff commented that they needed training to help people make their own choices – training in diversity, in communication skills, in the Mental Capacity Act, the use of the supported decision making framework, helping people to remain in control. They wanted to move away from the focus on *‘how can we keep you safe’* to *‘how can we help you live the life you want in the way you want.’*
- 6.25 What did housing organisations do if they were concerned about tenants? Some thought it was not their role to do anything unless there was a specific safeguarding alert. Others worked more preventatively. One organisation, for example, explained that its staff currently made calls to all their tenants over the age of 75 during the winter period to ask them if they had heating and hot water. This conversation was also to check on their general well being and sign-post them on if they needed anything.
- 6.26 Other organisations carried out **tenancy verification checks** annually, which updated the landlord on any changes of circumstances AND on any changes in vulnerability/risk. These were based on visits to all tenants and were thought to be cost effective means of identifying wider problems. Where concerns were identified further visits were made or tenants were signposted to other organisations – community organisations, advocacy organisations, to GPs, to social care if they needed more support – or safeguarding.
- 6.27 A few housing professionals raised the issue of **financial safeguarding** and questioned the reported practice of some local authorities making blanket referrals to the Court of Protection for all people with learning disabilities when they took up their own tenancies. So, although these tenants were given the keys to their own homes, they were having control over their finances totally removed. One housing provider asked if this was an abusive practice, out of step with the requirements of the Mental Capacity Act, which required the assumption of capacity and individualised assessments of capacity.

6.28 Some of the awareness and good practice were reported from specialist housing providers and we explored in our consultation whether it was possible to apply this also in general housing. The consensus was that much of this would be easy, and cheap to do. The customer data are already in the files and could be used to identify those who would benefit from sign-posting type of phone calls; pilots could take place with specific groups – over 80s living alone, for example, and then gradually could be extended to any other priority groups. The initial concern about ‘what would we do if we were worried about someone?’ needs to be addressed possibly with the help of a voluntary befriending scheme, a tenants’ association, or other community group.

6.29 Some housing staff were critical of mental health colleagues. They reported long arguments about whether someone had a genuine mental illness, which led to delays in assessment, support and treatment, and put people at risk. They also reported that arguments over NHS budgets put people at risk. Some asked for a designated safeguarding person in each GP health practice.

Housing and Community Empowerment

6.30 Community Empowerment means enabling more people to play an active role in the decisions that affect their communities. The consultation asked whether there are clear links between safeguarding, housing and community empowerment. Respondents reported that general housing providers had some links to community empowerment, but that these were few at present.

6.31 The links that were starting included:

- physical planning – and the link to designing out crime through the physical environment;
- community involvement in developing new services;
- links between safeguarding and the sustainable community strategy.

6.32 One respondent commented: *“Any community development that places local decision making at the heart of its objectives must also have in place requirements that the community in question understands its wider responsibilities to all the members of the community. It cannot be just survival/engagement of the fittest.”* Almost all respondents wanted closer policy links between safeguarding and community development and empowerment.

Box 9: Some perspectives from Registered Social Landlords (RSLs)

Some RSLs argued that their roles rested upon:

- RSLs have a value base which aims to strike a balance between privacy and independence, and offering support and assistance to facilitate people to live as they wish.
- RSLs proactively engage – to varying degrees – in building inclusive communities, supporting victims, developing community cohesion; addressing hate crime; working with domestic violence; safeguarding both adults and children; housing and managing sex and dangerous offenders, tackling drug supply and misuse, addressing alcohol misuse. Many of our tenants are disproportionately susceptible to the effects of crime or anti-social behaviour and live in the most disadvantaged neighbourhoods.

Box 10: Housing staff:

- can be key alerters
- can enforce tenancy agreements
- can take a range of actions to combat anti-social behaviour
- can take action against perpetrators
- can support victims
- can manage neighbours
- can enforce the 'respect agenda'
- can raise awareness
- can develop community cohesion
- can provide alternative housing
- can provide more specialist housing
- can liaise with community police
- can provide support to monitor a situation
- can provide support after a situation

6.33 Responses to Q7b show the variety of roles that the respondents thought housing staff might have. Top of the list is training – for tenants and providers and residents. Close behind is raising public awareness – for tenants, and also the families and carers and supporters of tenants. Some

suggested developing community networks was important, which would be built on partnership working. Underlying all of these were ‘the basics’ – seen as having relevant policies and procedures which were regularly updated and made widely available to both staff and tenants.

Housing and Criminal Justice

6.34 Many housing organisations work with the criminal justice system. Their tenants are both victims and perpetrators of crime. Some of the ways in which they worked together included:

- housing and police working together to identify vulnerable people/people at risk in the community.
- housing and police working together to look at the whole area/estate.
- housing and police working together to look at the whole person rather than just the crime committed.
- housing help to flag up the vulnerability of a person at arrest.
- joint risk assessments.

6.35 Some housing staff reported limited joint working and commented that ‘much police work is insular’. It was thought that the development of joint working practices took time. But once they were established this was mutually beneficial.

6.36 Housing staff reported a number of challenges of working with the criminal justice system:

- Knowing who to contact: many housing officers said it took hours to track down the right person in the police, and even officers within the police force did not always know who to ask for. Web information would be useful.
- Information sharing: many housing professionals commented that they opposed automatic data sharing without the informed consent of the tenants. *“Taking a person centred approach does not involve giving all names or photos of vulnerable people to the police.”*
- Partnership working: some housing officers also commented that sometimes their only role was thought to be handing information to the police. Many would have liked better partnership working where they were kept informed about the results of investigations and about risks to others.

- 6.37 Housing officers reported successful partnerships leading to individuals being safeguarded. One example given was the joint recognition of the need to 'understand' situations that the police and housing staff are called to. People are in general responsible for visitors/noise/anti-social behaviour in their own flats and their tenancy is at risk if they don't exercise control over their visitors. But housing officers together with their local police officers have developed a joint understanding in some areas that for some people, exercising control over people who have invited themselves in may be extremely difficult, and may require police support at times.
- 6.38 Another example given was liaison between housing staff and police when a tenant who was thought to be very vulnerable terminated their support arrangements. Housing officers told the tenant they would be informing the local police so that, if the tenant found themselves in difficulty, the police would have a greater understanding of their situation and their condition and would respond more appropriately.
- 6.39 Several respondents said that the links between safeguarding and crime reduction "*were crying out to be made.*" One housing officer commented that a situation that was not perceived to be urgent by a neighbourhood police officer or a community warden would often be recognised as urgent by police officers in Public Protection Units. Making these links and developing these partnerships were seen as part of community empowerment.
- 6.40 Housing professionals identified the following issues for the *No secrets* review to consider:
- a) The fact that the accused person is specifically excluded from special measures in criminal justice proceedings. Some staff commented that this was not appropriate if the accused person was vulnerable.
 - b) Making the court system more modern, bringing the good practice that is available for children to adults, so that those who have been abused do not have to face intimidating questions.
 - c) Having an intermediary service for people before they contact police – the idea of reporting abuse to police can be frightening.
 - d) More closed courts, pre-court questioning, and 1:2:1 sessions with judges.

Box 11: Summary of the main messages from housing professionals:

1. They wanted strong leadership on safeguarding within the housing sector.
2. They had a broad understanding of what ‘helping people to keep themselves safe’ meant, but wanted much more guidance on how to do it, when to do it and how to balance their duties of confidentiality with safeguarding.
3. They recognised the social inter-relation of some perpetrators of abuse and the people they abuse within their communities, and that in some instances the perpetrator could be a vulnerable person with their own needs. The role of the police and local authority safeguarding, in their view, needed to be flexible and to have regard to what action would achieve the most appropriate outcomes.
4. They wanted national procedures.
5. They wanted to work with Safeguarding Boards.
6. They wanted to work on prevention. A few housing organisations had vulnerability policies identifying customers from their customer profiles for preventive ‘well-being’ monitoring; and a small number used tenancy verification to do well-being checks.
7. Housing staff wanted training to help people make their own choices – helping people to remain in control. They saw training as extending to residents/tenants, in keeping themselves safe.
8. Many housing professionals wanted a national indicator, and suggested that the Quality Assessment Framework used for supported housing was a more appropriate framework than that of children’s safeguarding.
9. The vast majority of housing professionals did not see the need for safeguarding legislation. They wanted information sharing protocols based on people’s consent; they wanted stronger partnership working; and much stronger leadership from within the housing sector.

7. Safeguarding and the Criminal Justice System

Introduction

- 7.1 In 2000, when *No secrets* was published, and in 2008/9, when this consultation took place, there was a clear recognition that safeguarding and the criminal justice system were inextricably intertwined. This chapter reports the respondents' views of the relationship between safeguarding and the criminal justice system. It describes the views of: the police, offender management staff, some of the voluntary sector who work in this area, other professional bodies (such as the Law Society) as well as the safeguarding partners' views of the interface between safeguarding and the criminal justice system. The Crown Prosecution Service are feeding into the review directly rather than via the consultation and so their views are not reflected here.
- 7.2 The Association of Chief Police Officers (ACPO) was closely involved in the consultation. ACPO wrote to all police forces in England and Wales, inviting them to participate by responding to the consultation questions. ACPO compiled a summary of these responses and submitted a formal response on behalf of the Police Service. In addition many also contributed through the partnership responses. Some of the main messages from the Police Service included:
- Police commitment to safeguarding adults
 - Police support for effective multi-agency responses
 - Police support for statutory safeguarding boards with a statutory duty to cooperate and share information.
- 7.3 Probation Areas/Trusts had participated in a national adult safeguarding event for offender management staff. The conclusion was:
- offender management staff would like to be better linked to adult safeguarding – as long as safeguarding addresses issues relevant to offenders.
- 7.4 The voluntary sector organisations working with vulnerable adults in the criminal justice system were challenging. Many wanted:

- Crimes against vulnerable adults taken very seriously, and dealt with as crimes;
- To support and advocate for the person in the criminal justice system – and help to change the system to adapt to people’s differing capabilities;
- Several wanted to be involved in training the police and the CPS to be more aware, more informed and more skilled in adapting their role to disabled people.

Leadership

- 7.5 The Police Service view was that national leadership should lie with Adult Social Care/Health with a nominated responsible Minister.
- 7.6 At a local level they thought leadership should lie with Adult Social care. The safeguarding statutory lead should be the Director of Adult Services with the agencies leadership being provided around the Safeguarding Adults Boards, who would provide strategic direction. Social care should retain key responsibility, but joint working should be demanded from other agencies supported by a legislative duty to co-operate. Safeguarding Adult Boards should be placed on a statutory footing to mirror Local Safeguarding Children Boards.
- 7.7 The Law Society shared the view that leadership for safeguarding adults should lie with the Department of Health Social Care Directorate, but thought that they should be supported by other Government departments including the Home Office, Communities and Local Government, Department of Work and Pensions, Ministry of Justice and the Office of Disability Issues.

National procedures

- 7.8 The Police Service view was that there should be a national framework for local procedures to ensure as much consistency as possible across the country but they must allow sufficient flexibility to meet local requirements. There was a need for national minimum standards to be developed to support performance at local level. They thought national job descriptions would bring consistency and develop common understanding of the role within partnership organisations.

Accountability

- 7.9 The Police Service supported the introduction of national standards on safeguarding adults as these would provide a measure of the effectiveness of safeguarding boards. Whilst there was strong support within the Service for a scrutiny process by an independent inspectorate, clarity was necessary in the first instance around the question of governance arrangements of safeguarding boards. The involvement of HM's Inspectorate of Constabulary within any joint inspection process would require careful consideration where the focus was likely to be predominantly on Health and Social Care. It was also thought essential that people at the right level in the various organisations were represented on the board so they could undertake required change within the organisation/agency.
- 7.10 The Law Society believed that the Care Quality Commission should be responsible for inspection and enforcement under the regulations in the same way it was responsible for inspection and enforcement under the Deprivation of Liberty Safeguards. They emphasised that the role should move beyond just a periodic inspection to allow the CQC to be able to respond to notifications of abuse from stakeholders as well as engage in 'risk based' inspection and enforcement.

Prevention

- 7.11 The Police Service accepted that prevention was key to any strategy for safeguarding adults and thought safeguarding adults should be an integral part of general crime prevention work and embedded within the concept of Neighbourhood policing. Victim Support agreed with this, stating that any such national prevention strategy should be multi-agency and should include links with neighbourhood policing, and Public Protection Units. They thought it should also include an emphasis on training for home care and other staff, and supported the Voice UK position that prevention should be a matter for any individual whose work brought them into contact with adults.
- 7.12 The Police Service felt that responsibility for the prevention of harm within institutional care settings should sit with health and social care services.
- 7.13 The Police Service view was that information sharing was the key component to preventative measures and that it would only become truly effective when a statutory duty was imposed on all relevant agencies. Concerns were expressed about the failure of Health Services to engage in

the preventative agenda, by declining to share information on the basis of confidentiality. There had been a widespread response indicating that GPs in particular were not engaging in the safeguarding agenda and a national strategy might assist in providing a remedy.

- 7.14 They also felt that social responsibility should be proactively promoted and encouraged. Protecting the vulnerable in our society could not be achieved without the support of our communities. There should be a clear message to the public that every citizen had a moral responsibility to report issues of concern within their communities and any strategy should consider how to develop a strong cultural abhorrence to adult abuse within society. The Police Service view was that the message should be clear that the abuse of adults would not be tolerated and that communities had a vital role in prevention.
- 7.15 The view of many offender managers was that they were currently at the margins of the present safeguarding structures and process, although they worked very extensively with adults who would fall under the *No secrets* guidance. While most were aware of Safeguarding Boards and safeguarding procedures, in many areas there was only occasional contact. Yet much of the work of offender managers focused on the prevention of re-offending, and they had a lot of experience of what did and did not work in terms of prevention. A few areas were better linked and Probation Areas/Trusts were represented on the Safeguarding Boards.

Outcomes framework

- 7.16 Respondents from all sectors thought that an outcomes framework would be useful; and that it should not concentrate solely on criminal justice outcomes but should look at how safeguarding has reduced harm and brought positive outcomes for the people involved. For example, a successful outcome for a victim of abuse might be that they continued living in a home environment with the perpetrator of the abuse but the abuse ceased to take place. The Police Service felt that outcomes were important in focussing agencies on their objectives. The Adults Safeguarding Boards were there to ensure that each constituent agency was effective both individually and in partnership in terms of safeguarding performance. Any new measures should contribute to this process.
- 7.17 Some suggested outcome-based national indicators included:
- i) crime recording – number of victims identified as coming under the guidance;

- ii) number of repeat victims of crime under the guidance;
- iii) number of risk strategy meetings participated in;
- iv) percentages of successful prosecutions with victims who come under the guidance;
- vi) the volume of safeguarding referrals;
- vii) volume of 'notifications'- (This threshold is less than the safeguarding level and will evidence information sharing and recording opportunities to assist in future identifications of risks);
- viii) number of joint investigations;
- ix) number of interventions which prevented further abuse. Offender managers thought there could be outcome indicators which related to offenders as well – the prevention of re-offending was a safeguarding outcome; better preventative services for offenders under the guidance and better diversion from re-offending.

7.18 Offender managers thought that adults who would fall under the *No secrets* guidance were not always specifically recognised in their structures and systems – for example, in their tiering system. Voluntary sector organisations wanted recognition of when abuse was a crime and when criminal justice outcomes were needed.

Training

7.19 The Police Service saw training as essential. Training was generally divided into awareness training for front line officers and the more in depth training requirement for specialist officers. General awareness of front line officers needed to be increased in respect of adults under the *No secrets* guidance and their needs during a criminal investigation. Work was currently being undertaken with the National Policing Improvement Agency (NPIA) and voluntary organisations to develop an appropriate training package. The ACPO consultation also found that there was support for a nationally accredited multi-agency training course for workers specialising in this area. This would raise the profile of the importance of this type of work and recognise that individuals working within this field were professionals with defined skills and abilities. The Police Service also thought that this area of business would benefit significantly through the development of national guidance by the NPIA.

- 7.20 Several voluntary organisations reported being involved in police training, for example in helping understand the needs of people with learning disabilities or wider victim focused work.
- 7.21 Some of the partnership responses reported that the Crown Prosecution Service would also benefit from training about adults who came under the guidance – for example on how to communicate with people with learning disabilities, how to assess the evidence of someone with mild dementia and the possible new ways of hearing evidence and establishing credibility of vulnerable witnesses.
- 7.22 The Coroners’ Society of England and Wales stated that the review built upon the work already undertaken by Coroners. However in order that Coroners and their Officers (and Medical Examiners) could play a fuller role in Safeguarding Adults, appropriate resources would need to be applied in a range of areas such as awareness training and the impact of the relevant law and procedures. It was essential that all relevant agencies work together and that appropriate protocols were put into place **but** it should be recognised that Coroners would need to remain at arms length from any review processes as that could compromise their Judicial independence and the public nature of an Inquest.
- 7.23 Offender management reported very low levels of training specific to working with adults under the *No secrets* guidance. There was demand both for safeguarding training and especially for mental capacity training. Staff requested guidance on the application of the Mental Capacity Act to offender management. They commented that whereas there was an expectation that relevant training for children took place every three years there was no expectation that any training took place in relation to safeguarding adults.

Serious Case reviews

- 7.24 The Police Service thought there should be a national database of recommendations from serious case reviews to ensure that the lessons learnt were promulgated within the Service. Reviews should follow a threshold similar to that when child reviews were commissioned and the review should be independent. They should be commissioned by a high-level multi agency board/panel to ensure impartiality and transparency.

Joint Inspections

7.25 There was widespread support within the Police Service for joint inspections which were seen as essential in driving activity and helping to shape and define standards across the country. Although it made sense that the development of any joint inspection process should involve the police, as with Joint Area Reviews of Children's Services, such development would need to take account of each inspectorate's capacity (including HMIC) to resource the process within current business demands, and the proportionality of each inspectorate's contribution, given the potentially wide-ranging scope of safeguarding systems as a whole.

Integrating safeguarding into the mainstream criminal justice arena

7.26 The Police Service thought it was important to integrate safeguarding adults work into the mainstream criminal justice arena. They wanted this done by placing adult safeguarding on a statutory basis. They thought all agencies should be compelled through legislation to work together to investigate cases of abuse or potential abuse. All organisations having responsibilities within this arena would be obliged to co-operate, share information, report suspected abuse and work together to reduce harm and safeguard those at risk.

7.27 Voluntary organisations supported this aim, and were particularly concerned about the low numbers of vulnerable victims in court as victims and the even lower numbers of successful prosecutions for the abuse of adults under the guidance. Some respondents noted the high number of adults under the guidance in the prison system and also receiving ASBOs. Victim Support and other non-government organisations, believed that crimes against adults under the guidance should be recognised as such and treated accordingly. If potentially criminal acts were not identified, victims did not get access to justice, their rights under the Code of Practice for Victims of Crime¹ or even support provided by Victim Support and other agencies. They believed that *No secrets* (or its successor) needed to separate those aspects of safeguarding, response and prevention from abuse that are the remit of the criminal justice system from those that are the remit of social care/service providers.

7.28 The Police Service thought better integration could also be achieved by better joint working with the CPS especially around capacity and special

¹ <http://www.homeoffice.gov.uk/documents/victims-code-of-practice>

measures with support for the introduction of specialist case lawyers to deal with the more complex adult abuse investigations. Specialist courts for adult abuse cases similar to those held for domestic abuse would be of benefit.

- 7.29 The Police Service, safeguarding partners and the voluntary sector all thought there should be more use of special measures at court. Good examples exist. In one case achieving best evidence (ABE) involved a live link to Crown Court from a victim’s home; ABE statements had been played in court from a second victim who died before trial. This led to a successful prosecution of a care worker for theft, resulting in a custodial sentence.
- 7.30 One of the key drivers for police performance is the production of the series of NPIA doctrines. A widely supported view within the Police Service was that an important first step might be to commission some work by the NPIA in order that practitioners could refer to a body of knowledge from which to develop and build practice. Enhanced information sharing processes with all involved agencies was seen as a prerequisite for safeguarding to become fully integrated.
- 7.31 Offender management thought much could be done to integrate safeguarding into offender management and offender management into safeguarding. There was a suggestion that vulnerable offenders should be identified as a ‘hard to reach’ group in a revision of *No secrets*, with some specific guidance. The same suggestion was made in relation to Safeguarding Adults Boards – whether work in relation to adult offenders under the *No secrets* guidance could perhaps be identified as a separate stream of work or sub committee.

Staffing of adult protection police units

- 7.32 The Police Service view was that safeguarding adults was a high-risk area of work that has grown extensively. Resources committed to this area of work should be kept under review. They thought consideration needed to be given to matching the staffing and training needs to the increased demand in this area of work, and that specialist teams were best placed to ensure the highest levels of investigation and support were provided to their victims under the *No secrets* guidance.

The need, or otherwise, for a more formal system, as in MARAC (Multi-Agency Risk Assessment Conferences) and MAPPA (Multi-Agency Public Protection Arrangements), with regular police-led safeguarding meetings for serious cases.

- 7.33 The existing safeguarding meeting structure, coordinated by social services, was seen as sufficient by the Police Service providing it had the authority to ensure attendance and co-operation from all agencies (especially GPs). The Police Service view was that the most effective way to achieve this was to place it on a statutory footing with an appropriate governance, funding and compliance structure similar to the Local Safeguarding Children Board arrangements.
- 7.34 If existing safeguarding adult processes were strengthened and the involvement of statutory agencies was placed on a statutory footing then it was felt that there should be no need to bring high-risk victims to a MARAC/MAPPA type process, as they should be dealt with through well managed and timely strategy meetings and case conferences. The Police Service felt that the addition of safeguarding cases to MARAC would make it too unwieldy.
- 7.35 Victim Support called for more research into this area. They were particularly interested to know whether cases of domestic violence which were perpetrated against adults under the *No secrets* guidance were being referred to MARAC at present. They questioned the premise that a separate system was necessary for such individuals; what was needed was for structures to be put in place to ensure that they had access to mainstream services.

Co-location of multi-disciplinary teams/joint investigation teams.

- 7.36 The Police Service recognised that whilst every opportunity should be pursued for co-location and establishment of cross-partnership teams, logistical and financial difficulties made this difficult to achieve. Of greater importance was the need to ensure that agencies share appropriate information with a strong view favouring joint working rather than joint investigation teams.
- 7.37 Parallels were drawn with Safeguarding Children where co-location has not happened but teams still have excellent working relationships and that investigations are best handled by a lead agency with support from others where required. Safeguarding children services were seen to have

more defined national guidance and a statutory framework to support its implementation.

Risk assessment and risk management

- 7.38 The Police Service saw it as essential that there was a national multi-agency standardised assessment tool for the identification and categorisation of risk. There were differences of approach across and within Police Forces and this indicated a need for national guidance on this issue.
- 7.39 The Police Service was undertaking a significant amount of work in developing its methodology around the identification and management of risk in a number of areas of business. It might be appropriate to share the outcome of this work with partners in order to develop a joined up approach.
- 7.40 A level of culture change across the Police Service and agencies was necessary to move from risk aversion to effective risk management.
- 7.41 There was also a suggestion from offender management that prisons identify vulnerability in their release plans. Vulnerability required ‘additional measures’ in release plans.

Box 12: Good Practice Example

Lancashire Constabulary had a new ‘Vulnerable Adult Abuse Investigation Policy’ and procedures (including risk assessment factors), approved by the local Safeguarding Board. This brought a realisation that the police had experience in fast time response because of 24/7 responsibility and good dynamic risk assessment ability – but less experience with longer term assessments with lower threshold risk. The PPU provides the point of contact for all adult abuse referrals from other agencies with the exception of financial abuse. The Detective Sergeant had responsibility for all strategy discussions and sharing information. There were performance indicators to ensure attendance at all initial Safeguarding Adult meetings. The officers had all been trained in the Mental Capacity Act assessment principles and the best interest check list. A new form had been introduced in Lancashire to report concerns regarding adults who might require safeguarding and the delivery of additional services by other agencies. This was used to populate police systems and also as a referral form to other agencies.

Sharing information about the safety of a person

- 7.42 Clarity about information sharing was thought to be essential. Some respondents wanted guidance, some legislation. Although there was existing legislation that enables professionals to do this, contained in the Data Protection Act 1998 (the Act), there was thought to be a lack of understanding about how it applied in adult safeguarding.
- 7.43 The Information Commissioner's Office (ICO) are the regulator for the Act and responded to the consultation. They were concerned that little reference was made to the Act in the original *No secrets* document, given that safeguarding adult functions depended so much upon information sharing. Their view was that fully incorporating the principles of the Act into future guidance would help ensure that the proper, proportionate and secure use of personal data was embedded into safeguarding at the outset. A clear commitment to the data protection principles would also increase public confidence in the use of personal information and the ICO had developed an Information Sharing Code of Practice to assist in such situations.
- 7.44 The Police Service view was that information sharing guidance was essential and should be supported by legislation. They stated that information exchange would need to be put on a statutory footing as was the case in child protection. Multi-agency policies needed to be very clear about the roles and responsibilities of staff in terms of exchanging information and what the implications were for failing to disclose in relevant cases. In order that the Police Service was able take appropriate and proportionate action, it was essential that it should have access to up-to-date and accurate information/intelligence. Information sharing should also take place between partners in order to effectively identify and manage risk.
- 7.45 In contrast some voluntary organisations, for example those working with people with mental health needs, thought information sharing often led to the labelling and stigmatising of people, and should rarely be done without the informed consent of the people concerned.
- 7.46 The NHS was regarded as the agency with the most information about adults under the *No secrets* guidance and their possible abuse; yet information gathered from Police Forces suggested that health and mental health practitioners, especially GPs, were nervous about sharing information due to their perceived responsibilities to keep information confidential and possibly data protection/human rights concerns. The Police Service

felt that this was often the case despite there being clear safeguarding or other public interest considerations. Legislation introducing a statutory requirement for health to share more openly was widely supported within the Police Service and was felt to be urgently required.

- 7.47 The view from some in the NHS and from some in the voluntary sector, in contrast, was that the criminal justice system holding information on individuals who had not committed any crime was an infringement of their right to privacy and the right of adults under the *No secrets* guidance to be treated the same way as other members of the public.

Guidance on information sharing when the victim expresses a wish that it is not shared

- 7.48 The Police Service view was that a National Guidance document supported by a legislative framework was required to provide clear policy and procedure to all agencies. The guidance should assist professionals in reaching disclosure issues and should provide for a standardised assessment tool for the identification and categorisation of risk. They thought there needed to be a presumption that information would be shared amongst partners where the potential existed that people might be harmed if this was not done. Their view was that professionals could not be allowed to remain silent where there was evidence of the commission of a crime that involved a risk of harm to an adult under the *No secrets* guidance.
- 7.49 Victim Support and Voice UK agreed that sharing such information was in the best interests of victims. Domestic violence was a particular example of where victim information could be shared at a MARAC even against the victims’ wishes, if they were deemed to be at high or very high risk. It was essential that adults under the *No secrets* guidance were able to benefit similarly.

Reporting abuse

- 7.50 Victim Support commented that people who were subject to abuse should know how to report it, who to report it to, and have confidence that when they did report they would receive an appropriate response. Making it easier for people to report abuse was of course an important element in giving people the confidence to come forward. As part of this process they believed that the government should examine what the barriers were within current structures which were preventing people from reporting. Whilst initiatives such as third party reporting centres could be a useful tool, they

should not be used as a substitute for increasing the accessibility of existing reporting methods. They agreed with the Voice UK suggestion that work be done to examine how healthcare professionals could support adults under the *No secrets* guidance to report crime.

- 7.51 The Ann Craft Trust also believed that it was important to examine ways of making it easier for people who might be vulnerable to report crime and abuse. They also thought there was scope for examining how healthcare professionals in A&E departments might support adults in reporting crime and how they might make direct reports (in the same way as occurred in cases of suspected child abuse). Making it easier for people who might be vulnerable to report crime and abuse was therefore likely to involve training for professionals backed-up by procedures and clear messages from the top. In addition, advice and support provided by helplines could assist and empower victims to make reports.

An annual analysis/review of all information held on care/nursing homes.

- 7.52 In the Police Service there was support for this concept in principle. It was recognised that a number of care settings were unlikely to be visited annually particularly if they had received a good rating. Such a review would provide checks and balances for the Safeguarding Adults process and the compilation of all relevant information in one database would ensure that important information was not being missed. The lead agencies responsible for its implementation should be those with statutory responsibility for commissioning, inspecting and regulating the service. The Police Service noted that such a system would have resource implications.

Financial abuse

- 7.53 There was widespread belief by all the safeguarding partners, the Police Service, and the voluntary sector, that financial abuse was a growing area of concern with anecdotal evidence suggesting that it might account for approximately one-third of all safeguarding referrals to the police.
- 7.54 Financial institutions currently share information with the Police through suspicious activity reports (SARS) and was felt by many Forces that these principles should be applied to safeguarding. There was a need to conduct further research into this area in order to explore potential solutions and build on existing work in this area.

- 7.55 For example, the Metropolitan Police Service Violent Crime Directorate, who hold the Safeguarding Adults portfolio, was currently developing a training package with their Economic Crime Unit with a view to working with the British Bankers Association (BBA) and the Law Society to raise awareness of fraud targeted against those in vulnerable situations.
- 7.56 Both the British Bankers' Association (BBA) and the Building Societies Association (BSA) responded to the consultation. The BBA explained that the financial abuse of an adult under the *No secrets* guidance was a very complex problem, which was often not easily discovered even by relatives, friends or neighbours, and it was therefore very hard for banks and other institutions to identify such cases. Often there was little or no hard evidence that abuse was taking place so no simple solution or set of best practice existed which the financial services industry could refer to. It was difficult to define who was at risk. Customers would not usually tell their bank that they saw themselves as vulnerable, or they might be under the perception that they were in full control of their finances. Risks could change at short notice with changing circumstances. There were also problems with successfully monitoring accounts as abuse could take many different forms, varying in size and regularity of withdrawal.
- 7.57 The BSA felt that there was a need for a strategic approach to preventing financial abuse covering not just reporting but also identification of high risk persons, intelligence sharing, case reviews, investigation and enforcement. Both organisations agreed that further dialogue was required to identify the way forward.

Strategic links between homicide reduction strategies, crime reduction partnerships, children's safeguarding boards, adult safeguarding boards, domestic violence forums and disability hate crime

- 7.58 The Police Service view was that multi-agency groups should be strategically linked to each other and should have further links into key strategies such as the Homicide Reduction Strategy. Victim Support shared the view and stated that it was important that agencies and strategies worked together and cross referred victims where necessary. It was also important that Local Children Safeguarding Boards and Safeguarding Adult Boards took a joined up approach to ensure a smooth transition from children and young people to adult.

- 7.59 Other non-Government organisations shared this view. For example, the Ann Craft Trust stated that there needed to be a smooth, seamless transition in safeguarding people as they moved from being children to adults and as responsibility for their safeguarding moved between bodies. Concern had been expressed for some time that young people, particularly around the ages of 17 to 19, effectively fell through gaps in processes and practice as there was the possibility for uncertainty over which professionals and bodies had safeguarding responsibility. This was particularly problematic if there was a safeguarding concern which lasted some time and covered the transition from child to adult services. The view of the Trust was that stronger links between Children Safeguarding Boards and Adult Safeguarding Boards, as well as better information sharing, was essential.
- 7.60 Offender management commented that sometimes Safeguarding Boards seemed to have a rather narrow agenda and focused primarily on care homes. Whilst perhaps understandable, it did make it hard for organisations without that focus to think that the work of Safeguarding Boards was directly relevant to them. It was argued that Safeguarding Boards needed to develop an inclusive approach to the interface of safeguarding and the criminal justice system if this agenda was to make a difference, so that Boards were genuinely multi-agency and well linked to other Local Partnerships.
- 7.61 Offender management also commented that there was sometimes prejudice from some partner agencies about previous offenders. They thought there should be a recognition that safeguarding involved working with offenders as much as with victims. They hoped that revised guidance would address this.
- 7.62 Some of the non-Government organisations stressed the need for particular attention to be given to disability hate crime. The Ann Craft Trust, Respond and Voice UK summed this up when they stated that they believed that this review had a great opportunity to set out how health and social care professionals might contribute to efforts to tackle these crimes. Health and social care professionals sometimes had regular contact with potential or actual victims of disability hate crimes in a way in which they would not with victims of other hate crimes and in which other professionals (e.g. the police) would not. They were therefore able to identify victims who have not reported crimes they have experienced. With under-reporting of disability hate crime a widely recognised and large problem, health and social care professionals were in an excellent position to enable victims (a) to make reports they would otherwise not have made and (b) to access

practical and therapeutic support services they would not otherwise have been able to access. The identification of disability hate incidents or crimes was of particular value in allowing early interventions which could prevent escalation into more serious crimes.

- 7.63 Several non-Government organisations suggested that the Government recommended to all local authorities and NHS Trusts that they integrated action on disability hate crime into their safeguarding procedures and training for staff. Also, that they work with local Crime and Disorder Reduction Partnerships to ensure linkages between their actions and measures by other bodies. In addition, they asked that any guidance produced as a result of this review set out how health and social care professionals should support victims of disability hate crime.

Increasing the ability of the police to participate fully in adult protection/safeguarding

- 7.64 The Police Service view was that their ability to participate fully in adult protection would be supported by a comprehensive adult protection Act providing the framework (relating to adults with or without capacity) to compel multi-agency co-operation, supported by multi-agency guidance and underpinned by effective performance management.
- 7.65 The consultation also found that a number of Forces felt that there needed to be a cultural change in the Police Service with the concept of safeguarding being placed at the heart of neighbourhood policing.
- 7.66 Victim Support stated that developing strategic links and partnerships with the police was important to ensure that adults who came under the guidance got the protection and intervention that they needed. In addition to on-going links, it was crucial that suspected criminal offences against vulnerable adults were reported to the police in order for them to undertake an investigation. The organisation believed that new adult protection guidance should include a duty to report suspected abuse.

Improving the identification of vulnerable adults by criminal justice practitioners

- 7.67 The Police Service thought training was a key component in providing officers with the skills and knowledge to improve the identification of adults under the *No secrets* guidance, and this view was shared by Victim Support. Forces were of the opinion that student officers should be provided with

training developed by NPIA. This training should include how to deal with mental vulnerability and signposting to specialist support groups. ACPO was currently working with NPIA and voluntary agencies to develop an appropriate training package to deliver nationally to student officers.

- 7.68 Changes to crime reporting systems would be beneficial to ensure that adults under the *No secrets* guidance were identified at the outset. This would enable existing support functions such as special measures to be given to the victim at the earliest opportunity.
- 7.69 Forces recognised the key role that Neighbourhood Teams played in the identification of adults under the *No secrets* guidance. A pilot project was underway in Southwark Borough around the concept of Safer Neighbourhood Teams introducing processes for referral of adults under the guidance to Social Services. The pilot also sought to structure the teams around the visiting and monitoring of adults and venues. It was necessary to ensure that identified areas of good practice around this area of work were applied consistently across the Service.
- 7.70 Police practitioners had expressed difficulties in obtaining the cooperation of relevant professionals in providing an assessment of an adult's condition for court purposes when requested by the CPS. There was a need for this area to be addressed in order to prevent cases being lost due to delay and abuse of process.
- 7.71 As noted earlier, it was thought important for prisons to identify adults under the guidance on release – in order to enable better planning and better outcomes. Offender management, however, reported that identification was less of an issue for them – it was the next step that was difficult. They wanted more information on what mainstream community services were available to their clients in the local areas. Many reported struggling to make the necessary connections with voluntary organisations, advocacy organisations, housing organisations, educational opportunities, leisure and other activities. These were all part of the prevention/diversion/safeguarding strategy and linkages were very important.

Raising awareness of the local availability of intermediaries

- 7.72 The Police Service supported any new safeguarding guidance including the role of intermediaries within the criminal justice system and the raising of their profile.

- 7.73 The consultation found that good work was already underway in this area. One force has placed posters in all Achieving Best Evidence interview suites and made a video ‘Sally can Dance’ available on the force Intranet – which could be accessed by all staff. Details of the Intermediaries scheme were also included on the force’s ABE interview training course. The application for the intermediary scheme was available for officers to download from the force Intranet. In another force, workshops had been held and information had been cascaded to every member of staff through e-mail and the intranet. Videos and information which enabled practitioners to see real examples of where intermediaries had made a difference assisted wider take up of the scheme.
- 7.74 A further force had commissioned the design of a training course for all frontline staff in relation to the responsibilities the implementation of the Witness Charter in 2009 could place upon all officers in respect of assessing all witnesses for consideration of special measures including intermediaries.

Other things that would make a difference

- 7.75 The view of the Police Service was that the following measures would be beneficial:
- The introduction of specialist case lawyers to deal with the more complex adult abuse investigations.
 - A comprehensive adult protection act would ensure that clear policy and procedure was developed.
 - Partner agencies must work together in a spirit of openness and transparency. Each agency must have clear boundaries as to what was expected of them, what their obligations were and where their involvement ended. The Police Service needed to get to the position where they had absolute clarity around what they as a Police Service expected their partners to contribute. Equally, they needed to fully understand what their partners expected from the Police Service.
 - In addition to student officer awareness training, comprehensive joint agency training was required, nationally accredited and delivered.
 - Joint policy, joint protocols and the pooling of knowledge were seen as the most effective ways of investigating adult abuse.

The need for updated and refreshed *No secrets* guidance

- 7.76 The Police Service view was that updated guidance should be produced and underpinned by legislation compelling agencies to work together and share information. It should be one document and should be joint guidance as it was for safeguarding children. Multi-agency procedures should be signed up to by all agencies and others sharing in safeguarding activities. This should be supplemented by clear operational guidance for the police based on local arrangements and service delivery.
- 7.77 The Law Society agreed that there should be an updated and refreshed *No secrets* guidance which should be one document for all relevant agencies. They also agreed that new legislation was necessary because the current guidance had no mandatory force except in relation to local authorities.
- 7.78 The Law Society agreed that adult protection procedures compared unfavourably with the clarity and structure of child protection procedures. One significant difference was that with child protection issues, carers were left in no doubt of a local authorities power and in some cases, their duty to issue care proceedings if, for example, a family does not improve or agree to accept help. Hence, any new guidance must reflect an understanding by relevant professionals of the expanded role of the Court of Protection. This would make it very clear to families and carers that failure to improve or agree to accept help, could result in removal of the adult without capacity from their care.
- 7.79 Victim Support's shared the view that *No secrets* needed to be revised. It was particularly important that new guidance had a greater emphasis on the role of the criminal justice system in safeguarding, and therefore ensured greater access to justice for adults under the *No secrets* guidance.

The need for legislation

- 7.80 The view of the Police Service was that legislation was necessary to place adult protection on a statutory basis. Presently there was no legal requirement for partners to engage with the safeguarding processes and no duty to share information or report abuse.
- 7.81 There were currently many different areas of legislation covering this area of work, often with conflicting definitions and thresholds for receiving support and state involvement. The Police Service saw a need for these aspects to be reviewed with a view to introducing a single modern piece of legislation to help and support individuals. The Law Society shared this view. They

thought that existing guidance and legislation was too diverse and difficult to follow. They too believed that there should be one consolidating statute to overcome these issues.

- 7.82 The Law Society provisionally supported additional legislation along the lines of the Scottish legislation, which would include additional powers of entry, a duty to co-operate, banning orders and a duty to investigate. They looked forward to analysis of the operation of the Adult Support and Protection (Scotland) Act 2007, that was being carried out by the Law Commission in its review of adult social care and anticipated that it would greatly inform the debate on the introduction of additional legislation.

Placing Safeguarding Adults Boards on a statutory footing

- 7.83 Safeguarding Adult Boards, the Police Service argued, needed to be placed on a statutory footing for the following reasons:

- Safeguarding Adults Boards were finding it difficult to achieve parity with the children’s equivalent – to a great extent due to the difference in funding arrangements. In a number of Forces they currently struggled to attract membership and funding as they were not recognised as statutory bodies that required participation.
- The structure and role of Boards were different across the country. Legislation defining clear roles and responsibilities would remove this inconsistency.
- Boards currently had little influence over their partner agencies other than what could be achieved through goodwill and coercion. There should be a legal duty for the police and other agencies/organisations to take part. A statutory framework was essential to enable Safeguarding Adults Boards to be effective and to encourage effective strategic buy-in and co-operation from all agencies.

The introduction of a wider duty to co-operate in relation to safeguarding

- 7.84 The Police Service supported the need for legislation to put safeguarding adults on a statutory footing which would include a duty to co-operate in serious case reviews and ensuring strategic managers attend Safeguarding Adults Boards and relevant sub groups.

- 7.85 Forces thought there was some ambiguity about the requirements of duty to cooperate (DTC) agencies so the guidance should be clear about what was expected.
- 7.86 The Law Society supported the introduction of a wider duty for agencies to co-operate in principle, particularly given reports of some significant agencies refusing to co-operate.

A new power to enter premises where it is suspected that a vulnerable adult is being abused

- 7.87 Currently, under section 17 PACE, a constable may enter and search any premises for purposes that include arresting a person for an indictable offence and to save life or limb. Concerns had been raised that the high threshold of 'life or limb' was preventing police officers from entering premises where abuse was taking place but was not immediately life threatening.
- 7.88 Within the Police Service opinions were divided about this issue, with a number of Forces suggesting that the current police powers were adequate. It was felt that if such a power were to exist then it should be by means of a warrant authorised by a Magistrate who could determine all the relevant factors. There was strong opposition to social workers being given powers to enter premises by force and remove adults unless accompanied by police officers and only then when it was based on sound risk assessment.
- 7.89 Victim Support wanted this area addressed, whether by limited legislation or other means, in order to protect adults in emergency or crisis situations. They believed that the police should have broader powers in this regard, to enable them to enter premises where there were reasons to believe that an adult under the *No secrets* guidance was being abused. They would, however, have concerns about such powers being extended to social workers and would want to see compelling evidence before such powers were extended further.
- 7.90 The Law Society thought that any new powers to enter homes needed to be very carefully considered, and there should be a thorough review of the use of existing powers before new ones were introduced. Several remedies already existed – if the adult lacked capacity the Court of Protection could authorise removal, and in the cases of some adults the inherent jurisdiction could be used.

- 7.91 The Police Service explained that when an adult had mental capacity and might be self neglecting or self-harming, section 17 of PACE was used where self neglect or harm reaches a serious level. In terms of a new power, they felt there would be a fine line between unwarranted state intervention and intervention for the good of the individual. There was a majority opinion amongst police practitioners that the Magistrates Court had a strong role to play and that entry to the premises in these circumstances should be by means of a warrant issued at the Magistrates Court. Similarly the decision as to whether to grant the Police the power to remove someone with capacity against their will should be a matter for a court to decide.
- 7.92 If there were to be a new power, the Police Service view was that any additional power should only be accessed via a warrant authorised by an Inspector and issued through a Magistrates Court. Both the Police or social services could apply but the power to force entry if necessary should only be exercisable by Police officers.
- 7.93 The Law Society did not support the extension of a power when an adult had mental capacity and might be self-neglecting or self-harming because in some circumstances the power already existed. There was no requirement for lack of capacity in section 135 Mental Health Act (MHA), although there was a requirement that the person concerned had a mental disorder. If such a power was supported, it should, as a minimum, be authorised by a magistrate and evidence of risk of significant harm or likely risk to the person in question shown.
- 7.94 The Law Society expressed its concern that *No secrets* made no reference to powers under section 135 MHA to obtain a warrant to enter homes and remove the person to a place of safety. The MHA provided a number of existing mechanisms for safeguarding. These included powers of entry and removal to a place of safety. The expansion of the definition of mental disorder under the MHA 2007 meant that these powers could be used more widely in a safeguarding context.

Potential new offence of ill-treating or neglecting a vulnerable adult with capacity

- 7.95 It is currently an offence to ill-treat or neglect a vulnerable adult who lacks capacity but not an offence if the adult has capacity. Although most Forces were in favour of such legislation, it was recognised that the existing offence under section 44 of the Mental Capacity Act 2005 concerning

the ill-treatment or neglect of a vulnerable adult who lacks capacity is not without difficulties. Whilst it was recognised that the legislation was a step forward in protecting people who lack capacity there were clear difficulties around the issues of vicarious liability for owners and managers of services. It was felt that a great deal of learning could be applied from the experiences with section 44 MCA and ACPO would welcome further research in this area.

A new power to remove an adult who does not have capacity and who does not consent, but who is thought to be being subjected to harm

- 7.96 This issue divided opinions within the Police Service and their view was that it would benefit from further research to assess the scale of any problem and consider the implications of such powers. There was an opportunity to learn from the experiences of the Scottish Forces where the power existed but at the time of the consultation had yet to be used.
- 7.97 The Law Society considered that apart from those who came within the inherent jurisdiction of the court and only with the authority of the court, there should not be a power to remove an adult who does not have capacity and who does not consent when it is thought they are being subjected to harm. However, the Law Society did have concern that the inherent jurisdiction was too narrow and far too costly and time consuming to be effective. Therefore, it recommended that this particular issue be revisited.
- 7.98 Many voluntary organisations felt that if an adult had capacity they should be free to decide whether they wished to stay in a place where they might be subjected to harm. The function of the protective agencies was to ensure that they were offered support, possibly good social work, and that they were able to make an informed choice. Those who felt that there should be a power to remove someone with capacity against their will, believed that it should be a matter for a court to decide. Courts were best placed to balance human rights, self-determination and the best interests of the person in question and it was felt that any such power should only follow an independent assessment by the judiciary.

Use of force to remove a person who is self-neglecting or self-harming

- 7.99 Police Forces held divided opinions on this issue and the Police Service felt it was an area that would benefit from research. There was a clear moral

and ethical responsibility for the Police and other agencies to consider intervention in the most extreme cases and this could involve removal at a point where self harm or neglect may result in death, serious injury or lasting harm. It was recognised that there were clear human rights issues and implications in respect of unlawful detention of adults with capacity who do not wish to co-operate.

7.100 The Law Society view on the use of force to remove a person who was self-neglecting or self-harming was that most current powers provided guidance as to the use of force which was likely to be reasonable in the individual circumstances. The Court of Protection could, and did, specify limits on force to be used in a given case.

Was current care standards legislation sufficient for closing down poorly performing care homes in a timely and effective manner

7.101 The police consultation found very strong views from those Forces with experience in this area, in particular Gwent with its experience in dealing with a major investigation into a number of suspicious deaths within nursing homes. Experience indicated that what was clearly needed was a set procedure for addressing escalating concerns within a home. This must provide consistent definitions, trigger points and action to be taken. It was seen as essential that the regulator was given sufficient power to ensure that improvements are made. There was also support for a review of The Care Standards Act. The process for closing poorly performing homes was seen by practitioners within the Police Service as being overly bureaucratic and ineffective.

Revision of the definition of a vulnerable adult?

7.102 The Police Service view was that significant harm as the current threshold should be retained to prevent an unmanageable volume of cases, which might result in focus being lost on the most critical cases. They felt that police intervention should primarily occur where the harm or wrong was likely to amount to a criminal offence to prevent the Service from being overwhelmed. As with the child protection process, the police could still contribute to the information sharing, risk assessment and care plan aspects of the safeguarding process. The guidance would need to be fairly explicit about thresholds and when intervention was required and by which agency. However care must be taken not to set too high a threshold that may expose an adult to further harm.

7.103 The Law Society were concerned that the existing definition of a 'vulnerable adult' was sometimes misinterpreted by local authorities as only applying to people who received social care services and that there was no requirement for agencies other than local authorities to comply with it or to co-operate with local authorities. They did not agree with the term 'vulnerable adult' since this suggested that the person was themselves vulnerable rather than emphasising the way in which the situation they were faced with made them vulnerable. The Law Society believed that the definition provided in the Safeguarding Vulnerable Groups Act should be used.

7.104 Victim Support commented that the language which was used, and connotations the language carries, sent an important message about the seriousness of offences against adults. They felt that using words such as 'abuse' to describe acts which are clearly criminal was not helpful. The use of 'perpetrator' was accepted language which was used in the context of other crimes including domestic violence. They therefore saw no reason why it should not be used in the context of those who committed crimes against adults under the *No secrets* guidance. Whether or not the perpetrator was a family member did not have any bearing on whether or not their acts were criminal.

BOX 13: Summary of the main messages from the Police Service

- National leadership should lie with Adult Social Care/Health with a nominated responsible Minister. Leadership at a local level should lie with Adult Social care.
- A National Guidance document is required that is supported by a legislative and inspection framework. The guidance should assist professionals in deciding disclosure issues and should provide for a standardised assessment tool for the identification and categorisation of risk.
- Legislation is necessary to place adult protection on a statutory basis. All organisations having responsibilities within this arena would be obliged to co-operate, share information, report suspected abuse and work together to reduce harm and safeguard those at risk.
- Information sharing seen as the key component to preventative measures. Requires a statutory duty to be imposed on all relevant agencies in order for it to become truly effective.
- There should be a national database of recommendations from serious case reviews to ensure that the lessons learnt are shared within the Service.

- The present law on safeguarding issues is very fragmented and a comprehensive adult protection act would ensure that clear policy and procedure is developed.
- Police intervention should primarily occur where the harm or wrong is likely to amount to a criminal offence. Significant harm as the current threshold should be retained to prevent an unmanageable volume of cases.
- Support for a nationally accredited multi-agency training course for workers specialising in this area.
- Support for a review of the Care Standards Act. The current process for closing poorly performing homes is seen as being overly bureaucratic and ineffective.

The main message from the National Offender Management Service

- Probation Areas/Trusts are generally marginalised in local safeguarding arrangements, which are not always good at recognising the importance of working with offenders; this needs to change as offender management staff are often closely engaged with adults under the guidance.

8. Guidance, Legislation, Definitions and BME concerns

- 8.1 At many of the consultation events there was widespread and vociferous support for new legislation. The written responses showed similar support, although not as strongly. Chart Q9b shows that 252 out of 500 written responses replied to the legislation question. Of these, 171 or 68% supported the need for new legislation. Twenty-one per cent did not support new safeguarding legislation, while 11% either made other suggestions or expressed a 'maybe' response. The highest support was from the safeguarding partnerships. The lowest support was from service user groups, where more groups thought that we did not need safeguarding legislation than thought that we did.
- 8.2 We asked whether Safeguarding Boards should be placed on a statutory footing (Chart Q9c). There were 153 responses saying yes and 7 saying no/not sure. This means 92% of respondents who replied to this question wanted statutory safeguarding boards.
- 8.3 Chart Q9d shows the replies to the question on whether there should be a wider duty to cooperate in relation to safeguarding. One hundred and eighty respondents supported the introduction of this duty of cooperation. This is 86% of those who responded. There was near unanimous support from the three main partners: social care, police and the NHS.
- 8.4 We asked about the power to enter premises (Chart Q9e). One hundred and twenty-seven respondents were in favour of this power – which is 60% of the respondents who replied. In relation to this power applying when an adult had mental capacity, a much smaller number of respondents (38) replied yes, 22% of those who replied.
- 8.5 The consultation then asked whether we should introduce a new offence of ill-treating or neglecting a vulnerable adult with capacity. Seventy-two respondents thought we should. This was 50% of those who responded.
- 8.6 'Should there be a power to remove an adult who does have capacity and who does not consent who is thought subject to harm?' received very little support: 19 respondents replied yes, which is 13% of those who replied (Chart Q9i). And should force be used to remove such a person? Twenty-

one respondents said yes, which again is 12% of those who replied to the question.

- 8.7 In summary, of those who answered the questions on legislation, there was much support for some legislation. The highest support was for a) the introduction of legislation, b) for putting Safeguarding Boards on a statutory footing and c) for introducing a duty to cooperate in relation to safeguarding.

The reasons given for wanting new legislation included the following:

a) Arrangements for the safeguarding of children are based on legislation.

- 8.8 Current principles underpinning the safeguarding of children were first established in the Children Act, 1989 – a legislative framework for safeguarding and promoting the welfare of children.
- 8.9 This Act was supplemented by the Children Act 2004, which followed the Victoria Climbié Inquiry report. The Act introduced a statutory duty on local authorities, the NHS, the police and other partner agencies to co-operate on safeguarding children; it also established statutory Local Safeguarding Children Boards.

b) Legislation would make safeguarding a higher priority, both in terms of commitment and resources.

- 8.10 A theme throughout the consultation was that for safeguarding to work effectively a multi-agency approach was required. In particular it required the NHS, social care and the police to work together effectively.
- 8.11 Respondents argued that these three key partners would prioritise this work more highly if there were a statutory duty to do so, as they did with children's safeguarding, but would give it a lower priority if there were no such duty. Many examples were given of low prioritisation and ineffective co-operation: staff were not attending safeguarding meetings or were fielding junior staff who could not make decisions, not sharing information, working in silos, shifting responsibility to other agencies, or were not contributing towards the cost of the safeguarding system.
- 8.12 Respondents argued that: “Boards should be on a statutory footing to increase the likelihood of adequate funding, to reduce variation in

performance; to deliver a consistent nationally based set of procedures; to ensure accountability."

Box 14: Examples of respondent comments supporting the case for legislating to place adult safeguarding on a statutory footing:

Legislation raises its profile

Duty to co-operate is very important

Boards should be statutory

Adults are no less important than children

We have a duty to protect

It will channel money into it

To make it more consistent

It will draw in more partner organisations

It will save lives

I would like a duty to communicate!

c. Scotland.

8.13 In 2007, Scotland introduced the Adult Support and Protection Act. This came into effect in October 2008. This Act introduced a number of new measures and new powers. It made Scottish Adult Protection Committees statutory, with a statutory duty to provide information, a biennial report to be produced; and a statutory duty to follow any national guidance about how they should be run. The Act attempts to balance assessment and assistance for people, with: the introduction of local authorities' duties to make enquiries if an adult is at risk (defined broadly as risk in 3 areas: well-being, property and financial affairs); the duty to consider providing advocacy and other services to people at risk, and the right for council officers to enter a place in order to visit a person. Stakeholders argued that similar measures should be introduced in England.

d. The government's choice agenda in both the NHS and in social care needs to be balanced with the government's safeguarding agenda.

8.14 The argument is that the government has done and is doing a lot to increase choice for people, including people who might be considered to be vulnerable due to their age, their frailty, their health condition, their disability or the situation they live or are cared for in. The government agenda has removed barriers, opened up opportunities, encouraged responsibility for making health choices and lifestyle choices, social care choices and financial choices. This has taken place at a time when an increasing number of

very elderly people are living not just alone, but in isolation, without the protection of employment, friends, and social care workers.

- 8.15 The same applies to people with learning disabilities many of whom also increasingly live without the support of families and friends. The argument is that increased choice means increased opportunity for harm, particularly financial abuse but also other kinds of harm, such as ‘grooming’ of people by individuals who set out to harm vulnerable people.

Reasons for not thinking that legislation would solve these problems

- 8.16 Those who did not think that legislation would solve the problems made the following arguments:

a) Adult safeguarding has achieved much of what children’s safeguarding has achieved – without having legislation.

- 8.17 Some of the stakeholders at the consultation events and in the written responses were proud of what adult safeguarding had achieved. They thought this was an immense and unacknowledged success story. They argued that *“adult protection here is probably the best in the world – and we have done this without any specific legislative underpinning or any targeted money.”*
- 8.18 No one argued that it was perfect or that it did not need reviewing and strengthening. They simply said they had built a system by taking relevant parts from other areas such as children’s safeguarding, added it to the work practices of working with adults, with consent issues, with the Mental Capacity Act, and had come out with a system which – more or less – worked. In many geographical areas there were reports that *“It works quite well here.”*
- 8.19 Some respondents were more questioning about going down the children’s route. Some argued that this route had not necessarily achieved protection for children; had set up large bureaucratic process-driven systems; relied on a specialist workforce approach whereas with adults safeguarding needed to be more mainstreamed; that it was a system designed to work with a client group who could not consent (young children) whereas work with adults had to be based on something very different – consent, partnership, dignity, choice, control. None of these ‘adult focused values’ were key to safeguarding young children. Others commented that the solutions needed to be different too – adoption and fostering did not apply in the same way

to older people and adults with learning disabilities, who were, as often as not, legally self-determining tenants or owner occupiers. These stakeholders questioned whether legislation which mirrored children's legislation would be useful or necessary. Some said it would turn the clock back.

b) Legislation would not necessarily lead to adult safeguarding becoming a priority.

8.20 Some stakeholders argued that because adult safeguarding structures were already in place and were funded, legislation confirming that these were required in law would not necessarily give this area more priority (see Box 15). The view was that if we were starting from a blank sheet, then legislation would lead to new structures and new posts and a greater financial and policy priority. However if legislation was mainly underpinning existing structures then it would not. Some thought that it was 'personal champions' who made a difference while others thought it was 'performance targets'.

8.21 Many stakeholders thought GPs' participation in safeguarding children work was as problematic as their participation in safeguarding adults work.

Box 15: Views against the need for legislation

Respondents reported:

The need for new legislation has not been established

Existing legislation should be adhered to

If all agencies worked together.. better, there would be no need for new legislation

The main issue to raise the profile of this very important issue, not to introduce legislation to make us do what we are already doing

Since many of the issues are already a crime, we don't need more legislation to tell people how to deal with them

Danger that legislation encourages a risk averse approach rather than a culture of appropriate risk taking

Legislation may also encourage LAs and others to take a narrow approach to ensuring they meet legislative requirements rather than empowering citizens

Can you legislate for empowerment?

You can't make organisations work together if they don't want to..you need incentives rather than laws... make it easy for them and reward good practice...

If you define who the duty to cooperate applies to it will detract from the principle that it is everybody's business

c) Scotland

8.22 The view of some of the stakeholders was that the legislation in Scotland was interesting and we needed time to evaluate how it was working. Since it had come into effect in October 2008, the new orders had hardly been used in the period in which the consultation was taking place.

8.23 Many stakeholders were also very worried about the new orders introduced in the Scottish legislation. It was argued that removing people who have capacity to make a decision about their own safety, against their wishes, would not be an improvement in policy or practice. Even assessing people’s situation and safety without their consent was regarded, by some, as dangerous.

d) Balancing the choice agenda with the safeguarding agenda

8.24 All stakeholders wanted a balance between the choice and the safeguarding agendas. Those who did not think that legislative solutions were necessary argued that the most effective safeguarding is when safeguarding becomes part of mainstream activity – part of effective commissioning, part of mainstream assessments of care and support needs, mainstream assessments of care services, part of routine housing work.

8.25 There were some respondents who did not wish to give a view on whether there should be legislation. Many of those reported that what they wanted was a framework based on clear values and direction. Whether or not the framework was underpinned by more legislation was not their main concern. The first question was what values and what framework do we want and need for a new safeguarding. Many thought that we had not yet decided on what the direction of safeguarding should be. If we developed a new safeguarding *“around citizenship and strengthened community engagement in keeping people safe then our chances of helping people stay safe will be much greater”*. However *“if we go down the path of promoting dependency on unsafe and institutional services we will perpetuate the current unsafe practices which are prevalent.”*

8.26 One voluntary organisation conceptualised risks of abuse as threats to safety and also as threats to citizenship, and developed a model with seven threats to citizenship. These included threats to self determination, threats to control over own money; threats to control over who comes in or lives in one’s home; threats to lack of control over support, and the threat of not being part of the community. It argued that safeguarding be developed to address these risk factors.

8.27 Another organisation asked for: *“A new No secrets, which included the world as it is now, with more people in control over their own lives, but also more people isolated in the community, with the MCA and the MHA, with agreed definitions and values and principles, with clear outcomes and standards and clarity.”*

Box 16: Concerns about new powers

Powers of entry: would significantly extend the government power over people's lives and is not a decision to take lightly...The power to enter could quickly become the expectation to enter – whether the expectation by the media, the public, or line management..... entry and intervention carry significant risks....

There are already powers of entry.. ...difficult to see how a wider power could be used effectively and there is danger of it being abused.....power minus resources with which to help support the person afterwards, risks being abusive... the relationship between abuser and abused is complex; other remedies should be sought...

Powers to remove:... we urge you bear in mind the controversy over force-feeding prisoners... we see the power of removal unacceptable in virtually any scenarios....this is deprivation of liberty of people who do have capacity..... the trauma of the removal could be worse than the abuse... the National Assistance Act already permits this.. why not barr the perpetrator?

Definitions and Language

8.28 Almost everyone agreed that the definition of ‘vulnerable’ in *No secrets* was no longer useful. Chart Q10a shows that 90% – or 149 respondents – agree that the definition should be revised. Most agreed that there was a need for a new definition, although a sizeable minority argued that they were not convinced that any definition would work – all definitions left people at risk. Many preferred the term ‘adult at risk’ because it focused attention on the risk rather than the vulnerability; there were those who put forward the Scottish definition of ‘risk’, those who preferred the Independent Safeguarding Authority one and those who wanted to develop a brand new definition.

8.29 Some organisations wanted the definition to include ‘people at risk of harming others’ (as well as at risk of being harmed) and a much clearer understanding that most/all perpetrators/offenders were themselves people at risk and people in need of assistance. Some wanted a focus on ‘the relationship’ between abused and abuser.

- 8.30 Many housing organisations pointed out that the definition of vulnerability in housing law was unhelpful in a safeguarding context: where someone is not homeless they may not be considered vulnerable in housing law, and therefore are not recognised as needing help or alternative housing on the grounds of the abuse being experienced. Police officers wanted a threshold retained, to prevent an unmanageable volume of cases which may result in focus being lost on the most critical cases.
- 8.31 The issue of language also elicited a full range of responses. These included those who thought the current language of ‘abuse’ and ‘perpetrator’ was useful and those who thought it should be changed. Those who wanted it changed included those who wanted much of it recognised as crime and called crime; while others thought ‘abuse’ should be used only when there was purpose and intent. There were many respondents who said they were uncomfortable with the words ‘abuse’ and ‘perpetrators’ being applied where family members were not coping with intensive caring roles – such as the elderly spouses of people with dementia. Some said it was ‘convenient’ calling this abuse when it was an inadequacy of formal support.
- 8.32 There were equally mixed responses about whether or not to distinguish the harm carried out by a person in a position of trust or power – although many commented that as a society we must hold people in paid work – and their employing organisations – much more clearly accountable. There was widespread support for operationalising the principles of the Mental Capacity Act and the Human Rights legislation in a new safeguarding framework.

Black and Minority Ethnic Issues

- 8.33 In this consultation we sought the views of people and organisations from Black and Minority Ethnic Communities (BME) both in the general consultation events and in targeted consultation with community groups. We advertised for community groups to carry out consultation events and funded eleven organisations. Many of the views expressed are incorporated under the general headings. But we wish to highlight some specific ones here.
- 8.34 People from BME communities expressed the full range of responses, from good awareness of safeguarding to little awareness. People from the older generations had less understanding of what abuse meant; what help and assistance they might get; and how to get help. Many did not understand the term ‘abuse’ and did not understand at all any role that social services might have. Many were more comfortable with reporting harm to the police than to social services.

- 8.35 Many people from BME communities thought the family played an important protective role and they would seek assistance there first. This has implications for any preventive or awareness-raising strategy. They had significant concerns about 'being treated differently' from white people, a mistrust of agencies and also significant concerns about 'professionals taking over'. BME older people spoke about the need for respect being shown to them from professionals.
- 8.36 There were also calls for investment in 'communities coming together'. Some abuse was seen as racially motivated and had a significant local community element – it needed to be addressed locally 'on the estate' and at 'our shops'.
- 8.37 Some BME older people raised issues of confidentiality and of family honour. These made reporting 'outside of the community' much more difficult. There was also a strong message that reporting might be perceived as 'your family was a failure' and 'your community was a failure' and that any public intervention would intensify this. There was little expectation amongst the older generation that intervention would assist them in solving the problem with their family honour intact. There were clear age related differences in what people said they would do. Older people from BME communities said 'they might stay quiet and put up with problems', whereas no younger adults reported this. Older people reported greater reliance on community organisations and faith organisations, younger ones less so.

9. Next Steps

- Twelve thousand people took part in the consultation about the safeguarding of adults who come under the *No secrets* guidance in England. Events took place across the country and some 3,000 members of the public and a wide range of professionals took part, including lawyers, police officers, doctors, nurses, social workers, care workers, housing staff and provider organisations. Nearly 500 written responses were also received.
- This report has set out the main issues raised. The Government is now looking at all the evidence and working to develop a response taking into account what we have learned from the consultation.
- The Government considers all forms of abuse to be unacceptable but the abuse of those who are in situations that make them vulnerable, and do not have the capacity to safeguard themselves from harm, to be particularly abhorrent.
- This Government has a vision of an inclusive society with opportunities and justice for all. It has a vision of a future for the safeguarding of those at risk of harm which is empowering and person centred, preventative and wide-ranging. This vision extends to the whole criminal justice system, whether the adult at risk is a victim or has committed a crime themselves. Most importantly, the delivery of this vision will require strong multi-agency and inclusive partnership working.
- We must develop strategies for people who have capacity to make decisions and those who do not, to ensure we balance the individuals right of self-determination with the responsibility of Government and society to safeguard its most vulnerable people. We will need different partnerships when addressing specific issues, such as working with the banking industry when looking at financial safeguarding or working with providers when we are commissioning safe and sensitive services in our hospitals and care homes.
- The Government is considering how best to achieve these far reaching aims and is developing a cross-Government response.

Appendix A: Quantitative Analysis of Responses

Introduction

The following report shows a sample of the results of a selection of quantifiable questions (shown at the end of the report) from the consultation on the review of the *No secrets* guidance. This report focuses on 33 questions from the consultation and the results are shown in bar chart format with both numbers and percentages in the accompanying commentary.

Methodology

There are 64 main questions in the consultation and each question raised a further one or two supplementary questions bringing the total to over 100 questions. Each chapter of this document drew on a combination of quantitative and qualitative answers in response to the questions and issues raised. For the purposes of this report the following considerations were given to the analysis of the data:

- Responses were only counted when the respondents expressed a view on the specific question
- In many instances, some of the questions were answered but not all appeared to be answered consistently
- Where there were significant reservations but without a clear statement, or where the response was hedged with conditions, or where the response noted different contributors to the response having different views, this was counted as other or a 'maybe'
- Where the response was a clear yes/no, this was counted as such
- A large number of responses did not attempt to answer some or many of the questions
- Some responses gave examples or views that could not be given a definitive categorisation so have been excluded from the quantitative analysis; although they have been considered within the consultation
- These data issues combined indicate that each question may have been answered by different groups of respondents so may not be fully comparable between questions or representative of all respondents.

There were nearly 500 consultation responses in total and the responses were divided into 7 of the 9 main categories of respondents as listed in Appendix B. (Two categories have not been quantified as they largely contributed to the variety of multi-agency responses and events.) In many cases although a response was counted as one (1) they often represented the views of many participants or several other partner organisations; or in some instances one individual or a few people. This is an important point to consider when looking at the numbers and percentages.

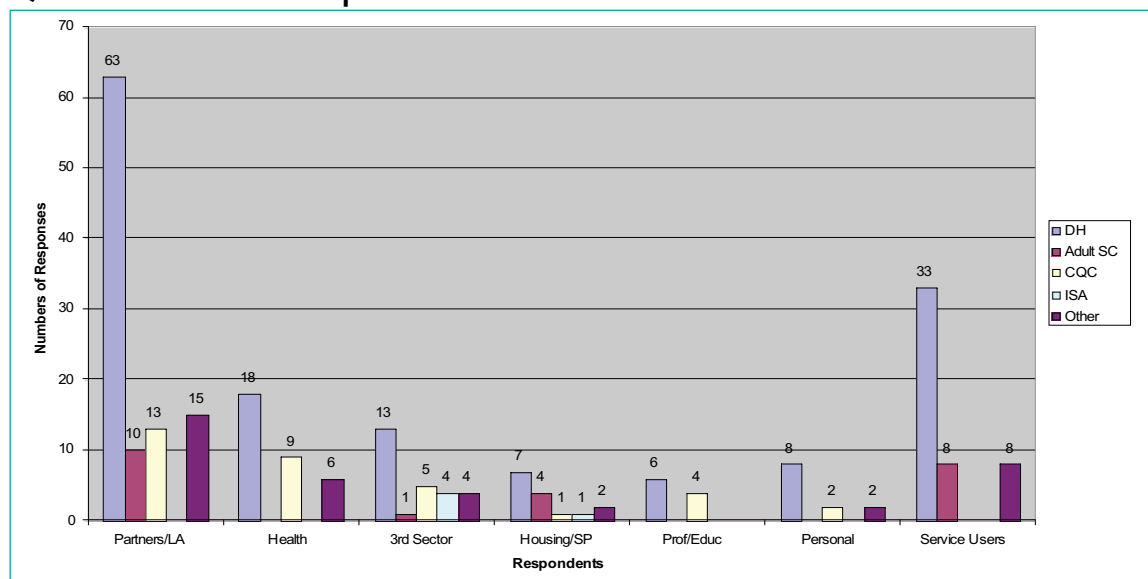
The percentages given within this report have been calculated by using the total number of definitive responses given for each of the questions answered as opposed to the numbers of respondents or the numbers of participants. The results are shown below in a separate bar chart for each of the questions measured for this report and are presented in number and percentage format.

The bar charts are numbered to relate to the original consultation questions for the review and therefore show which questions were quantified in this report. A definitive list of the questions in this report is shown at the end of this section.

Leadership

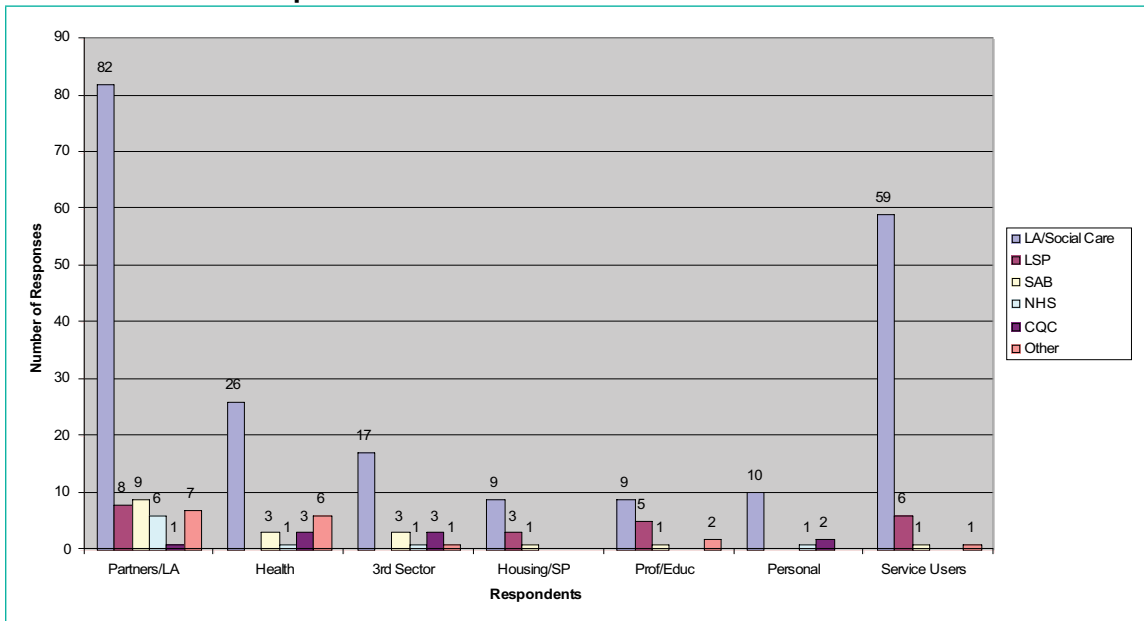
Q1a: ‘Where should leadership for safeguarding adults lie nationally?’ The bar chart below shows that 60% or 148 respondents stated that the Department of Health should take responsibility for national leadership for safeguarding. Adult social care was nominated in 9% or 23 of the responses, with 14% or 34 responses nominating the Care Quality Commission (CQC), 2% or 5 responses the new Independent Safeguarding Authority (ISA), while 15% or 37 responses made other suggestions, such as one overall independent advisory body or a ministerial lead.

Q1a National Leadership



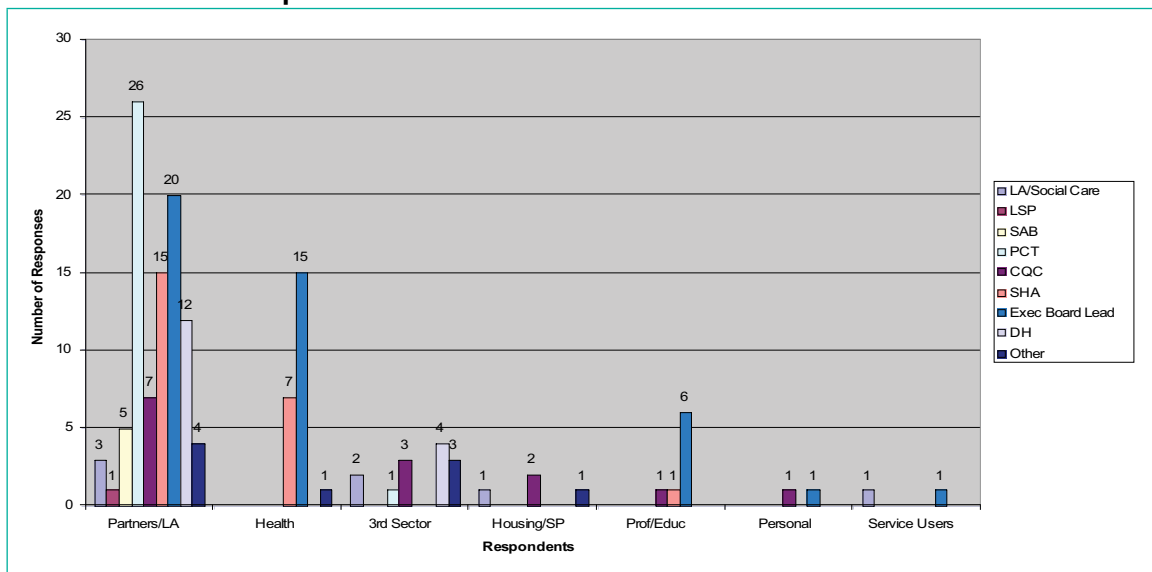
Q1b: 'Where should it lie locally?': Adult Social Care was the preferred local leader, being chosen by 74% or 212 of the respondents, Local Strategic Partnerships (LSPs) received 8% or 22 nominations, and Safeguarding Adults Boards (SAB) were given 6% or 18 nominations. Most of the respondents acknowledged that local authorities had made good progress and partnership working was vital at the local level.

Q1b Local Leadership



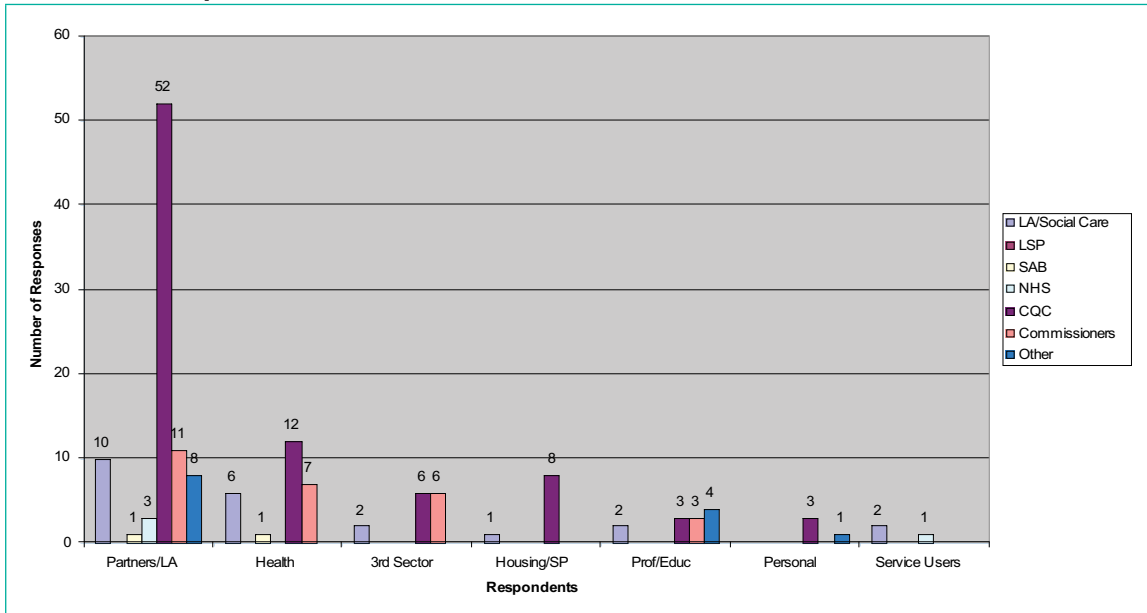
Q1e: ‘Where should leadership for NHS safeguarding issues lie?’ 29% or 43 of the respondents expressed preferences for safeguarding to have an ‘executive board’ focus within the NHS, with a ‘designated’ director with board responsibility. The strongest responses for this came from SABs, health and professional and regulatory bodies. A further 19% or 27 responses supported leadership from the PCT as the commissioner of services with overall responsibility for the performance of its providers. 16% or 23 responses felt that the SHA should have some leadership responsibility and 11% or 16 respondents wanted involvement from the DH.

Q1e NHS Leadership



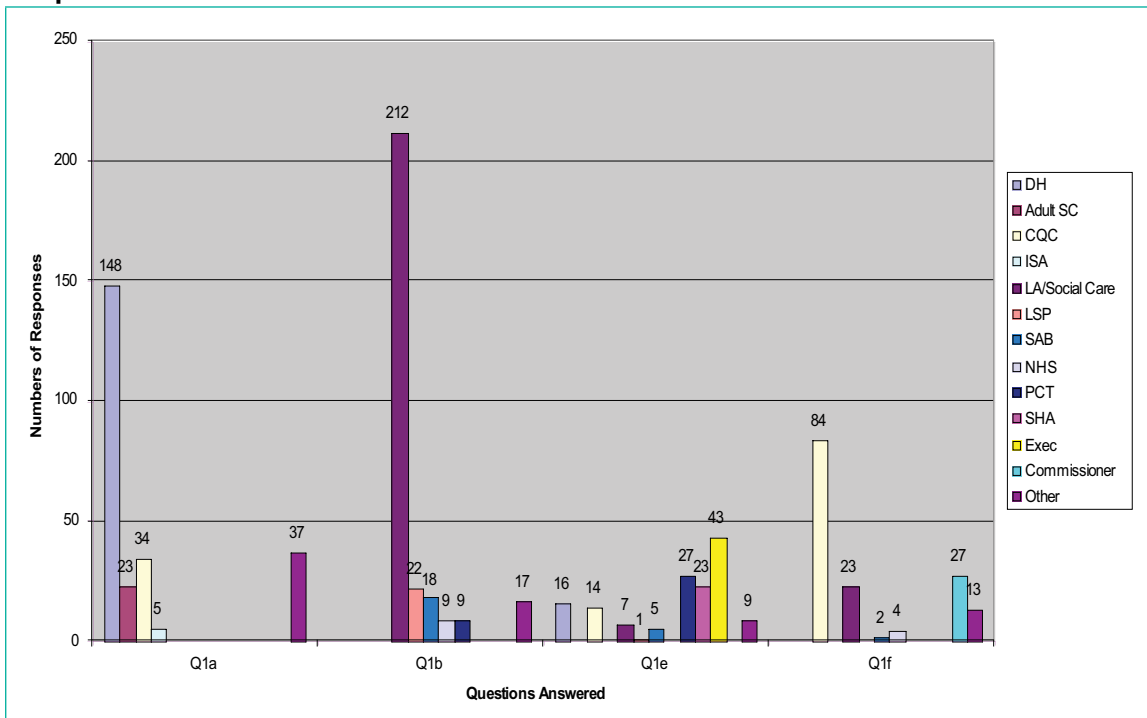
Q1f: 'Where should leadership for safeguarding in the care home sector lie?' The chart below shows that 55% or 84 respondents thought that the CQC should have leadership responsibility. 18% or 27 of the responses show that commissioners should lead, 15% or 23 responses suggested adult social care and 8% or 13 responses nominated others, which included care home providers themselves.

Q1f Leadership for Care Home Sector



The chart below shows the total of responses to question 1 in bar chart format.

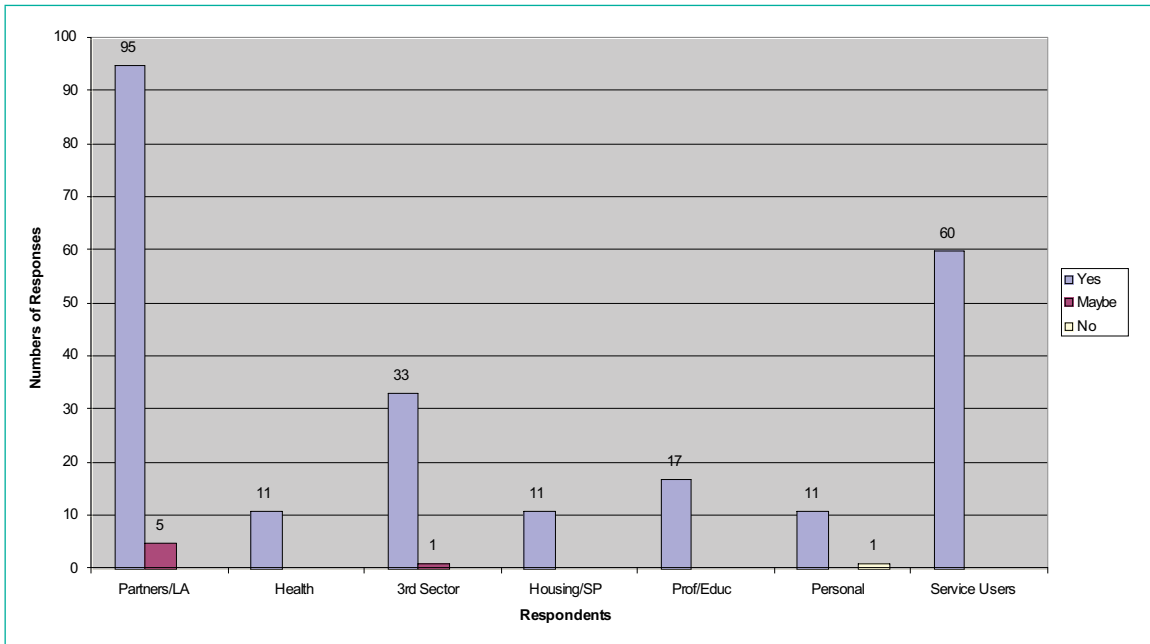
Responses to Q1



Prevention

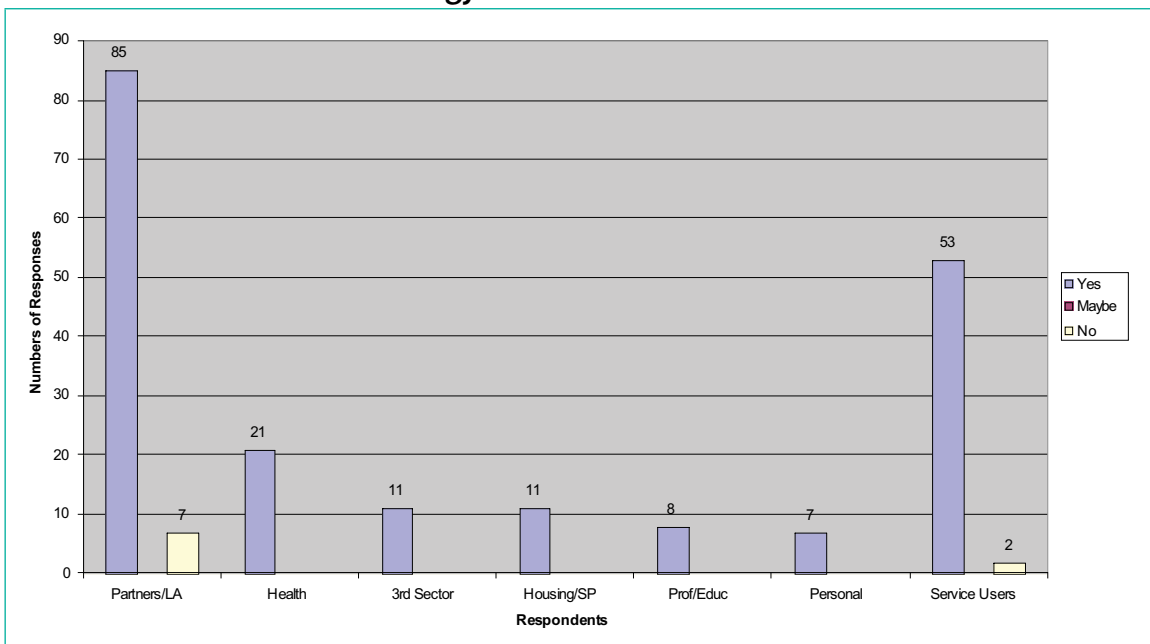
Q2a: ‘Should we be doing more work on prevention?’ The chart below shows that 97% or 238 respondents agree that more work is needed on prevention.

Q2a Preventative Work?



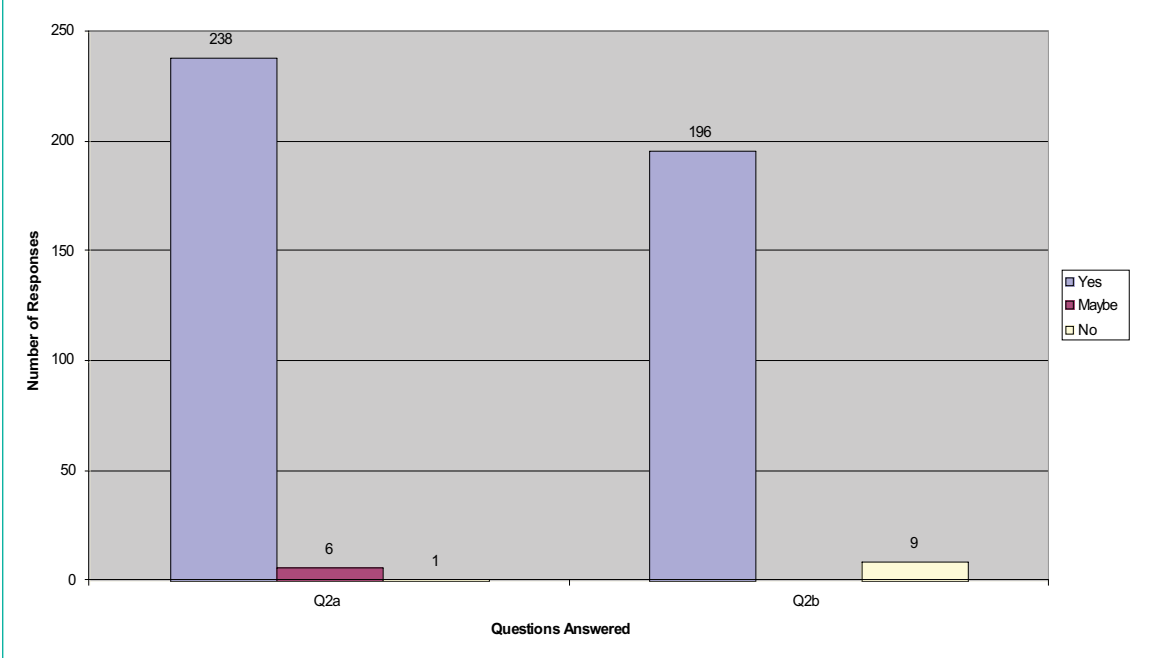
Q2b: ‘Should we develop a national prevention strategy for adult safeguarding?’ The chart below shows that 96% or 196 respondents agreed that there should be a national prevention strategy.

Q2b National Prevention Strategy?



The chart below shows the total of responses for question 2.

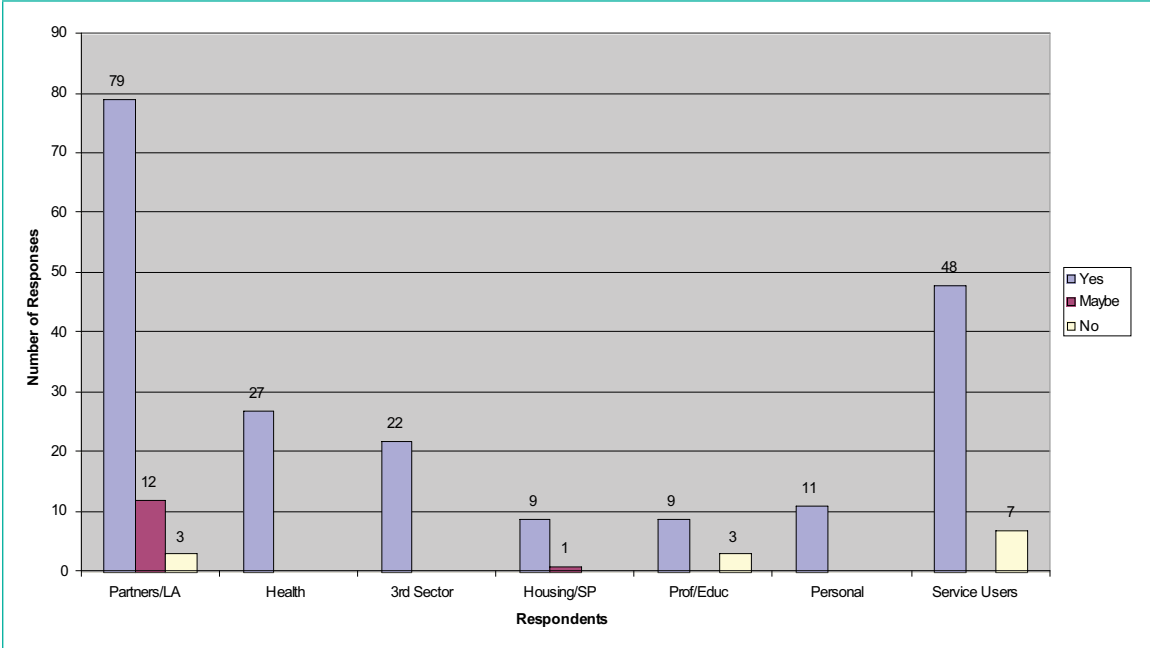
Totals for Q2



Outcomes

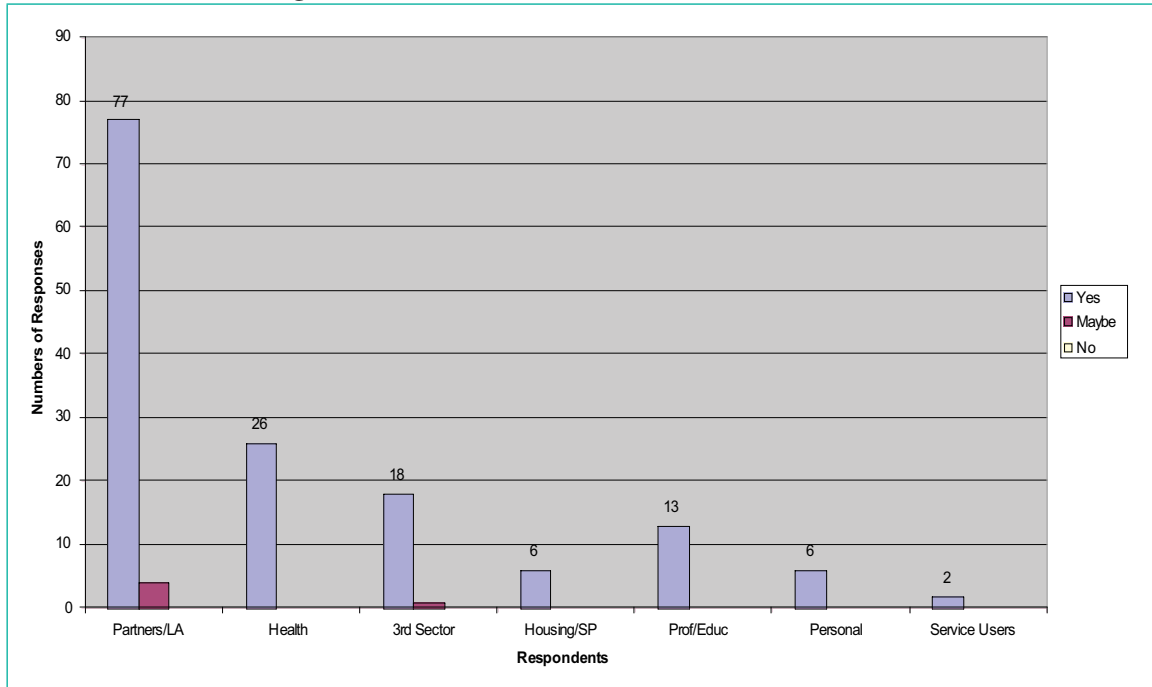
Q3a: 'Would an outcomes framework for adult safeguarding be useful?' The chart below shows that 88% or 205 respondents agreed that an outcomes framework would be useful.

Q3a Outcomes Framework?



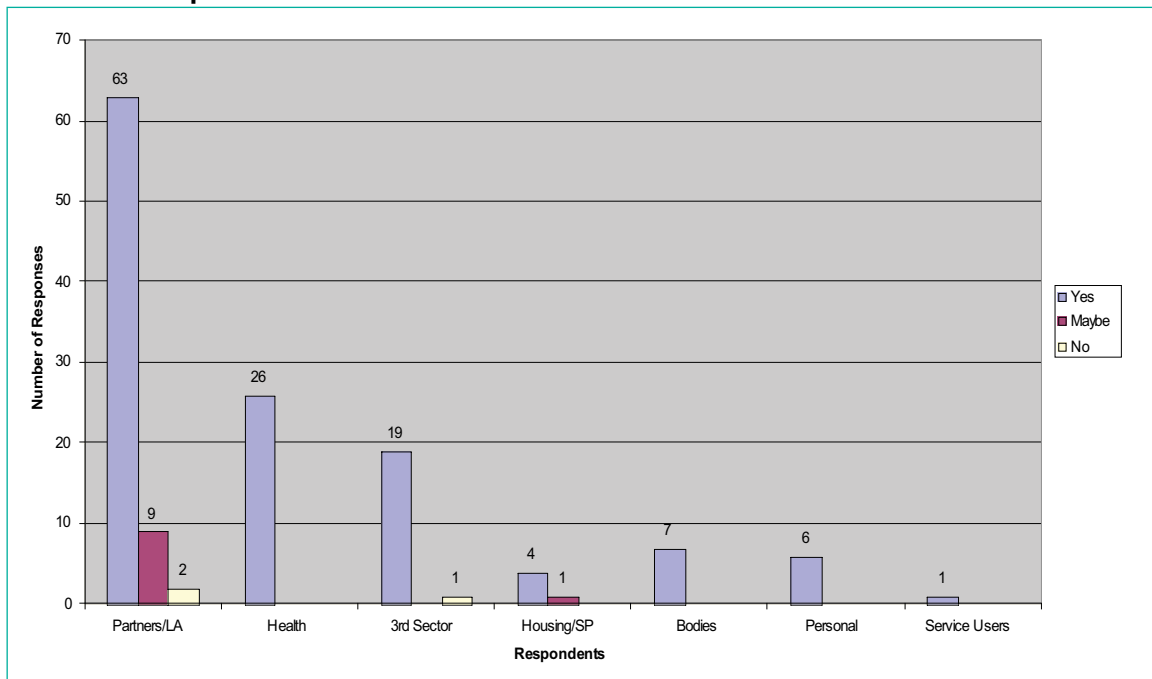
Q3d: ‘Should we review current arrangements for delivery of safeguarding adults training?’ 97% or 148 respondents agreed that training should be reviewed with a view to developing a national occupational standard across all agencies.

Q3d Current Training



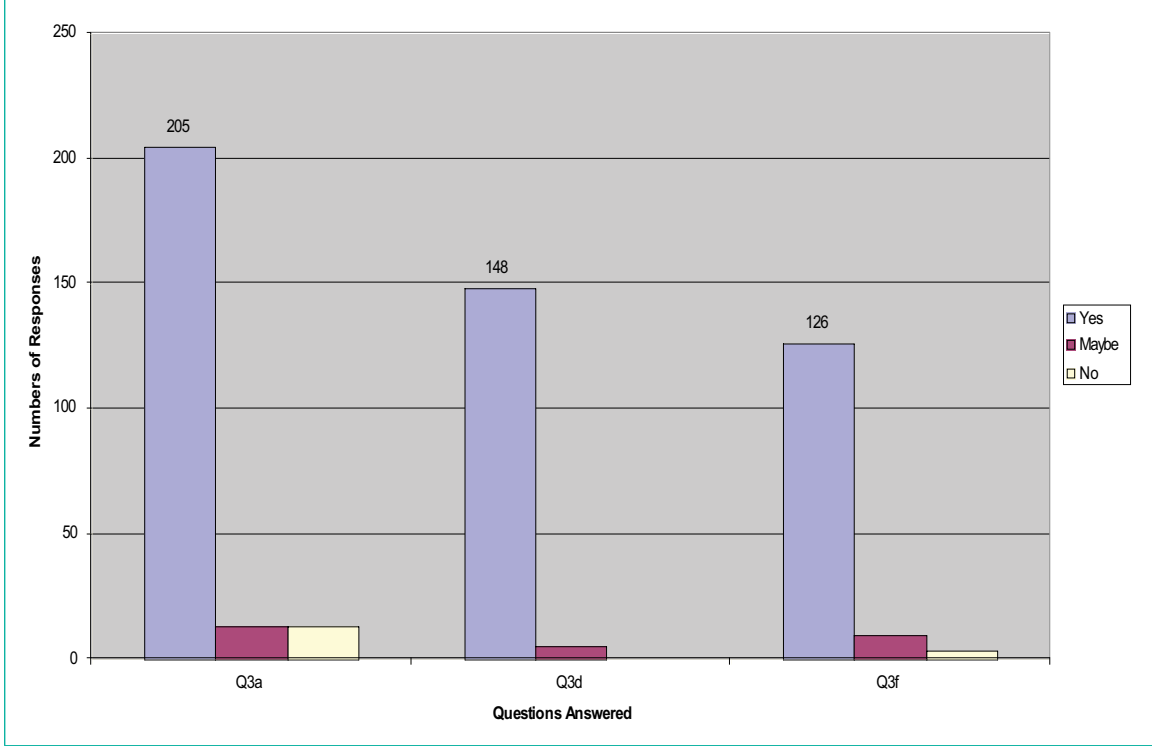
Q3f: ‘Should we develop joint inspections to look at safeguarding systems as a whole?’ The chart below shows that 91% or 126 respondents agree that joint inspections should be developed.

Q3f Joint Inspectons?



The chart below shows the totals for question 3.

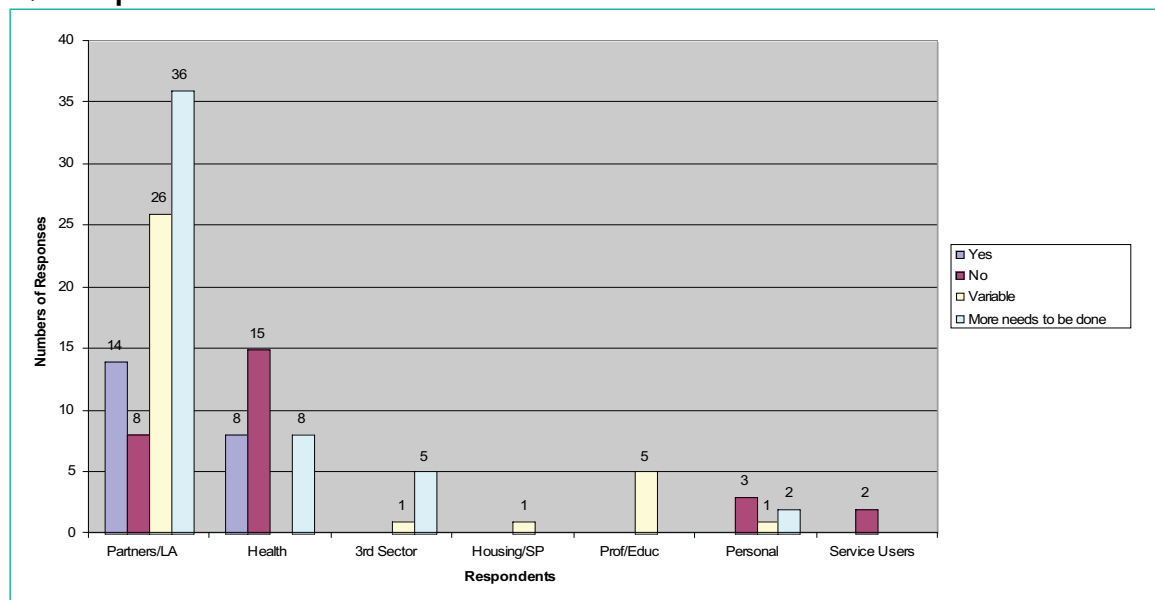
Totals for Q3



Health Services

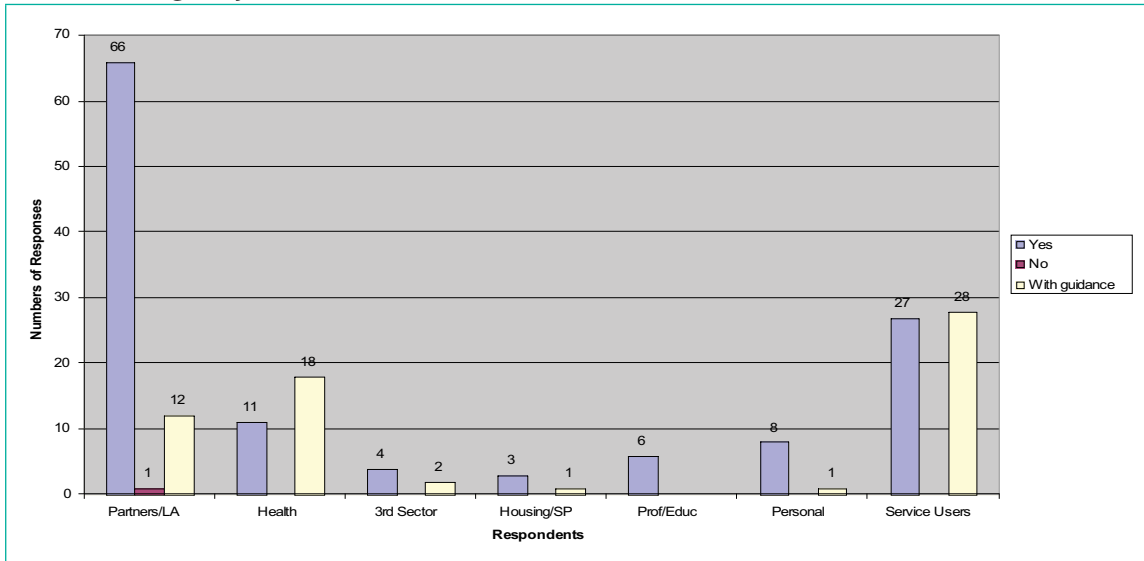
Q6a: ‘How is *No secrets* being implemented and applied to ensure that it enables staff in the NHS to recognise, investigate and act on abuse?’: The chart below shows that 38% or 51 respondents thought that more needs to be done to implement *No secrets* within the NHS. 25% or 34 responses considered that implementation has been inconsistent and variable, while 21% or 28 state categorically that *No secrets* has not been fully implemented. 16% or 22 responses felt that it has successfully been implemented. The strongest respondents advocating that more needs to be done were local authorities and safeguarding partners and health.

Q6a Implementation in the NHS?



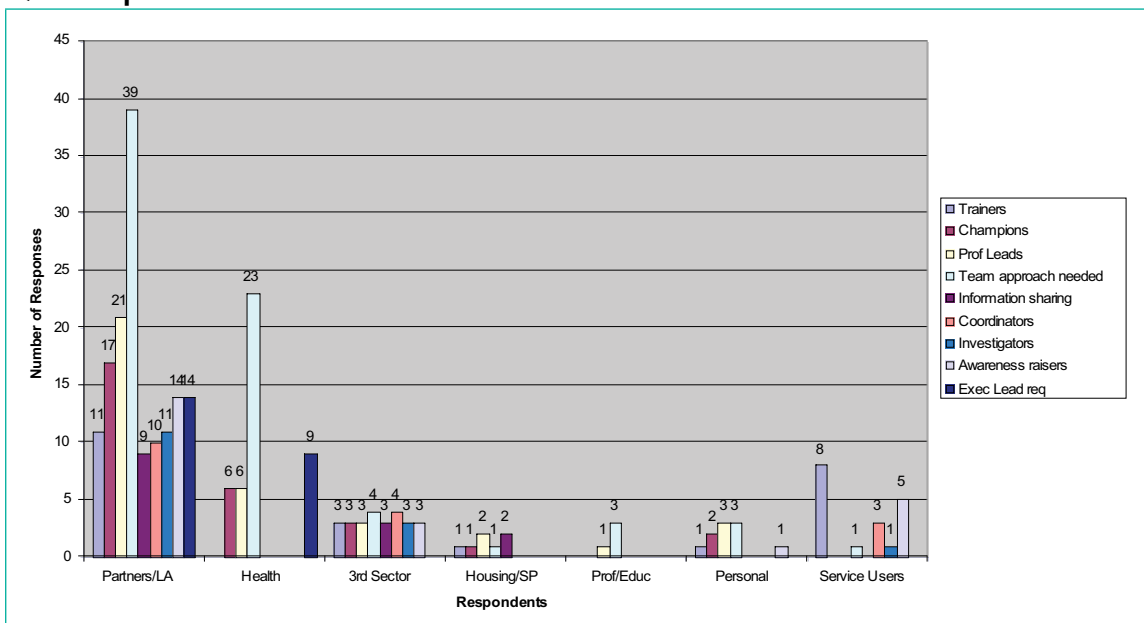
Q6b: 'Are health organisations able to work with and adopt multiagency guidance?' 67% or 125 respondents agreed that the NHS should be able to work within a multiagency guidance document but 33% or 62 responses felt that there would still need to be some sort of health specific guidance to sit within a multiagency document.

Q6b Multiagency Guidance?



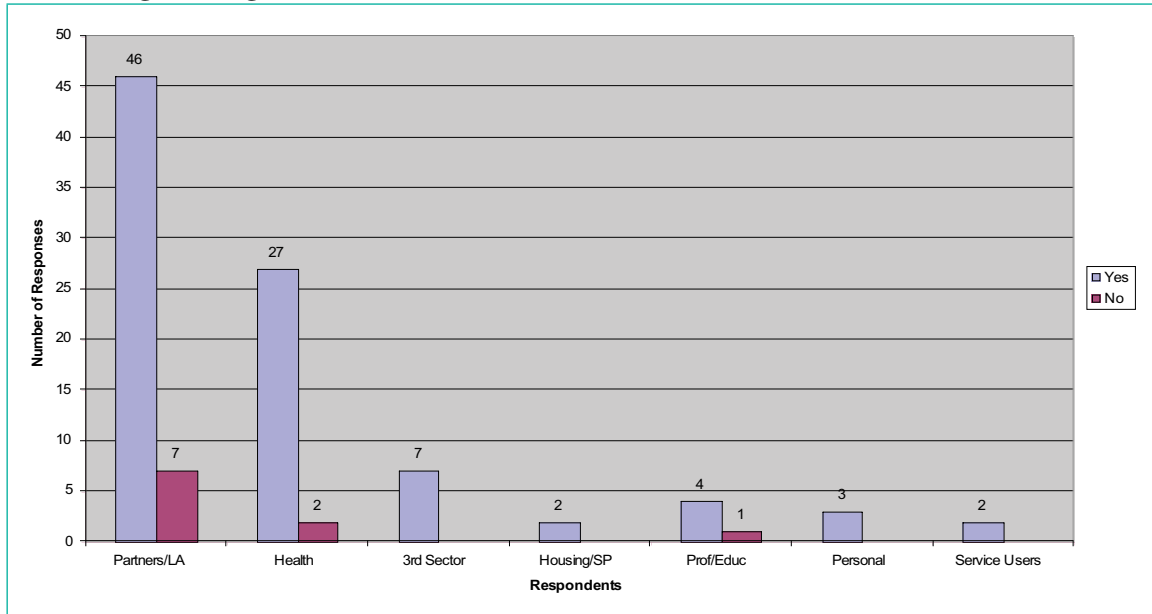
Q6c: 'What are the responsibilities of the NHS safeguarding leads, can one person fulfil all these roles?' 29% or 74 respondents stated that a team approach was needed rather than safeguarding in the NHS being part of one person's responsibilities. 7% or 17 responses also feel that the main role of the safeguarding lead would be to coordinate safeguarding activities with emphasis on partnership working across all agencies.

Q6c Responsibilities of SG Leads?



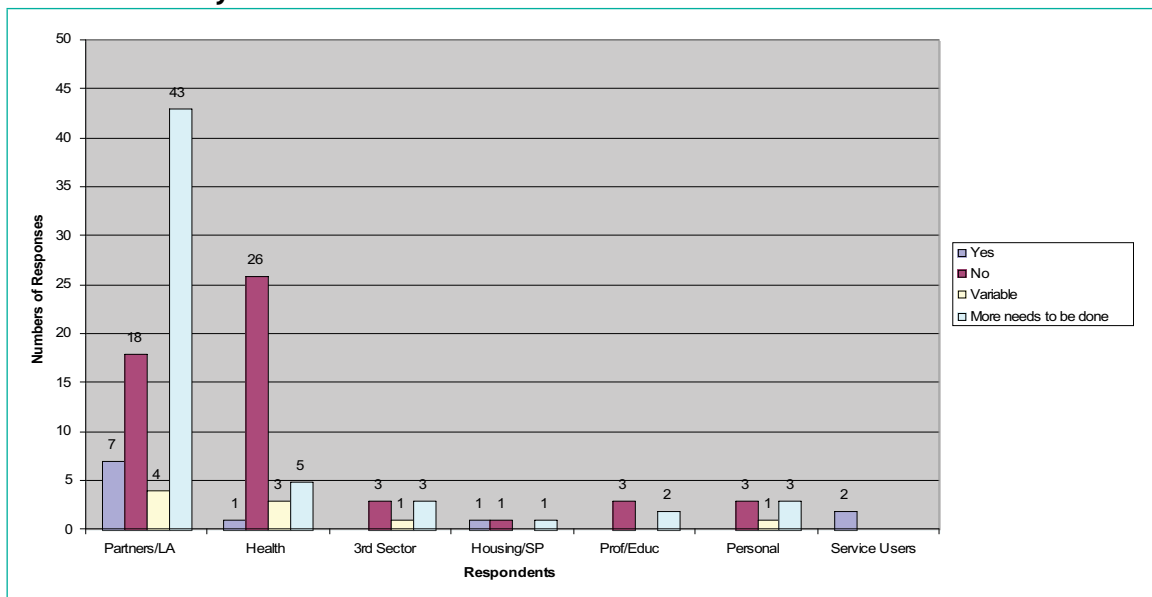
Q6d: ‘Is there a need for regional safeguarding forums where health organisations can share good practice and learning?’ The chart below shows that 90% or 91 respondents support the need for regional safeguarding forums.

Q6d Safeguarding Forums?



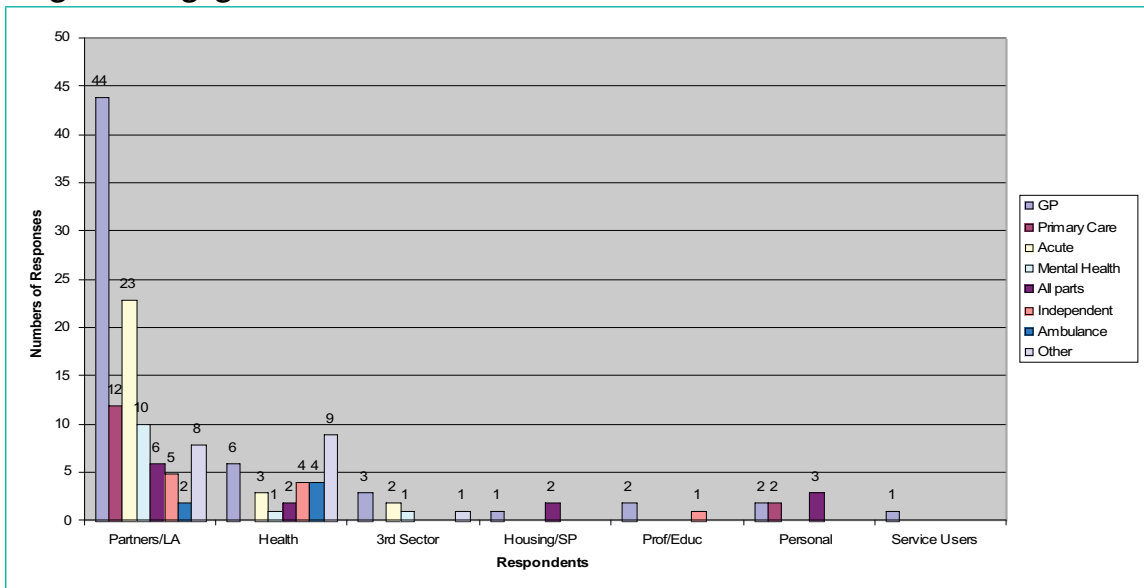
Q6f: ‘Are adult safeguarding systems in the NHS effective?’ 41% or 54 respondents felt that safeguarding systems within the NHS were not effective with a further 44% or 57 responses stating that more needs to be done. Only 8% or 11 responses felt that systems were in place. Health organisations that responded to this question recognised that systems are inadequate.

Q6f Effective Systems?



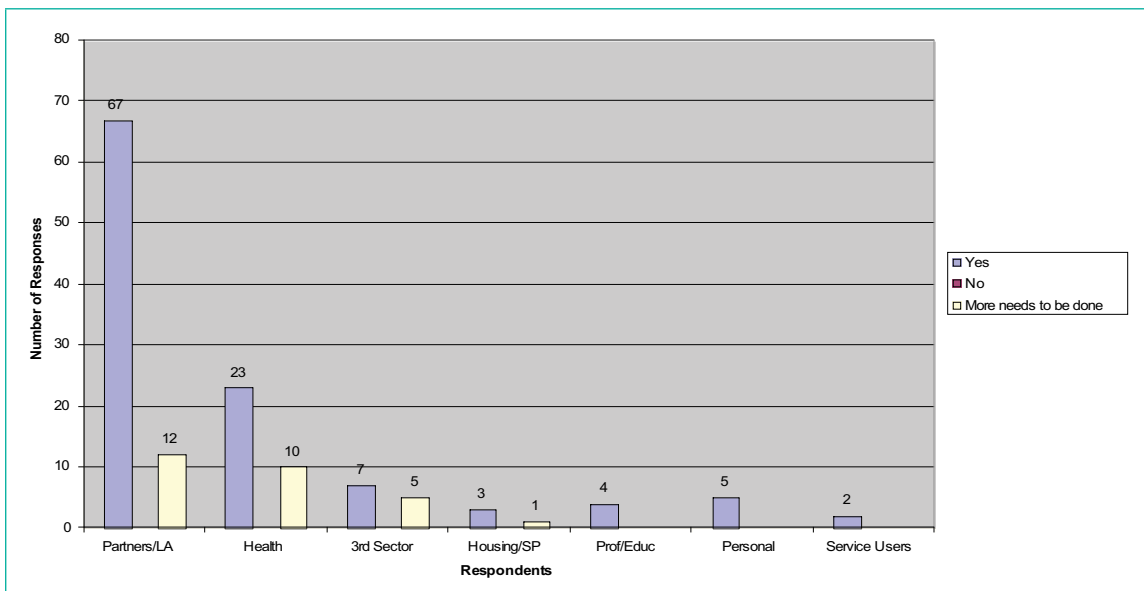
Q6g: Are any parts of the NHS sector less engaged?' The chart below shows that 37% or 59 respondents perceived that GPs were less engaged in adult safeguarding. 18% or 28 highlighted that acute hospitals are less engaged and indicate that this particularly refers to medical staffing and A&E departments. 8% or 13 responses felt that all parts of the NHS were less engaged. 11% or 18 responses identified other parts of the system, which are also less engaged, such as independent providers, dentists, optometrists, commissioners and drug and alcohol services.

Q6g Less Engaged?



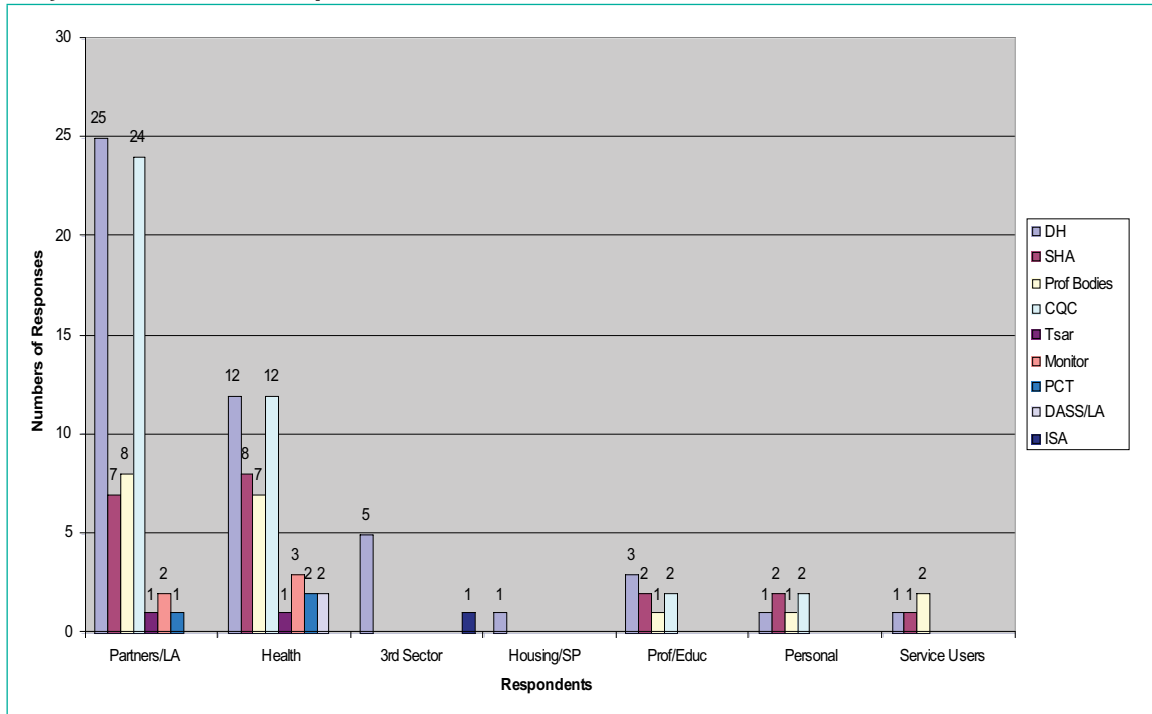
Q6h: 'Is the role of GPs a crucial role for safeguarding in the NHS?' 80% or 111 respondents agreed that the role of the GP is crucial in adult safeguarding with 20% or 28 responses recognising that more needs to be done to engage GPs in this work.

Q6h Is the Role of the GP Crucial?



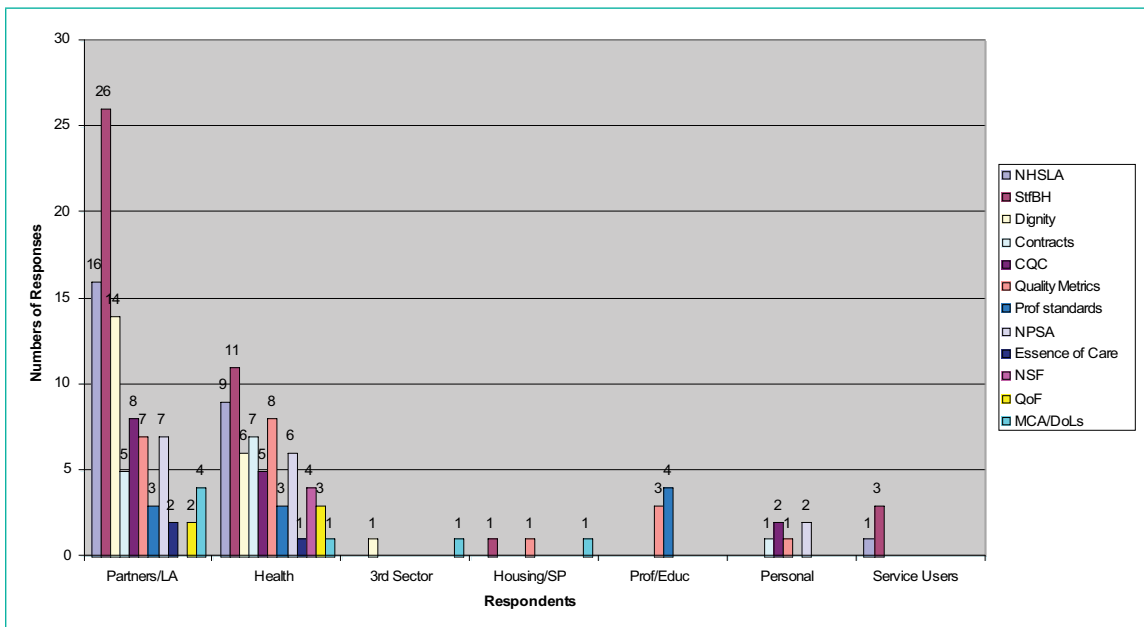
Q6j: ‘What central leadership role should there be?’ The chart below shows that 34% or 48 respondents indicate that the Department of Health should have central leadership responsibility for the NHS, with 29% or 40 nominating the CQC, 14% or 20 nominating the strategic health authorities (SHAs) and 13% or 19 responses nominating the professional bodies.

Q6j Central Leadership



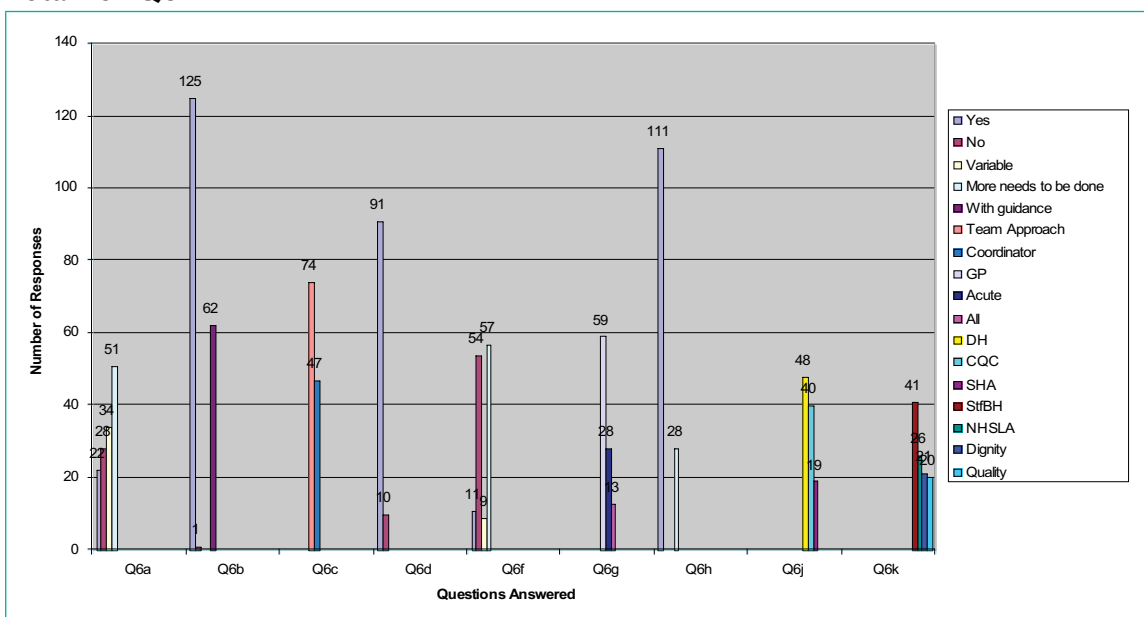
Q6k: 'What are the main drivers for standards?' The chart below shows that 23% or 41 respondents agreed that standards for better health (StfBH) fit well with adult safeguarding aims, 14% or 26 responses recognised that the NHS Litigation Authority (NHSLA) have explicit links to standards for adult safeguarding which are already part of compliance expectations and 12% or 21 responses mentioned dignity indicators and 11% or 20 responses for quality metrics.

Q6k Main Drivers for Standards



The chart below shows the main totals for question 6.

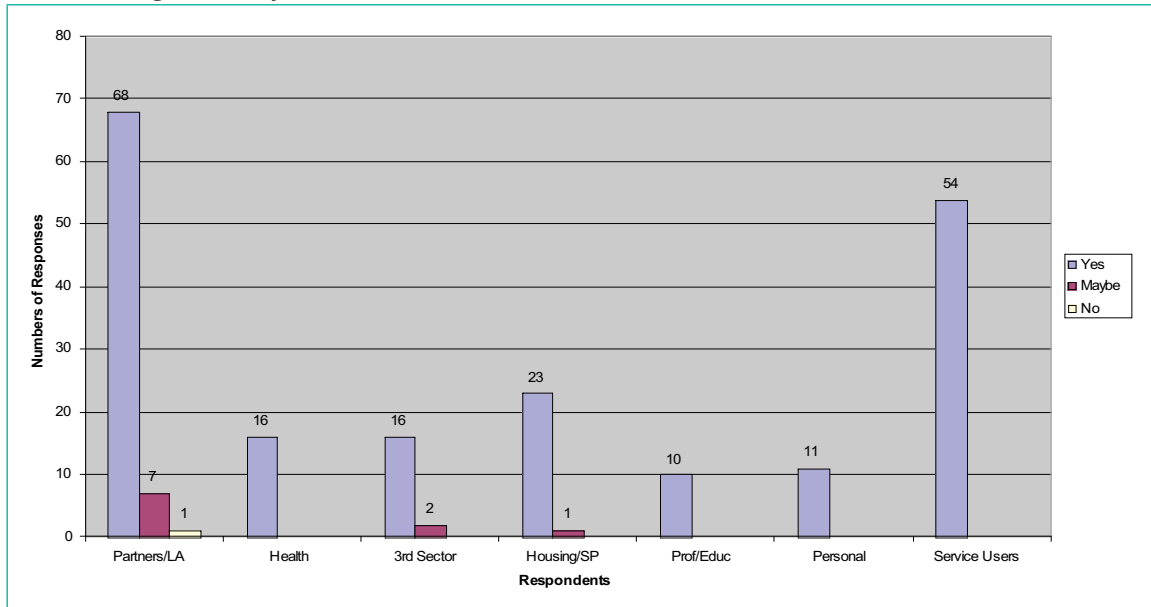
Total for Q6



Safeguarding, Housing and Community Empowerment

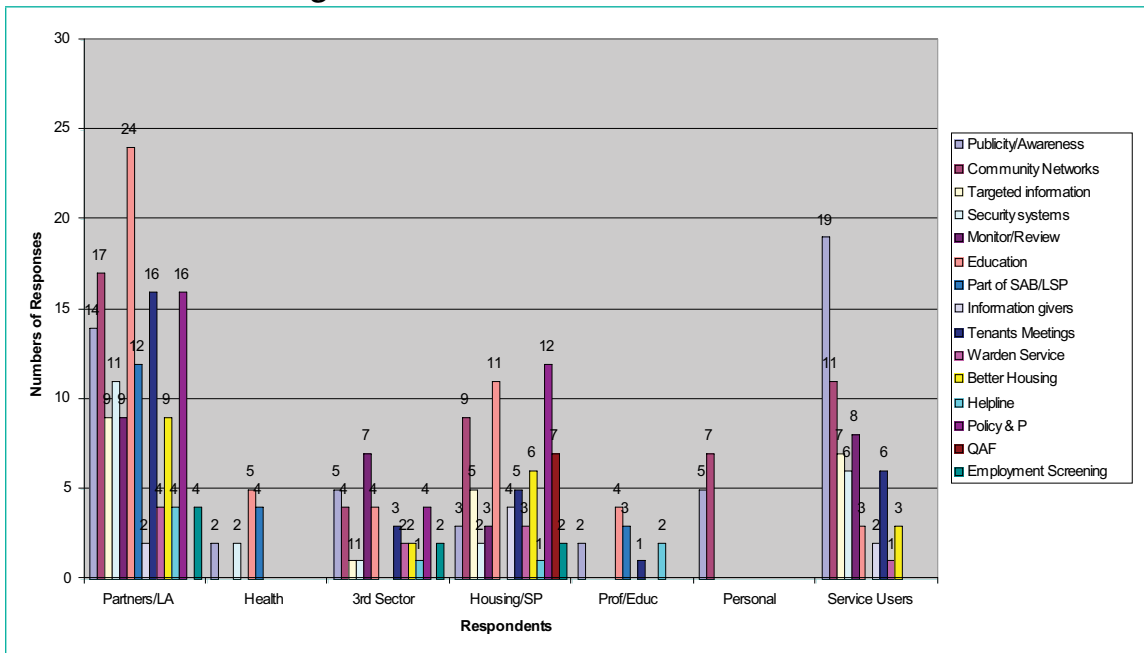
Q7a: ‘Do we need stronger policy links between safeguarding and community development and empowerment?’: The chart below shows that 95% or 198 respondents agree that stronger policy links with safeguarding community empowerment and housing would be beneficial.

Q7a Stronger Policy Links?



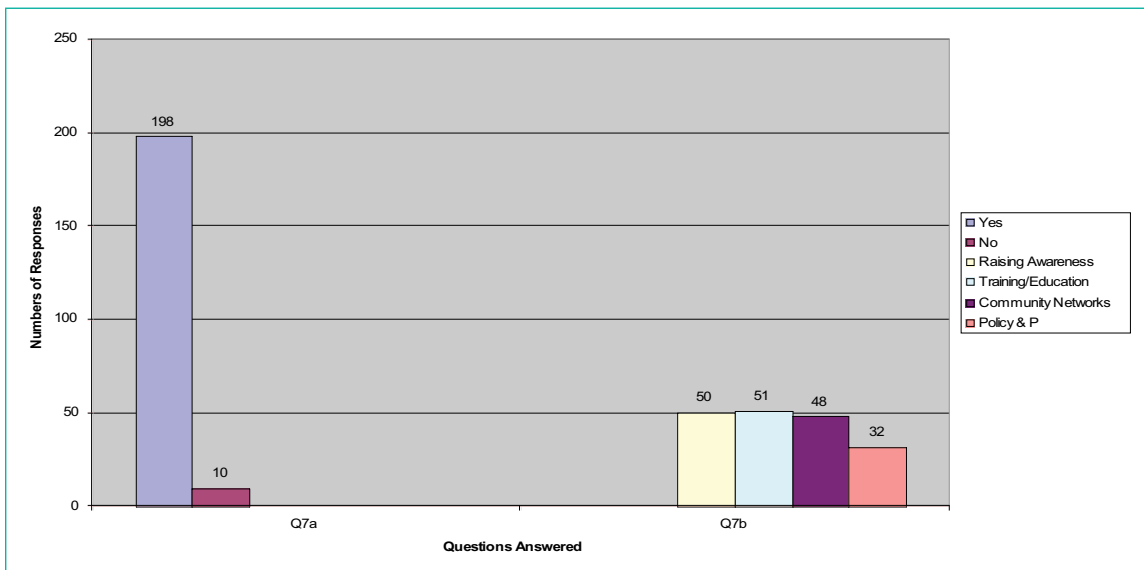
Q7b: 'How can housing providers contribute to safeguarding?': 15% or 51 responders highlighted training and education for tenants, providers and residents as an important aspect of safeguarding and empowerment, in addition to 14% or 50 nominations of raising public awareness and 13% or 48 for developing community networks which include partnership working. Implementation of policies and procedures was also mentioned by 9% or 32 respondents and seen to be a crucial part of the prevention of harm.

Q7b How can Housing Providers contribute?



The chart below shows the totals for question 7.

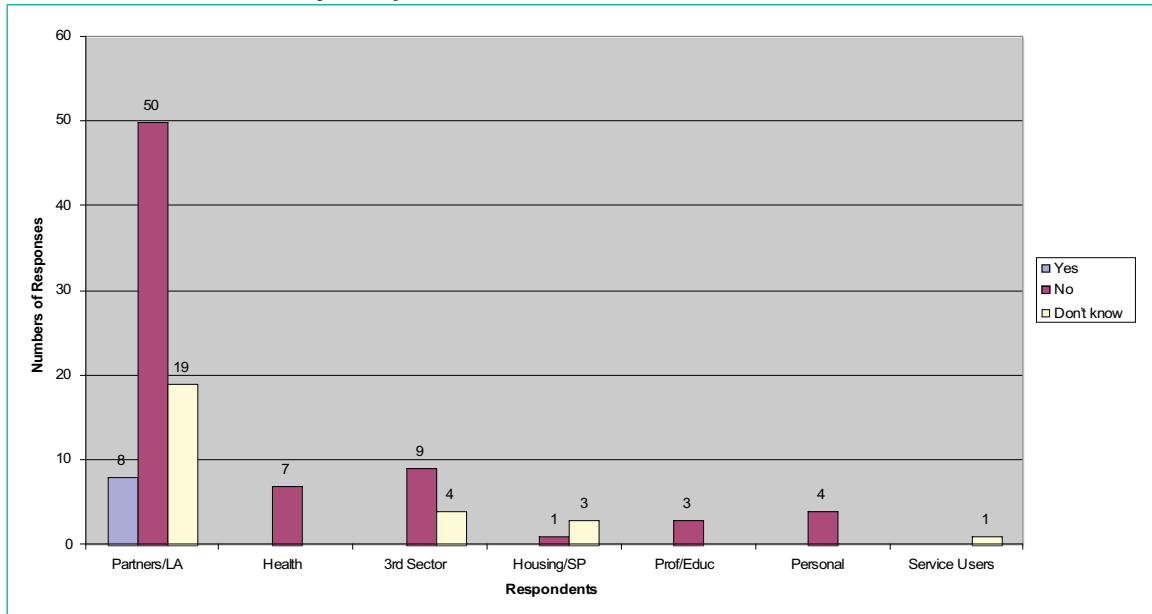
Total for Q7



Access to the Criminal Justice System

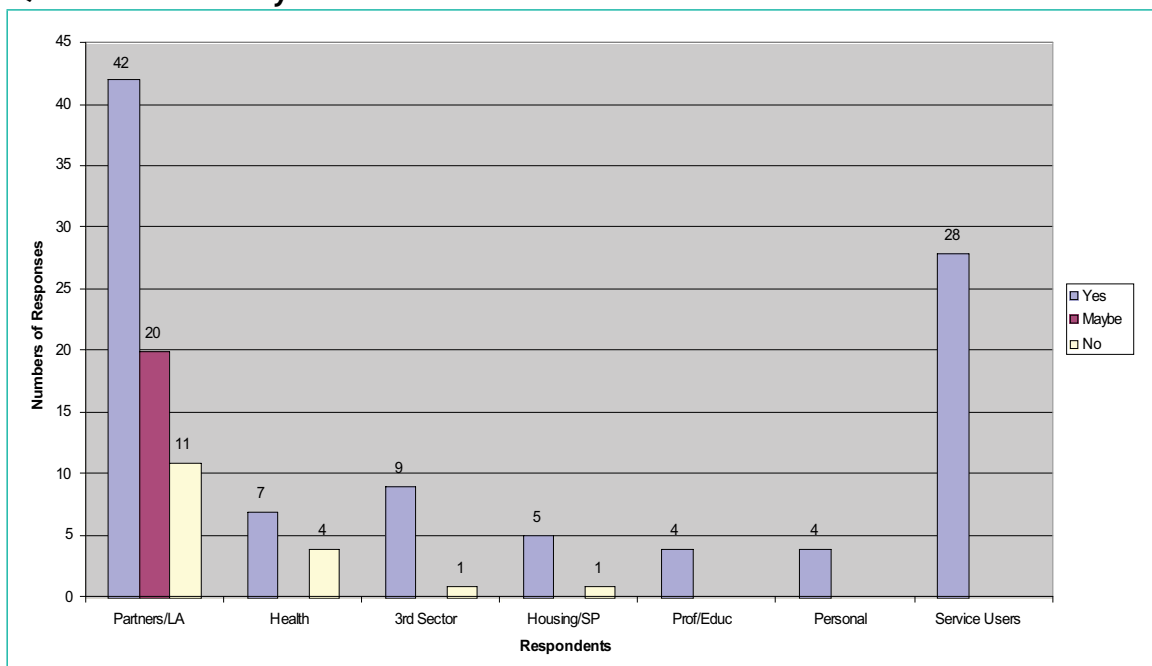
Q8b: ‘Are police units adequately staffed?’ 68% or 74 respondents thought that police units are not adequately staffed to respond to safeguarding demands. Only 7% or 8 felt that they were adequate while a further 25% or 27 respondents were not able to answer the question about police specific resources.

Q8b Police Units adequately staffed?



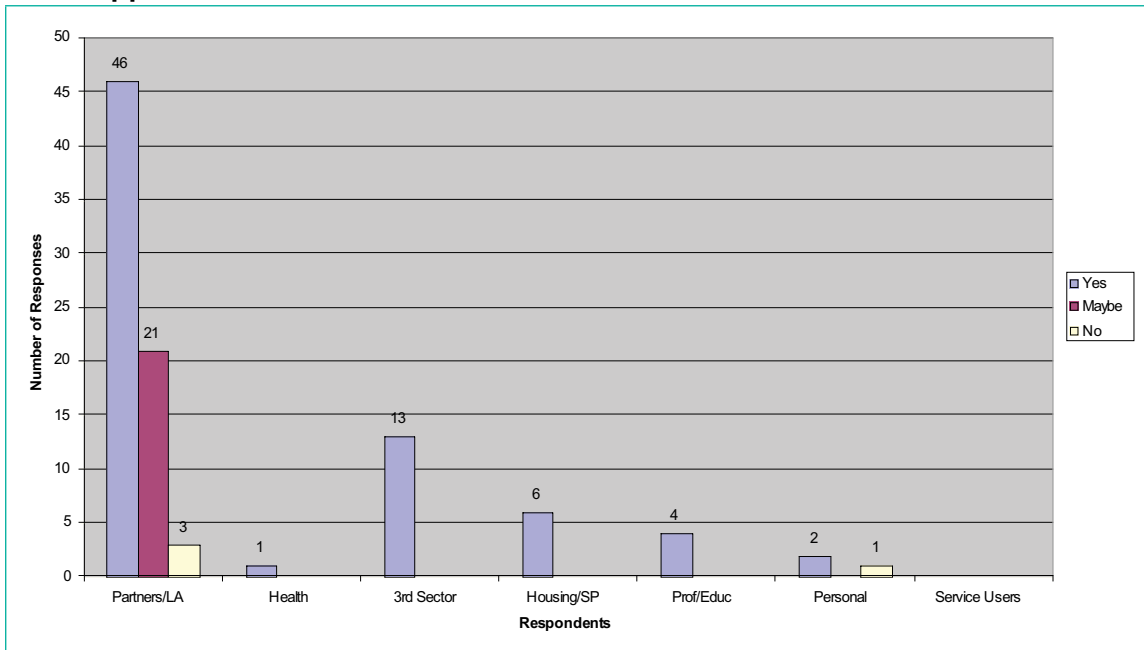
Q8c: ‘Is there a need to develop a more formal system as in MAPPA or MARAC?’ The chart below shows that 73% or 99 responses felt that more formal systems would be beneficial. 15% or 20 felt that there are good systems in place already and 12% or 17 responses did not feel that a more formal system would be required.

Q8c More formal system?



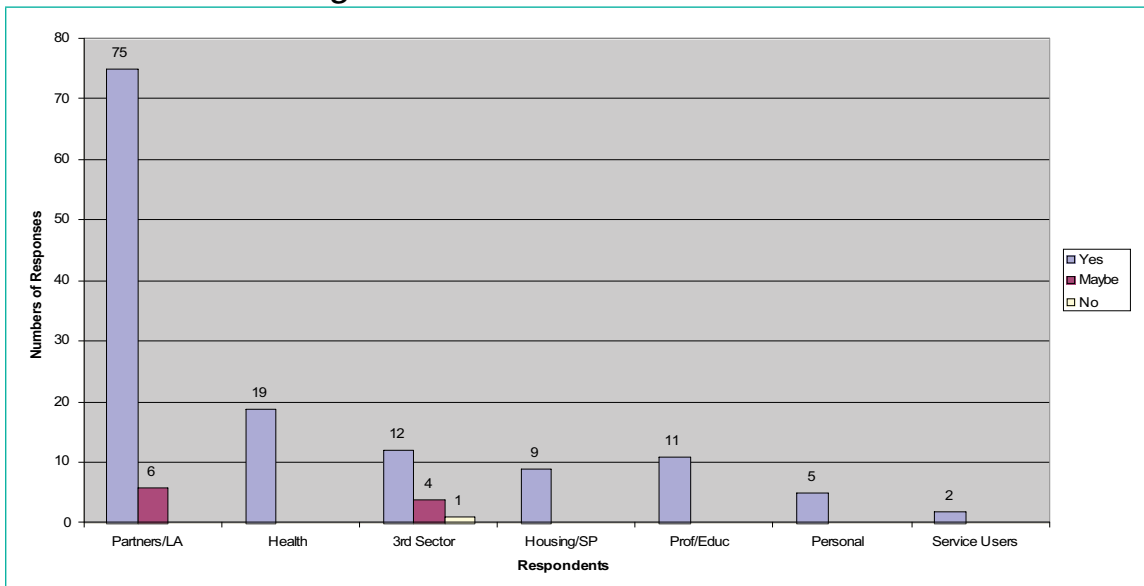
Q8d: 'Is there support for multidisciplinary teams (MDTs)/joint investigation teams working together?' 75% or 72 respondents agreed that they would support MDT/ joint investigation teams, 21% or 21 felt that it was potentially a good idea and only 4% or 4 responses did not agree.

Q8d Support for MDT/Joint Teams?



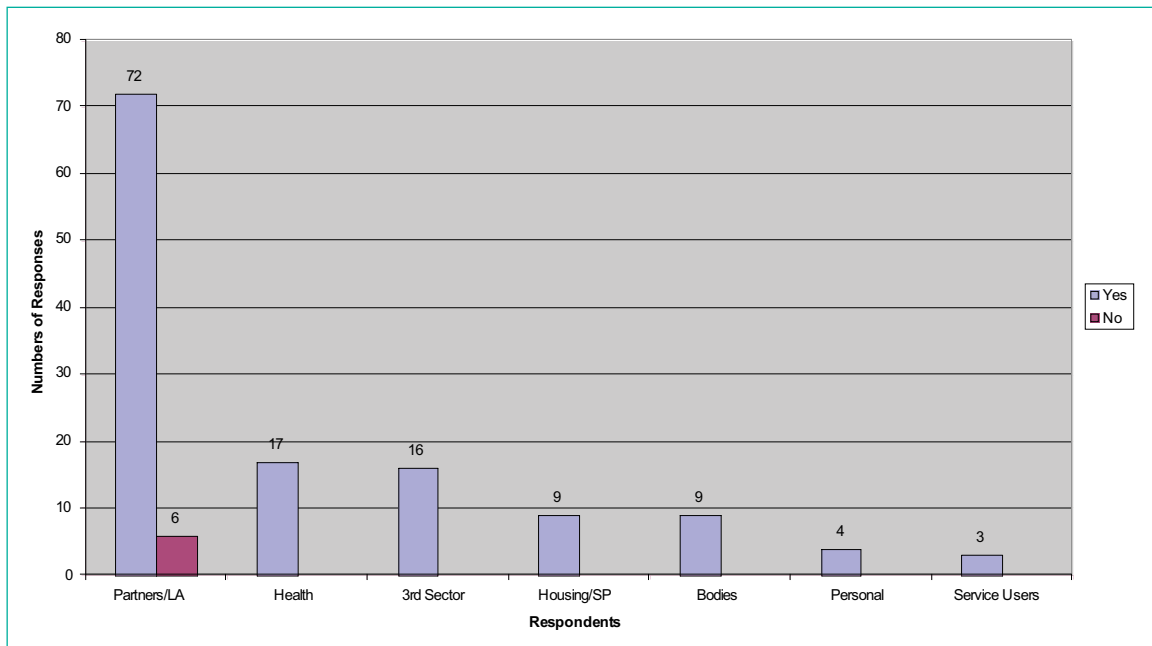
Q8f: 'Should information about the safety of a person be passed between health and social care organisations?' The chart below shows that 92% or 133 respondents agreed that sharing information was essential with 7% or 10 responses stating that this was already the case in some areas.

Q8f Information Sharing?



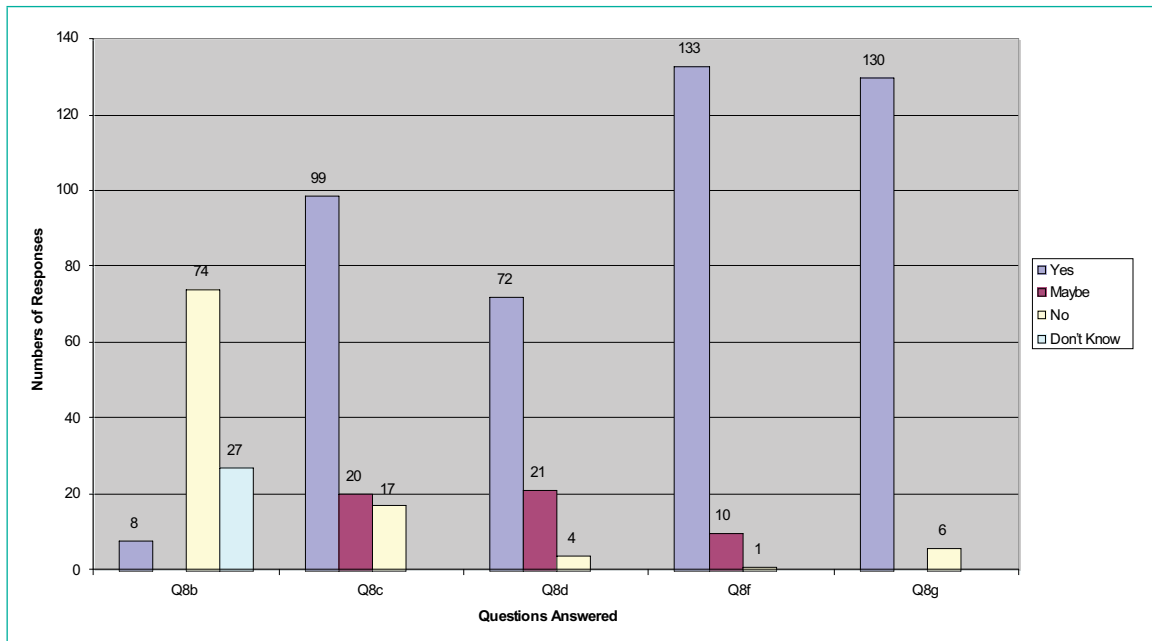
Q8g: ‘Should we have guidance on if and when information should be shared?’
 96% or 130 respondents were in support of the development of guidance for information sharing, 4% did not want this and felt that existing guidance was sufficient.

Q8g Information Sharing Guidance?



The chart below shows the totals for question 8.

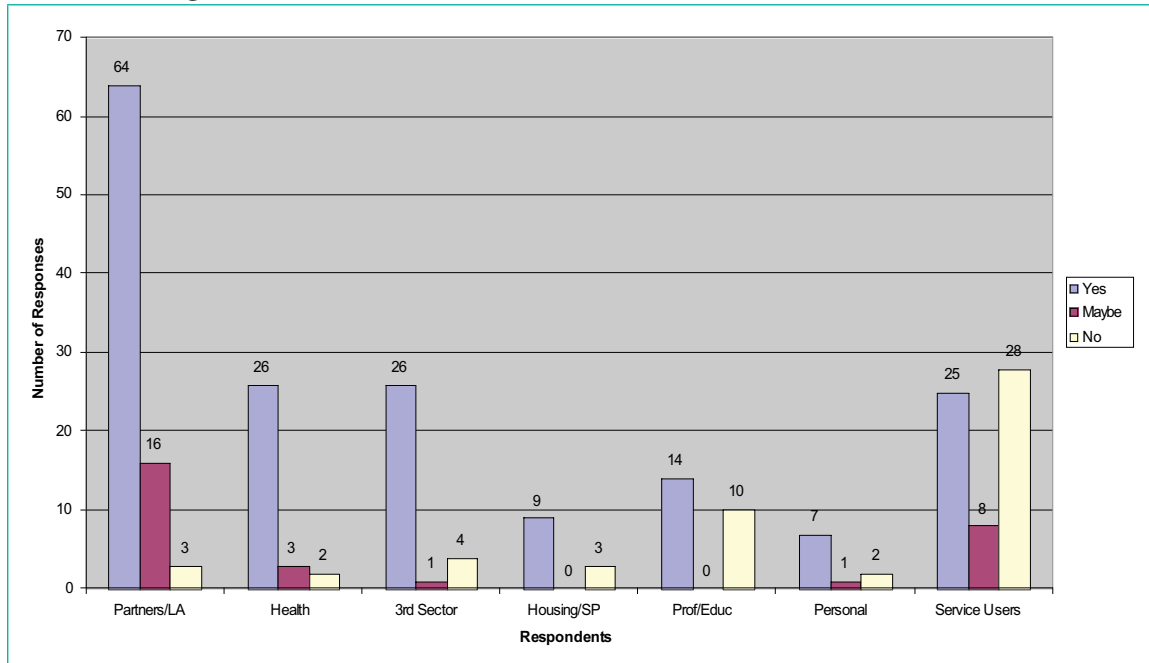
Totals for Q8



Guidance & Legislation

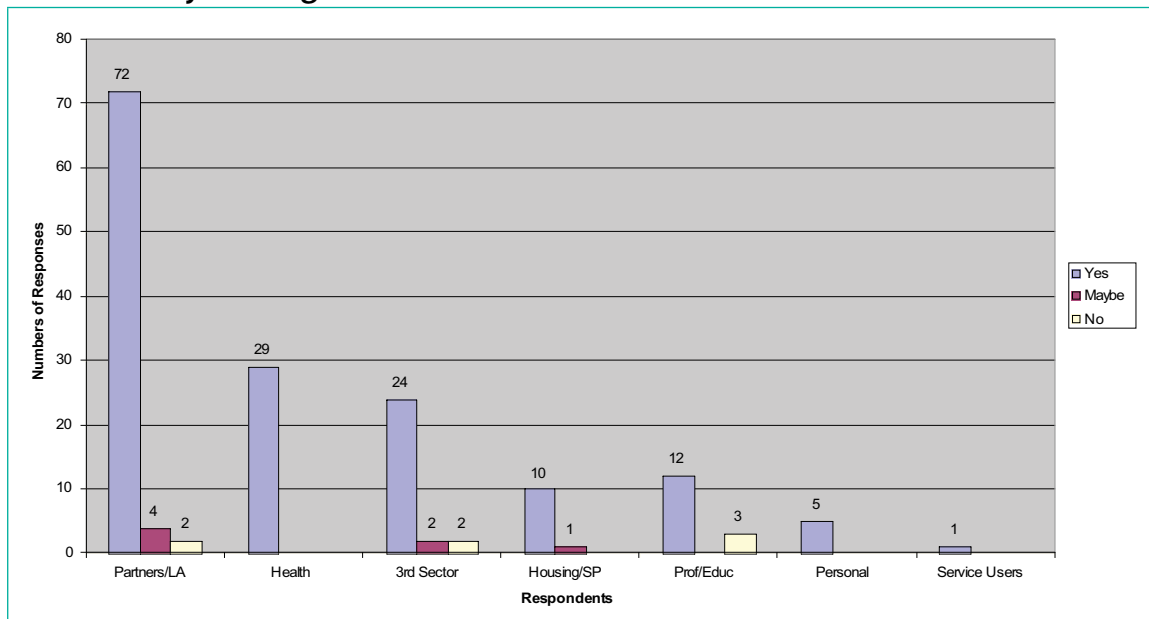
Q9b: 'Do we need new legislation?' The chart shows that 171 or 68% of the respondents absolutely support the need for new legislation, 21% do not support new legislation, and 11% either made other suggestions or have expressed a 'maybe' in response to the question.

Q9b New Legislation?



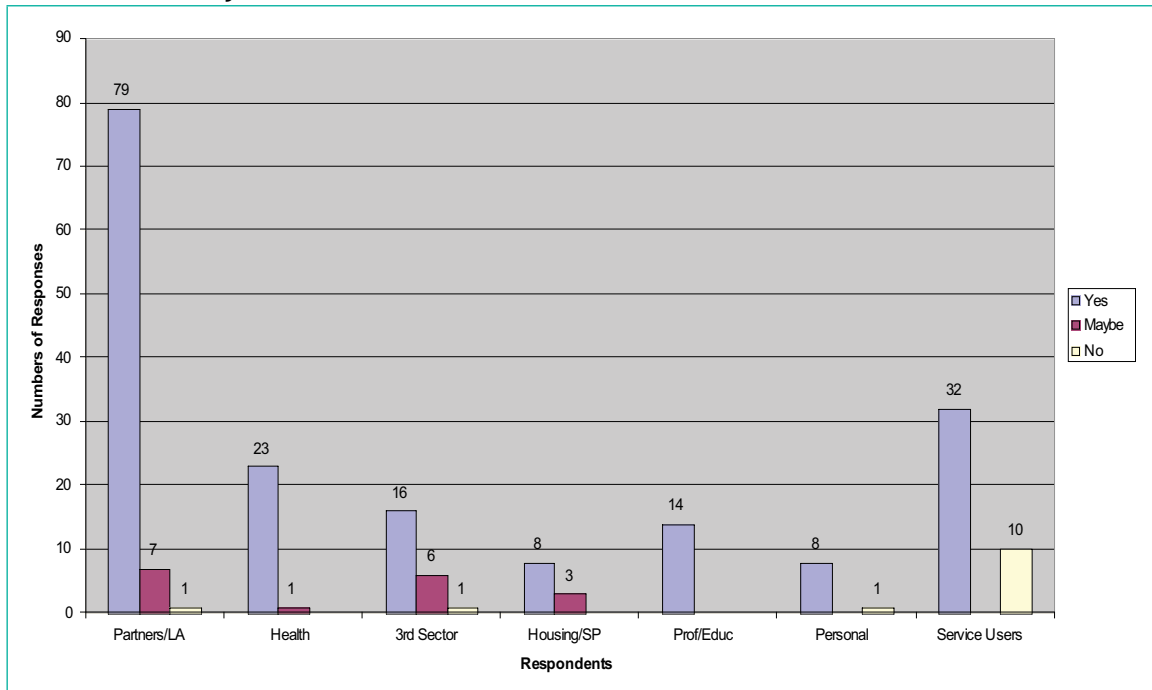
Q9c: 'Should legislation place SABs on a statutory footing?' 153 respondents or 92% agreed that SABs should be on a statutory footing and 4% or 7 responses disagreed.

Q9c Statutory Footing for SABs?



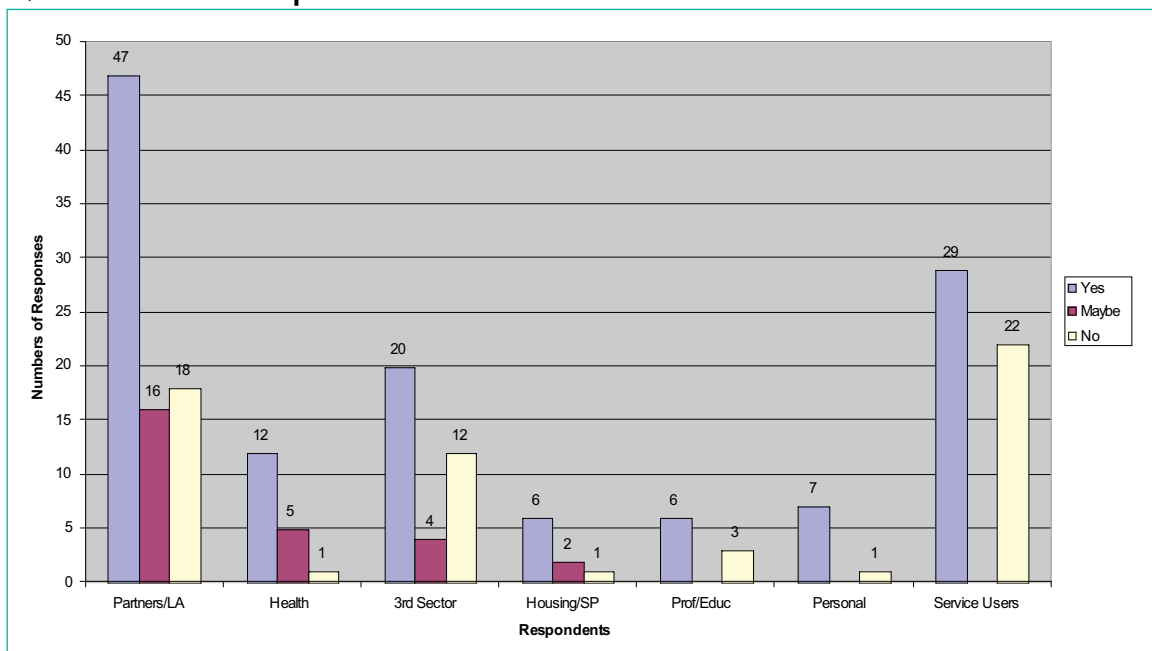
Q9d: ‘Should we introduce a wider duty to cooperate in relation to safeguarding?’ 86% or 180 respondents supported the introduction of a wider duty to cooperate, 8% or 17 did not support this duty, 6% or 13 responses expressed other views or a ‘maybe’.

Q9d Wider Duty?



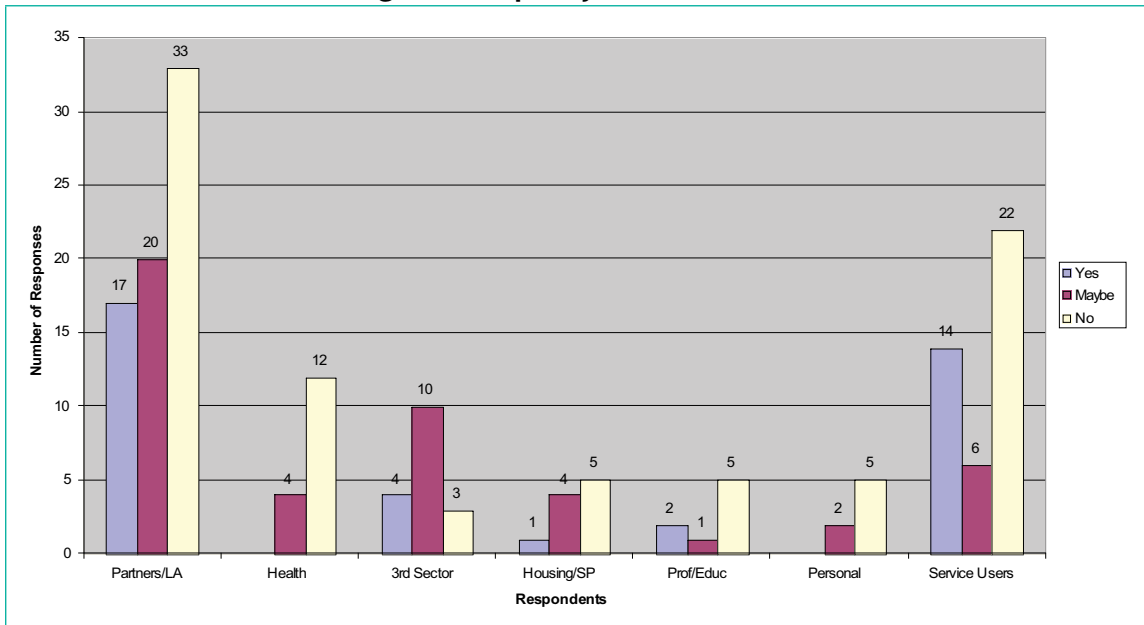
Q9e: ‘Should there be a power to enter premises where it is suspected that a vulnerable adult is being abused?’ 60% or 127 respondents agreed that there should be such a power, 27% or 58 did not support this view, and 13% or 27 expressed other/maybe opinions.

Q9e Power to enter premises?



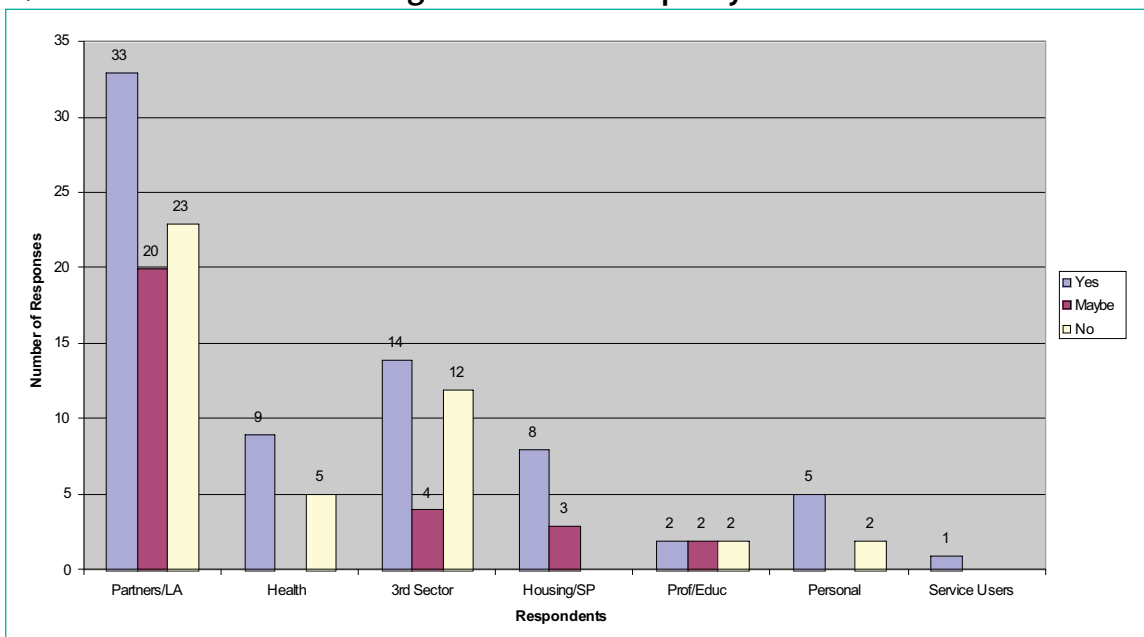
Q9f: 'Should such a power apply when an adult has mental capacity and may be self neglecting or self harming?' 22% or 38 respondents agreed that such a power should apply when an adult with capacity is self harming/neglecting, 50% or 85 did not want to see such a power, 28% or 47 expressed other views.

Q9f Powers if Self-Harming with Capacity?



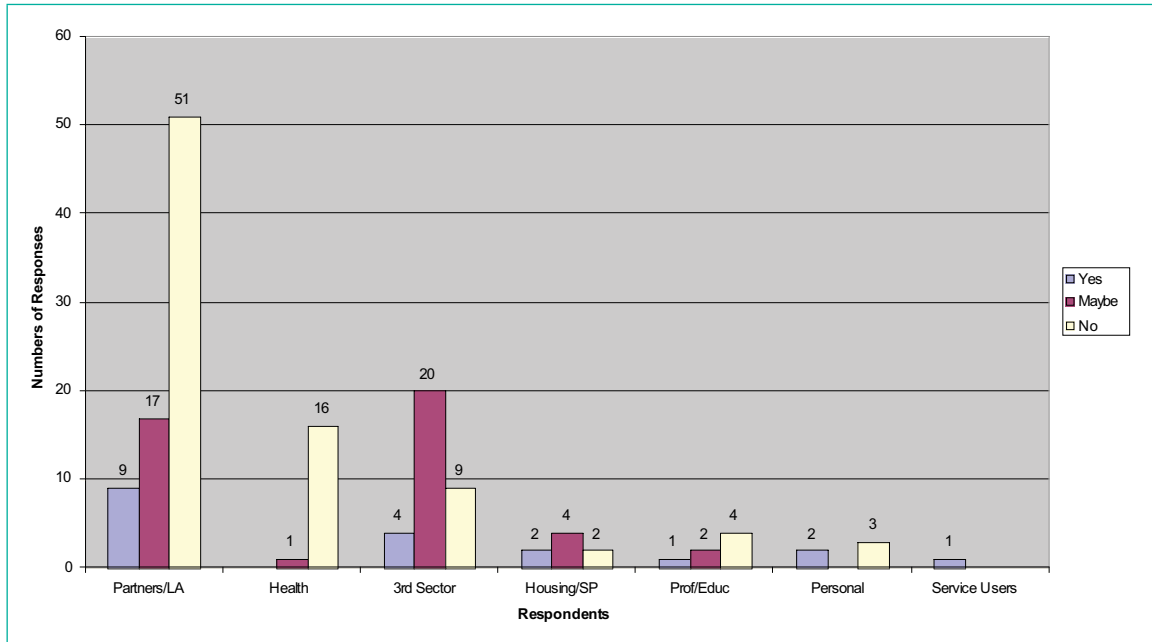
Q9h: 'Should an offence of ill-treating or neglecting a vulnerable adult with capacity be introduced?' 50% or 72 responders agreed that an offence should be introduced, 30% or 44 did not agree, 20% or 29 responses expressed other opinions.

Q9h An offence of ill-treating an adult with capacity?



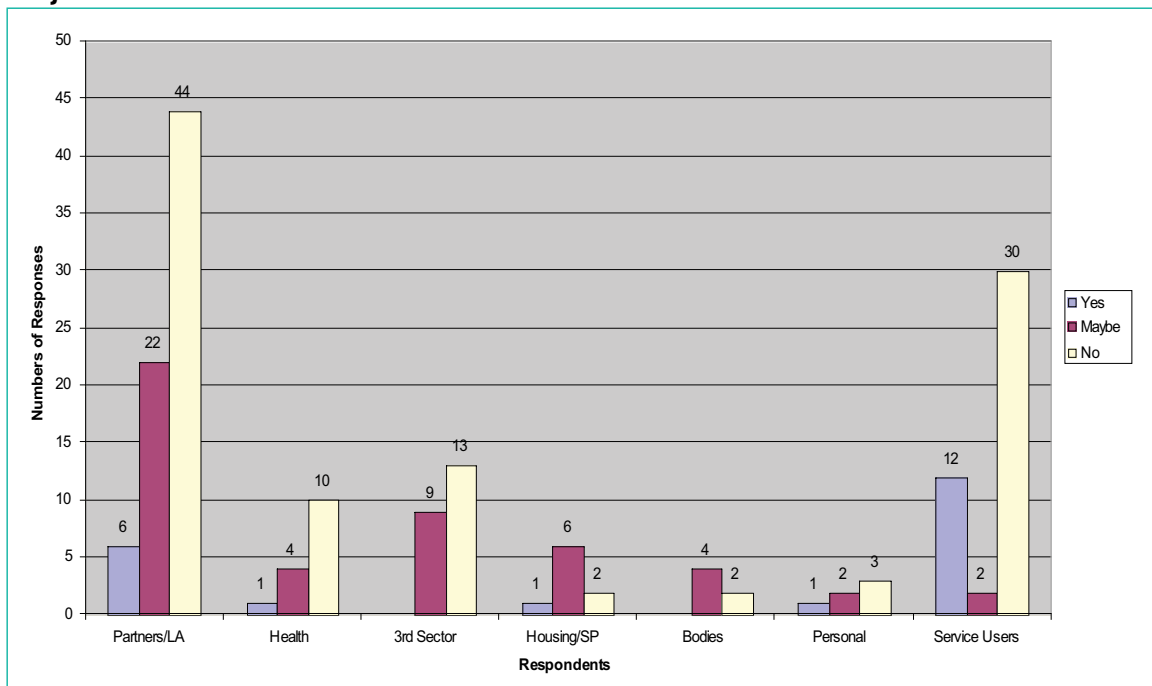
Q9i: ‘Should there be a power to remove an adult who does have capacity and who does not consent who is thought subject to harm?’ 13% or 19 respondents agreed that there should be a power to remove an adult, while 57% or 85 responses did not support such a power, and 30% or 44 responses expressed other opinions.

Q9i Powers to remove?



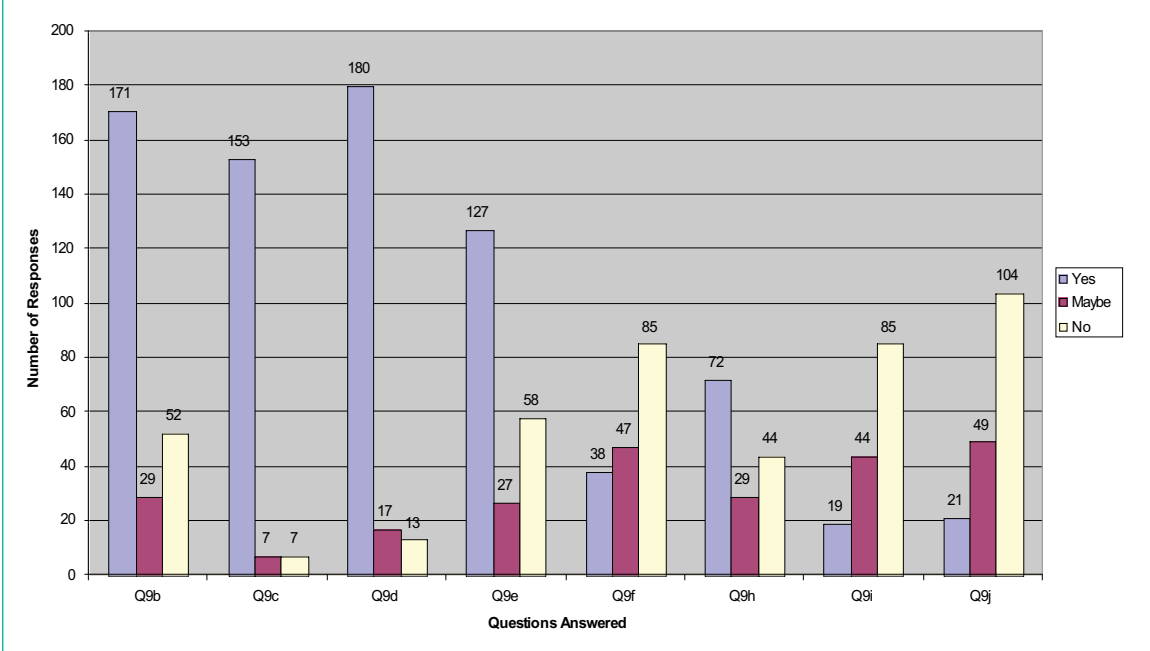
Q9j: ‘Should force be used to remove a person who is self neglecting/harming?’ 12% or 21 respondents supported the use of force to remove an adult: 60% or 104 responses did not support this view, and 28% or 49 expressed other opinions.

Q9j Should force be used?



The chart below shows the totals for question 9.

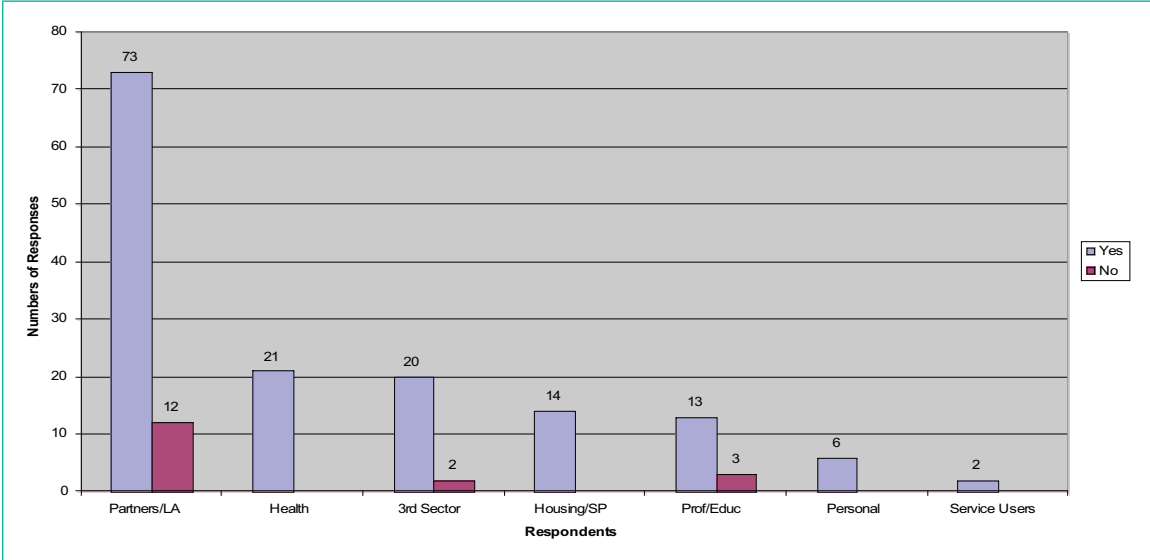
Total of all responses to Question 9



Definitions

Q10a: 'Should the *No secrets* definition of a vulnerable adult be revised?': 90% or 149 respondents agreed that the definition should now be revised while 10% or 17 responses felt that the current definition is sufficient.

Q10a Revise *No secrets* definition of a Vulnerable Adult?



List of Questions

1. Leadership

- Q1a Where should leadership for safeguarding adults lie nationally?
- Q1b Where should it lie locally?
- Q1e Where should leadership for NHS safeguarding issues lie?
- Q1f Where should leadership for safeguarding in the care home sector lie?

2. Prevention

- Q2a Should we be doing more work on prevention?
- Q2b Should we develop a national prevention strategy for adult safeguarding?

3. Outcomes

- Q3a Would an outcomes framework for safeguarding adults be useful?
- Q3d Should we have national occupational training standards across all agencies?
- Q3f Should we develop joint inspections?

4. Health Services and safeguarding

- Q6a Where should leadership for safeguarding adults lie nationally?
- Q6b Are health organisations able to work with and adopt multiagency guidance?
- Q6c What are the responsibilities of the NHS safeguarding leads?
- Q6d Is there a need for regional safeguarding forums?
- Q6f Are adult safeguarding systems within the NHS effective?
- Q6g Are any parts of the NHS less engaged?
- Q6h Is the role of GPs crucial for safeguarding in the NHS?
- Q6j What central leadership role should there be?
- Q6k What are the main drivers for standards?

5. Safeguarding, Housing and Community Empowerment

- Q7a Do we need stronger policy links between safeguarding and community development and empowerment?
- Q7b What could housing departments do to enable their tenants and residents to live safer lives?

6. Access to the Criminal Justice System

- Q8b Are police units adequately staffed?
- Q8c Is there a need to develop a more formal system?
- Q8d Is there support for multidisciplinary/joint investigation teams?
- Q8f Should information about the safety of a person be passed between organisations?
- Q8g Should we have guidance on when information should be shared?

7. Guidance and Legislation

Q9b Do we need new legislation?

Q9c Should legislation place SAB on a statutory footing?

Q9d Should we introduce a wider duty to cooperate in relation to safeguarding?

Q9e Should there be a power to enter premises where it is suspected that a vulnerable adult is being abused?

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

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 who is thought subject to harm?

Q9j Should force be used to remove a person who is self neglecting/harming?

8. Definitions

Q10a Should the *No secrets* definition of a vulnerable adult be revised?

Categories of Respondents

Categories of Respondents (detailed below in Appendix B)

Safeguarding Adult Partners and Local Authorities

Health Organisations

3rd Sector: Voluntary and Private Organisations

Housing and Supporting People

Professional, Regulatory and Educational Bodies

Justice

Personal

Service Users

Regional Responses

Appendix B: List of Responses

1. Safeguarding Adult Partners and Local Authorities

Barnet Safeguarding Adults Board
Barnsley Safeguarding Adults Board
Birmingham Safeguarding Adults Board
Birmingham County Council, Communities Directorate
Blackburn and Darwen Safeguarding Adults Strategic Board
Bolton Safeguarding Adults Board
Bournemouth Borough Council
Bracknell Forest Council
Bradford Safeguarding Adults Board
Bristol Safeguarding Adults Partnership Board
Bromley Safeguarding Adults Board
Buckinghamshire Vulnerable Adult Safeguarding Board
Bury Safeguarding Adults Board
Calderdale Safeguarding Adults Board
Cambridgeshire Safeguarding Vulnerable Adults Partnership Board
Cheshire County Council
Cornwall & Isles of Scilly
Coventry City Council and Partners

- PPU Coventry West Midlands Police
- Coventry PCT
- Adults Physical & Sensory Impairment Partnership Board
- Coventry Council
- Coventry Safeguarding Adults Board

Cumbria Safeguarding Adults Partnership
Darlington Borough Council
Denbighshire Adult Protection Committee
Derby and Derbyshire Safeguarding Vulnerable Adults Partnership and Derbyshire County Council
Doncaster Safeguarding Adults Partnership Board
Doncaster Practitioners Safeguarding Adults Partnership Board
Dorset Safeguarding Group
Dudley Adult Protection Coordinators and West Midland Adult Protection Network
Dudley Safeguarding Vulnerable Adults Board
Eastern Region Adult Safeguarding Group
East Midlands Multiagency (CSIP)

East Sussex County Council Safeguarding Adults Board
 Essex Safeguarding Adults Board
 Enfield Safeguarding Adults Board
 Exeter Multiagency Group (CSIP)
 Gateshead Safeguarding Adults Board
 Gloucester Adult Protection Management Committee
 Greenwich Safeguarding Adults Multiagency Group
 Halton Safeguarding Vulnerable Adults Partnership Board
 Hampshire County Council, Hampshire service Users Forum and Partners
 Haringey Council and Haringey PCT
 Hertfordshire Safeguarding Adults Committee
 Hull City Council Voluntary People Partnership Board
 Hull and East Riding Safeguarding Adults Board
 Isle of Wight Safeguarding Adults Board
 Kent Adult Social Services
 Kent and Medway Safeguarding Adults Committee
 Knowsley Safeguarding Adults Board
 Lancashire Safeguarding Adults Partnership Strategic Board
 Leicester, Leicestershire and Rutland Safeguarding Adults Board
 Lewisham Multiagency Safeguarding Response
 Liverpool Safeguarding Adults Board
 London Borough of Brent Safeguarding Adults Board
 London Borough of Camden Adult Social Care
 London Borough of Ealing
 London Borough of Hackney
 London Borough of Hillingdon Adult Partnership Board
 London Borough of Newham Safeguarding Partnership Board
 London Borough of Richmond Safeguarding Adults Board
 London Network of Safeguarding Adults Coordinators
 Luton Safeguarding Vulnerable Adults Board
 Manchester Safeguarding Adults Board
 Manchester LD Partnership
 Middlesborough Department of Social Care, Teeswide Steering Group and Cleveland Police
 Monmouthshire County Council
 Newcastle Upon Tyne Multiagency
 NHS Medway and Medway Council
 Northampton Borough Council
 Northumberland Care Trust Safeguarding Adults Multiagency Partnership
 North Lincolnshire Safeguarding Adults Board
 North Somerset Safeguarding Adults Partnership Board
 North Tyneside Council and Partners

North West Multiagency (CSIP)
North Yorkshire Safeguarding Adults Board
Northern Region SVA Group
Nottinghamshire Safeguarding Adults Board and Nottingham City Safeguarding Adults Board
Nottinghamshire County Council Mental Health and LD
Oldham Multiagency
Oxfordshire Safeguarding Adults Board
Peterborough SAB
Portsmouth Safeguarding Adults Board
Rochdale Metropolitan Borough Council
Rotherham Metropolitan Borough Council
Royal Borough of Kensington and Chelsea Safeguarding Adults Board
Royal Borough of Kingston Practitioners Peer Review
Salford Safeguarding Adults Executive Committee
Sefton Council Health and Social Care Directorate
Sheffield City Council PD and Sensory Impairment
Sheffield Health and Social Care NHS Foundation Trust
Shropshire County Council Adult Protection Committee and Shropshire Council
Solihull Safeguarding Adults Board
Somerset Safeguarding Adults Board
Somerset Council
Southend Safeguarding Vulnerable Adults Board
South Gloucestershire Safeguarding Adults Committee
Southwark Safeguarding Adults Partnership
South West Safeguarding Coordinators (CSIP)
Staffordshire County Council
Staffordshire and Stoke on Trent Vulnerable Adult Board
Stockport Metropolitan Borough Council Safeguarding Adults Board
Stoke on Trent City Council
St. Helens Safeguarding Adults Board
Sunderland City Council Adult Social Care Partnership Board
Surrey Safeguarding Adults Board
Sutton and Merton Partners
Swindon Multiagency (CSIP)
Tameside Adult Safeguarding Partnership
Telford and Wrekin Council and Telford, Wrekin, and Shropshire Vulnerable Adults Partnership Board
Telford and Wrekin Joint commissioning Team
Torbay Care Trust
Torquay Multiagency (CSIP)
Wakefield Safeguarding Adults Board

Warrington Stakeholders, Warrington Borough Council
 Warwickshire Safeguarding Adults Board
 West Berkshire Council
 West Berkshire Safeguarding Adults Partnership Board
 West Berkshire Safeguarding Adults Partnership and Reading
 Westminster City Council Safeguarding Adults Board
 West Sussex Safeguarding Adults Training Sub-Group
 West Sussex Adults Safeguarding Board
 Wigan Council
 Wiltshire Safeguarding Adults Board
 Wirral Safeguarding Adults Board
 Worcestershire Safeguarding Adults Committee
 Wokingham Safeguarding Partnership Forum
 Wolverhampton Safeguarding Vulnerable Adults Board
 York Safeguarding Adults Board

2. Health Organisations

Avon and Wiltshire Mental Health Partnership NHS Trust
 Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust
 Berkshire East PCT Community Health Services
 Birmingham East and North PCT
 Birmingham Health and Well Being Partnership Trust
 Birmingham and Solihull, Mental Health NHS FT
 Bradford and Airedale Teaching PCT
 Cambridge University Hospitals Trust
 Chelsea and Westminster Hospitals NHS Trust
 Coventry and Warwickshire Partnership Trust
 Devon Partnership Trust (AST/ALDAT)
 Eastern and Coastal Kent NHS Community Services
 East London NHS Foundation Trust
 East and North Herts and West Herts PCT
 East Sussex, West Sussex, Brighton and Hove NHS Leads
 Gloucestershire PCT
 Greater Manchester West Mental Health NHS Foundation Trust
 Hampshire PCT
 Heart of Birmingham Teaching PCT
 Humber Mental Health Teaching NHS Trust
 Kidderminster, Older People Mental Health North
 Kings College Hospital NHS Foundation Trust
 Kirklees NHS PCT
 Lancashire Care NHS Trust

Liverpool PCT
Liverpool PCT, Safeguarding Commissioning
London Ambulance Service
Mersey Care NHS Trust
NHS East of England
NHS East Lancashire Service Provision Directorate
NHS Halton and St. Helens
NHS Hampshire, Hampshire PCT Commissioners
NHS National Advisory Group
North East Lincolnshire Care Trust
Northamptonshire PCT
Northumberland Tyne and Wear Trust
North Staffordshire
North Yorkshire and York PCT (LD Team)
Pan Dorset NHS
Peterborough PCT
Rotherham PCT
Sandwell PCT
Sandwell and West Birmingham Hospitals NHS Trust
Somerset Community Health and NHS Somerset
South Birmingham PCT
South Essex Partnership Trust
South Gloucestershire NHS
South London and Maudsley NHS Foundation Trust
South West London and St. Georges Mental Health NHS Trust
South Western Ambulance Trust
South West SHA
Tees Esk and wear Valleys NHS Foundation Trust
Tees Region

- Hartlepool PCT
- Middlesbrough PCT
- Redcar and Cleveland PCT
- Stockton on Tees PCT

The Leeds Teaching Hospitals NHS Trust
University Hospitals Birmingham NHS Foundation Trust
Wakefield District PCT
Walsall Hospitals NHS Trust
Worthing and Southlands NHS Trust
West London Mental Health Trust
West Midlands Ambulance NHS Trust
West Sussex PCT
West Sussex Health Provider Board

3. The Third Sector: Voluntary and Private Organisations

Action for Advocacy
 Action for Children
 Action on Elder Abuse
 Advocacy in Greenwich
 African Women's Group
 Age Concern Cambridgeshire and Age Concern England Eastern Region
 Age Concern Coventry
 Age Concern Nottingham and Nottinghamshire
 Agree Together (Hambleton and Richmondshire LD Partnership Board)
 Alzheimer's Society
 Ann Craft Trust
 BADDAC Access
 Berkshire Care Association
 Bradford Alliance on Community Care
 British Red Cross
 Centrepont
 Choice Supports Safeguarding Committee and 2 Forums for LD
 Community Action Hampshire
 Counsel and Care
 Downs Syndrome Association
 Dudley Voices
 Equal People
 In Control
 Isle of Wight Advocacy Trust
 Kirklees User Voice
 Lancaster Forum for Older People
 Latin American Elders
 Leonard Cheshire Disability
 Making Connections Isle of Wight
 Mencap
 Mind
 Moorlands day Centre Advocacy
 MS Society
 NAAPs
 NHPF (North Herts: Eastern Region Forum of People with Learning Difficulties)
 National Autistic Society
 National Care Forum
 National Centre for Independent Living
 Norwood
 NSPCC

Patient Concern
Pathway Project
PAVA UK
People First Campaigns
People First (Bath and North East Somerset)
Peterborough Rape Crisis
Public Concern at Work
Refuge
Rethink
Respond
Richmond Fellowships
RNIB
Royal Borough of Kingston LD Parliament
Saheli
Scope
Sense
SIFA Fireside
Somerset Care Group
Surrey LD Parliament
Survive
Swaffam and District (Norfolk) Pensioners Association
Swindon Mind
Taking Part
The Judith Trust
The Disabilities Trust
TH Friends and Neighbours
Thurrock Over Fifties Forum
The Methodist Church of Great Britain and the Church of England
Valuing People Support Team
VODG (Voluntary Organisations Disabilities Group)
Victim Support
Voice UK
Walsingham
West Berkshire Advocacy Service
Working Group of the Elders Council of Newcastle

4. Housing and Supporting People

Anchor Trust
Ashford LD CIC (Housing LIN)
A2Dominion
Cambridgeshire Supporting People
Chartered Institute for Housing

East Thames Group
 ERoSH (formerly Essential Role of Sheltered Housing)
 Hanover Housing
 Heritage Care
 Highlea Homes Ltd
 Housing Options
 Howard Cottage
 Independent Living Alternatives
 In Touch
 Jephson Housing (Housing LIN)
 Look Ahead
 London Borough of Camden (Housing LIN)
 Norfolk Housing LIN
 National Housing Federation
 Neighbourhoods and Community Care Sheffield
 Northwoods
 Orbit Group
 Penine Housing 2000
 Quantum Care
 Sanctuary Group
 Sanctuary Housing North (Glanford Lodge Residents)
 SITRA
 Social Landlords Crime and Nuisance Group
 South West CSIP Housing Support Workers MH
 Suffolk Supporting People
 Sue Garwood Extra care Specialist
 Supporting People Eastern Region
 Step by Step (Housing LIN)
 Stonham Home
 Telford (Housing LIN)
 Thames Gateway South East (Basildon, Thurrock, Castle Point, Southend, Rochford)
 United Kingdom Homecare Association
 Westlea (Housing LIN)
 West Sussex (Housing LIN)
 Your Homes Newcastle

5. Professional, Educational and Regulatory Bodies

ADASS (Association of Directors of Adult Social Services)
 British Banking Association
 BMA (British Medical Association)
 Building Societies Association
 BUPA Care Homes

British Psychological Society
British Society for Rehab Medicine
Canterbury Christchurch University (Hilary Brown)
Christian Science Committees on Publications
Coroners Society
CSCH
CQC (Care Quality Commission)
CSCI (Commission for Social Care Inspection)
Equality and Human Rights Commission
Family Planning Association
General Social Care Council
Healthcare Commission
Ibsen Report
Independent Care Group
Independent Safeguarding Authority
Information Commissioner’s Office
LGA (Local Government Association)
Making Connections
Mental Health Act Commission
NHS Alliance
NHS Confederation
NIACE (National Institute of Adult Continuing Education)
NMC (Nursing and Midwifery Council)
Reach
Registered Nursing Homes Association
Research in Practice for Adults
Royal College of GPs
Royal College of Nursing
Royal College of Psychiatrists
Sheffield Hallam University (Centre for Health and Social Care Studies, Margaret Flynn)
Social Care Institute for Excellence
Skills for Care
Social Care Association
University of Cambridge, LD Research Group and Dept of Psychiatry
University of Sheffield (Bridget Penhale)

6. Justice

Association of Chief Police Officers on behalf of the Police Service (ACPO)
Berkshire Joint Legal Team
Cleveland Police
Metropolitan Police Force

Northumberland County Council Legal Services
The Law Society
Vickers
Weightmans LLP
West Midlands Police

7. Personal Responses

Duffield, P & A
Enderby, Wendy and Graham
Giles, Roni
Greenwood, Tony Adult Protection Coordinator and Margaret Minoletti Adult Protection Officer
Hogan, George
Named Professional, Somerset Partnership NHS Trust
Named Professional, Worcestershire Mental Health Partnership NHS Trust
Phair, Lynne JP, Consultant Nurse OP (Safeguarding Adults)
Robinson, Lynsey Advocacy Empowerment Worker (Inclusion) Mencap
Steriu, Dr Andreea Isle of Man, Public Health Specialist
Wainwright, Jackie Pathways Development Nurse, Sheffield PCT
+ a number of anonymous responses and people who wished to be anonymous

8. Service Users

Beyond Existing
Bristol LD SU
14 Cedar House SU
22 Greenwich Council SU Forums
Hants SU
Neighbourhoods and Community Care Sheffield SU
40 Newcastle SU Forum
Newcastle Service User Response
8 Normanton Senior Citizens/Hemsworth and District OP Forum (Hope)
Oxford OP Forum
Reach SU Forum
Reach Staff Forum
Reach Individual responses
SEPT Services users
SEPT SU Focus group
13 Telford and Wrekin Service Users
20 Thurrock Council Disability Forum
8 Waterside SU
+ a large number of anonymous responses

Appendix C: Report on the Consultation Process

February 2009 – Executive Summary

1. This report outlines the **consultation process** on 'Safeguarding Adults' – carried out by the Department of Health, the Home Office, the Ministry of Justice and the Attorney General's Office. The consultation was launched on 16th October 2008 at the House of Commons and ended on 31st January 2009. This paper documents the consultation process and a separate report will analyse the responses.
2. The **main question** posed by the consultation was whether and how the *No secrets* guidance needed to change to enable society to keep adults safe from abuse or harm. This included whether additional legislation was necessary.
3. An **engagement strategy** was developed to set out the government commitment to a very wide listening process, and to stimulate a wide debate about the future of safeguarding with a large and diverse groups of stakeholders. This strategy was characterised by:
 - a) A focus on multi-agency partnerships discussing safeguarding as local partnerships; this meant that professionals from health, local authority, criminal justice, people in their capacity as citizens and others all worked together to discuss and debate the way forward;
 - b) Separate events for people as citizens, whether or not they had experienced old age, learning disability, mental health needs, or other forms of 'vulnerability', to articulate their views and experiences.
4. This engagement strategy delivered:
 - **Sixteen large multi-agency consultation events across the country from Newcastle to Exeter.**
 - **Targeted events for the Criminal Justice sector; the NHS, and Housing.**
 - **A survey by the Association of Chief Police Officers (ACPO) of police forces** in addition to organising police discussion events. The police also participated in many of the multi-agency events.

- **Separate consultation events for over 300 people with learning disability** organised through Valuing People and the National Forum, and separate events for older people.
- An advert in the national equalities newspaper for external organisations to bid for funding to run **small equalities local projects** to consult with hard to reach groups. 11 of these were funded. These included 900 people with mental health needs and many people from BME communities. A total of 2,000 people were consulted by this method.

5. Quantifying the outcome:

- A total of 228 events were supported, with approximately 12,000 participants.
- Over 3,000 of these were people who were service users/citizens/vulnerable adults.

6. Speakers/Participants

Speakers led and participated from all the different sectors involved in safeguarding. The Director of Public Prosecutions, human rights lawyers, police, directors of social care, CE of PCT's, regulators, advocates, probation staff, ambulance staff, care providers and safeguarding leads all discussed and debated the future direction of safeguarding.

People with physical disabilities were on the platforms as were people with learning disabilities, older people and people with mental health needs. One of the main messages from the events was that safeguarding to be successful must be a multi-agency partnership with everyone involved. Safeguarding is increasingly recognised as everyone's business.

7. Evaluating the process

The overwhelming message from the feedback shows that the events generated positive and energetic debate about the consultation. Many of the consultation questions were debated during the events and many ideas and experiences shared. Written responses were also invited. The events were booked out quickly and many people wanted more events and more time to discuss what they thought were fundamental issues. Some people thought there were too many questions in relation to the time available – and that they were difficult questions.

On some issues, there was consensus on others there was a wide range of views. Participants were however, overwhelmingly engaged, knowledgeable and passionate about safeguarding, about the quality and safety of people’s lives and very keen to contribute to the consultation.

Main Report on the Consultation Process

1. Introduction

1.1 A cross governmental consultation on the review of the *No secrets* guidance entitled ‘Safeguarding Adults’ was launched by Phil Hope, DH Minister for Care Services, on 16th October 2008 at the House of Commons. The consultation period ended on 31st January 2009. This paper documents the consultation process; a separate report will analyse the responses.

2. Background

2.1 The *No secrets* guidance was issued jointly by the DH and the Home Office in 2000. In February 2008, the Department of Health, the Home Office, the Ministry of Justice and the Attorney General’s Office launched a review of the guidance.

2.2 A consultation document was developed through discussions across the country with a wide range of people. It was published in October 2008. It posed the central question whether and how *No secrets* needed to change to enable society to keep adults safe from abuse or harm. It then asked a large number of questions, which people were asked to choose between. The document set out the consultation questions in nine themed sections as follows:

- Safeguarding is everyone’s business
- The new policy context: personalisation, community empowerment and access to criminal justice for all
- Leadership, prevention and outcomes
- Personalisation and safeguarding
- Health Services and safeguarding
- Community empowerment, housing and safeguarding
- Safeguarding and the criminal justice system
- The roles of guidance and legislation

- The definition problem

3. An Engagement Strategy

- 3.1 An engagement strategy was developed prior to the launch to set out the government commitment to a very wide listening process and to ensure full engagement with large and diverse groups of stakeholders was achieved. This strategy included involvement with the public, local government, social care, the NHS, the criminal justice system, and service users especially older people, people with learning disabilities, and people with mental health needs.
- 3.2 The engagement strategy also set out the governance arrangements and the objectives to help deliver the public engagement phase to shape the review of *No secrets* as follows:
- To build positive relationships with key stakeholders so that they could act as ambassadors for reform, representing the consultation to their own stakeholders
 - To receive feedback on the consultation questions from all audiences
 - To generate ideas and to collect best practice examples
 - To receive feedback on the emerging perspectives and general direction of the proposals
- 3.3 A Programme Board was set up at the beginning of the review and four advisory groups were developed. The advisory groups remit was to provide advice to the review and to ensure full engagement was achieved across and within their own organisations during the consultation phase.
- 3.4 The four National Advisory Groups were made up as follows:
- General Advisory Group (key voluntary organisations, police representatives, safeguarding leads, regulators,)
 - NHS Advisory Group (26 organisations represented including professional bodies and unions, acute, PCT and Mental Health Trusts, regulatory bodies and clinicians)
 - Criminal Justice Advisory Group (ACPO, Crown Prosecution Service, Probation) (These contributed separately)
 - Housing Advisory Group (CSIP Networks, SITRA, Care & Repair, Foundations, Supporting People, Chartered Institute)

4. Approaches to the Consultation Events and Activities

- 4.1 The DH – Care Services Improvement Partnership (CSIP) arranged and delivered a number of events across the nine national regions. (CSIP have been integrated back into the DH since 1st December 2008 and remain the regional delivery leads for local change.)
- 4.2 Each regional lead organised at least one large multiagency consultation event in their region to include representation from Primary Care Trusts (Commissioners and Providers), Mental Health and Acute Trusts, Local Authorities, Private Providers (e.g. Care Homes, Domiciliary Agencies), LINKs, local Charities, Voluntary Sector, Strategic Health Authority, Fire Service, the CPS and the local Police. Regional leads were also asked to arrange, support or facilitate a number of other targeted events such as focus groups with service users from Learning Disabilities, Mental Health and Older People’s services, local NHS meetings, safeguarding boards, strategy groups, and local partnerships.
- 4.3 Regional leads in partnership with the central team arranged targeted events for the Criminal Justice sector and the NHS, and worked with the Housing advisory group to present the consultation at eight of their large national events.
- 4.4 The DH invited external organisations to bid for funding up to £1000 to run small local projects to consult with hard to reach groups and advertised this through an invitation in the Guardian newspaper. The DH agreed to support 11 successful bids from different organisations such as BME groups, Physical Disabilities and MIND.
- 4.5 In recognition that some groups may not have been able to attend events a direct mailing approach was taken so that the consultation could be attached electronically and organisations were formally invited to respond. A sample of direct mailing is listed below and a full list is available within the engagement strategy:
 - Care Homes (e.g. BUPA, BML, Barchester, Southern Cross, Care UK)
 - User-Led Organisations (DH ULO Networks Action and Learning sites)
 - Leonard Cheshire
 - In Control
 - Financial Services Association

- Racial Equality Foundation
- Health Service Ombudsman
- Information Commissioner
- Monitor
- Lesbian, Gay, Bi-sexual, Transgender groups (Opening Doors Age Concern, Broken Rainbow, Consortium LGBT)
- RADAR

5. Regions

5.1 The nine regions across England are set out as follows:

- **Yorkshire & Humber** (South Yorkshire, West Yorkshire, North Yorkshire, East Riding of Yorkshire, Lincolnshire)
- **North East** (Northumberland, Tyne and Wear, County Durham)
- **North West** (Cheshire, Greater Manchester, Lancashire, Merseyside, Cumbria, Isle of Man)
- **West Midlands** (Herefordshire, Worcestershire, Shropshire, Staffordshire, Warwickshire, West Midlands)
- **East Midlands** (Derbyshire, Nottinghamshire, Leicestershire (including Rutland), Lincolnshire and Northamptonshire)
- **South East** (Berkshire, Buckinghamshire, Hampshire, Kent, Isle of Wight, Surrey, Oxfordshire, East Sussex, West Sussex)
- **South West** (Somerset, Bristol, Gloucestershire, Swindon, Wiltshire, Dorset, Devon, Cornwall)
- **Eastern** (Essex, Hertfordshire, Bedfordshire, Cambridgeshire, Peterborough, Norfolk and Suffolk)
- **London**

6. Format of the Multiagency Regional Events

6.1 The nine sections within the consultation document ask nearly 100 different questions on the safeguarding themes. The regional leads attended preparatory meetings to discuss the best way to facilitate as full a debate as possible within the constraints of a multiagency one-day event type format. Templates were developed to facilitate accurate records of all responses to the questions at each of the large events.

6.2 It was agreed that the format for the events would be primarily organised to spend as much time in discussion with participants and presentations would be as concise as possible to set the scene and to facilitate discussion for each of the workshops. Materials were developed in four themes listed below. They were arranged by selecting pertinent questions from the document.

- Prevention (Leadership, prevention and outcomes)
- Empowerment (Personalisation, managing risk, managing choice)
- Response (Access to criminal justice)
- Guidance and Legislation (Guidance and Legislation)

6.3 The four workshops above contained 19 standard questions and additional questions were used from the consultation document at some of the large events. All participants at the multiagency events were also encouraged to answer all or any further consultation questions as an individual or organisation and respond directly to the *No secrets* review email address.

6.4 Six events specifically addressed the interface between safeguarding and personalisation policy. At these events there was a mix of professionals working in safeguarding, and not knowing very much about what personalisation meant in practice and professionals working in personalisation, who did not know much about how safeguarding worked in practice. These were some of the events where people appeared to learn the most from each other, and where new common ground and interests were identified and common messages developed.

7. Service users/Citizens/Vulnerable adults

7.1 All the multi-agency consultation events were open to people to attend in their capacity as citizens rather than in any professional capacity. Most events had participants in this category.

7.2 Additionally The Valuing People Support Team organised a national consultation with people with Learning Disabilities. Working with the National Forum, the Regional Forums, Inclusion North, Making Connections, Rotherham Speak Up, they facilitated regional events which enabled 326 people with Learning Disabilities to have their voices heard. The report of this is published.

7.3 There were also a number of events specifically for older people, some organised by the consultation team and others by local authorities and other organisations.

7.4 The Consultation team published an advert in a national newspaper asking for bids for consultation events for harder to reach groups to be assisted to participate in the consultation. Eleven bids (table below) were selected which reached 2,000 people. These events were often with interpreters, for example for the Punjabi community and the Chinese community and, importantly, with community leaders. These became a very important part of the consultation.

Name	Target Group	Sample Size	Description of Project
SAHELI Group	Black and Minority Ethnic Community	120	Located in Gillington in Bradford, to include younger and older adults, men and women, BME and English people from this community.
ACWDC (African Caribbean Women's Development Centre)	Black and Minority Ethnic Community	200	ACWDC has partnerships with other BME charitable organisations and links with hard to reach groups.
Social Care Workforce Research Unit and Lancaster Older Peoples Forum	Older People and carers living in rural areas.	20	To listen to the views of older people and carers who face challenges associated with a declining service infrastructure as a result of their rural location in Lancashire and South Cumbria.
Middlesbrough 1st	Self-Advocacy and Personal Development for adults with a learning disability.	80	Service users, carers and professionals consulted using links within supported tenancies, independent living, Day Centres and care home environments.

Name	Target Group	Sample Size	Description of Project
SIFA Fireside	SIFA Fireside works with people that are socially excluded or disadvantaged, the homeless and health inequalities.	100-150	Local Birmingham based charity that provides support through emergency resettlement and tenancy support, counselling and specialist day and residential alcohol service, also works with offenders and ex-offenders.
Medway Council	Physical Disabilities Groups.	40	Clients within a disability resource centre and 3-4 clients who self advocate and are survivors of abuse. This project also encompassed engagement with carers and the older people's partnership.
BACC (Bradford Alliance on Community Care)	Older People in Bradford Community.	TBC	Engagement with older people who lived alone in private accommodation with family support, people in sheltered housing projects, those from west Indian heritage and people from south Asian heritage.
MIND	People with mental health problems.	1000	Mind engaged with Mindlink a network of people with direct experience of mental distress, Mind in Action the campaigning network, Local Mind associations which are voluntary organisations providing services to people with mental distress, and DiverseMinds a network of people and organisations with an interest in mental health and black and ethnic minority communities. This project also facilitated in-depth focus groups.

Name	Target Group	Sample Size	Description of Project
Kirklees User Voice	People who experience mental distress.	40-60	The Kirklees User Voice project is led by mental health service users and included people from BME communities.
LAEP (Latin American Elderly Project)	Older Latin American community living in London.	50	Ethnic minority groups that are linked to the Resource centre and included not only people from Latin America but also Africans and Spanish Europeans citizens who reside in London.
Rethink	Rethink is a voluntary organisation providing mental health services.	20	People With Mental Health Problems who have direct experience of the safeguarding procedures in Bradford Metropolitan District Council area
Totals		2,000	

- 7.5 A large number of organisations spontaneously organised consultation events with people they worked with. Housing organisations organised tenants meetings and service user events; local authorities organised a huge number of events where people they were working with could contribute, and voluntary organisations contacted and listened to the people they represented.
- 7.6 Feedback from many of these events showed that these events were a journey in participation and in learning. Many of the participants took part in such an event for the first time and many found their experiences taken seriously. Some people found it difficult to talk about sensitive issues. Others were very pleased to do so. Some prepared a DVD with their messages, and some of the facilitating organisations reported they learnt a lot, and that the messages sometimes challenged their own views.

8. Conclusion

- 8.1 The nine regions hosted **16** large multiagency events with approximately 1,900 participants. **Four** targeted events were hosted for Criminal Justice,

- Probation and NHS with 200 participants and attended **8** Housing and Supporting People events with approximately 800 participants. An additional **34** other targeted events were supported with over 5,000 participants.
- 8.2 The regional team worked with their local colleagues to ensure an additional number of meetings and events were held, **147** of these were recorded with an excess of 3000 participants. The results are represented in table 1.
- 8.3 The Valuing People Team focused on engaging with people with learning disabilities and held **8** different events with a total of 318 participants and there were at least **11** further events with over 3,000 participants with hard to reach groups.
- 8.4 The total number of events facilitated by central government was **228** with **12,000 participants** from a variety of groups across all sectors. This number does not include the numerous events held by safeguarding teams, by members of the advisory groups, additional regional events held by citizens and organisations, feedback from direct mailing and personal responses to the consultation.
- 8.5 The regional events were well received with good opportunities for networking, information sharing and informed debates on the issues raised. For some people this was the first time they had discussed safeguarding issues. For others safeguarding was part or all of their work and they were very knowledgeable and yet open to new ways of working.
- 8.6 The overwhelming majority of the feedback on the events was positive giving people a real opportunity to be involved in this consultation and to register all their comments as well as their responses to the workshop and consultation questions. There were however people who wanted more events, more time for discussion and who commented that it was difficult to address all the questions in one event. The main positive comment was that it was a valuable opportunity to reflect and share learning and the main criticism was the need for ‘more’ events and further opportunities to share experiences and develop a better understanding.

Appendix D: List of organisations working with Equalities, BME/Hard to Reach Groups, participating in the consultation

AEA
BACC OP Forum
Bristol LD
Dorset OP SU
Hampshire SU Forum
Hampshire LD Forum
Kirklees MH/BME
Lancaster Forum OP
Latin American Elders
London MH Peer SU
Mind Networks
Mind MH (Survey)
Mind Focus Groups
Medway Council PD
Medway Council Substance Misuse
Medway Carers
Newcastle SU and LD
Newcastle Elders
Neighbourhoods and Comm Care Sheffield
Norfolk Pensioners
Normanton Senior Citizens
North West BME
Oxford OP Forum
Redbridge OP Forum (residential care)
Redbridge Dom Care SU
Rethink
SEPT MH SU Focus Group
Sutton & Surry MH SU
SAHELI BME
SIFA Fireside
Thurrock Disability Forum
Thurrock TOFFS OP

Glossary

ABE	Achieving Best Evidence
ACPO	Association of Chief Police Officers
ADASS	Association of Directors of Adult Social Services
AEA	Action on Elder Abuse
AGO	Attorney General's Office
ASBO	Anti-Social Behavioural Order
BBA	British Banking Association
BSA	Building Society Association
BMA	British Medical Association
BME	Black Minority Ethnic
CDRP	Crime and Disorder Reduction Partnerships
CLG	Communities and Local Government
CPS	Crown Prosecution Service
CQC	Care Quality Commission
CRB	Criminal Records Bureau
CSCI	Commission for Social Care Inspection
DH	Department of Health
DoLs	Deprivation of Liberty Safeguards
DTC	Duty to Cooperate
DWP	Department of Work and Pensions
EoC	Essence of Care
FACs	Fair Access in Care Services
GMC	General Medical Council
GP	General Practitioner
GSCC	General Social Care Council
HC	Healthcare Commission
HMIC	Her Majesty's Inspectorate of Constabulary
HO	Home Office
ICO	Information Commissioner's Office
IMCA	Independent Mental Capacity Advocate
ISA	Independent Safeguarding Authority
LGO	Local Government Ombudsman
LSCB	Local Safeguarding Children's Board
LSP	Local Strategic Partnership
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MCA	Mental Capacity Act
MHA	Mental Health Act
MoJ	Ministry of Justice
MOU	Memorandum of Understanding

NHS	National Health Service
NMC	Nursing and Midwifery Council
NOMS	National Offender Management Service
NPSA	National Patient Safety Agency
NPIA	National Policing Improvement Agency
PA	Personal Assistant
PACE	Police and Criminal Evidence Act
PCT	Primary Care Trust
PPU	Public Protection Unit
QAF	Quality Assessment Framework
RSL	Registered Social Landlords
SAB	Safeguarding Adult Board
SAR	Suspicious Activity Reports
SE	Significant Event
SHA	Strategic Health Authority
SUI	Serious Untoward Incident
TSA	Tenant Services Authority
VPO	Vulnerable Persons Officer



Criminal Justice System: working together for the public

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