

NO SECRETS REVIEW CONSULTATION

Draft response from KASS

1. Leadership

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

The leadership of safeguarding nationally needs to be shared between the Department of Health, the Home office and the Ministry of Justice. These different agencies need to work together to ensure that guidance and legislation in co-ordinated and that they are all committed to the same outcome. Adult abuse needs to be shared within social and criminal policy. Both need to focus on empowering victims by providing information and support to enable them to make meaning full choices and decisions in a safe environment.

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

The leadership of safeguarding adults is appropriately sited within local authority adult social services departments. There is considerable expertise in working positively with people who need support and help to live their lives free from abuse. However there needs to be a mandate for partner agencies to actively contribute to and support safeguarding work. This should include; police, NHS, housing, and probation.

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

All local authorities have developed their own safeguarding arrangements and where these work well it would be counterproductive to make changes. Resources are limited and it is important that safeguarding is built in to JD's, with clearly stated accountabilities. Safeguarding receives greater focussed attention where there is a safeguarding champion to lead on policy and standards, and co-ordinators to support multi agency operational safeguarding work. Where local procedures have already been developed and are working well, implementation of national procedures would need to be managed carefully by being used to update local procedures and protocols.

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

Local safeguarding arrangements led by the board/committee should be presented in an annual report identifying activity undertaken in all aspects of the work, activity planned and identify areas for development. This report needs to be submitted to the Care Quality Commission and to elected council members. It also needs to be published in accessible formats. Lead partner agencies need to contribute to the annual report and the report should go to their agencies executive bodies.

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

Each local NHS body must have procedures to safeguard adults from abuse and dedicated staff to ensure that this has priority within the Trust governance arrangements. These procedures must support locally agreed multi agency arrangements. NHS bodies should be mandated nationally to engage fully in all

aspects of the safeguarding agenda and to take account of the requirements of their locality. PCTs should lead for the NHS in the delivery of performance in safeguarding vulnerable adults as a key deliverable within World Class Commissioning.

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

The Care Quality Commission should have the lead responsibility for ensuring that safeguarding arrangements within the regulated care home sector are managed appropriately. They should be actively engaged locally in any safeguarding adults' arrangements involving registered providers. Currently CSCI do not attend many safeguarding adults planning meetings even though they may have provided the required regulatory information and which may enable them to make decisions about actions they may wish to take. Receiving minutes of meetings provides the summary of discussion and action plans only, which may be insufficient to inform actions they should take.

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

The responsibility and accountability for safeguarding locally needs to be at a sufficiently senior level within the local authority to mandate actions that need to be carried out by all partner agencies. There must be joint multi agency responsibility to act at an operational safeguarding level in cases. Decision making at planning, review, case conferences and post abuse monitoring mandates action by staff and managers in all agencies. Where problems occur the Board representative for the agency concerned must be informed and address the concerns.

2. 2. Prevention

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

Prevention is an essential aspect of the safeguarding agenda. With more preventative work undertaken we should be able to reduce the level of abuse over time. A great deal of preventative work is undertaken, for example, and part of this is in the form of training of managers and staff in all agencies and services working with vulnerable adults. Currently work is underway with customers to develop an adult protection awareness training programme to enable the delivery of training to customers and users of services and carers along the lines of the expert patient model. The training the trainer courses enable staff and managers in services to deliver awareness training to their staff which can be tailored to their specific needs. We also have a very effective model of safeguarding awareness raising for older people in a rural area through a multi agency supported Comic Relief project. The project worker gives talks to small groups of older people in pop in centres in an isolated rural community. She follows up contacts with care homes in the area and has worked with an adult protection co-ordinator to help care home management, staff and residents to understand more about adult abuse and challenge it. The worker has also worked with elderly victims of abuse to build their confidence through targeted sessions which are evaluated.

The 'Quality in Care' project is working with care providers assessed as poor by CSCI, contract staff and/or commissioners. Focussed work in undertaken in partnership with these services which has improved the quality of care provided and

reduced the probability of abuse developing from poor care practices. Where the services have not been able to demonstrate a significant improvement in the quality of care provision, contractual and commissioning action is taken.

We ensure that safeguarding issues are always discussed with direct payment recipients when they are about to commission their own care either through an agency or through the recruitment of a personal assistant. We always offer to fund and carry out CRB checks on behalf of direct payment users who are recruiting personal assistants. This, together with well planned recruitment practices, should reduce the risk of unsuitable people getting access to people needing support.

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

It would be helpful generally to have a national prevention framework linked through all the current systems, although the strategy should be developed locally in line with local priorities. This would ensure that everyone involved in community safety at all levels would be aware of their responsibilities in the prevention of abuse. It is important to ensure that safeguarding adults' agenda is joined up with the wider remit of community safety including domestic abuse, MAPPA, MARAC and safeguarding children

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

Whistle-blowing policies need to be strengthened. Staff and managers who blow the whistle on poor and abusive practices in services often find themselves victimised by their own organisation and or by their colleagues. Even when their report of abuse/crime is recorded, noting that they wish to remain anonymous, the information becomes known if criminal prosecution or disciplinary action is taken. They may be the only witness to the abuse or crime and their identity is known. We rely on whistle-blowers to alert us to abuse but find it difficult to protect them from being victimised as a result of their actions to protect victims of abuse. Legislation needs to be strengthened to protect whistle-blowers but it cannot protect them from being ostracised by fellow workers.

3. Outcomes

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

The Safeguarding Adults National Framework of Standards published by the ADSS and written in partnership with safeguarding leads across the country from local authorities, NHS, ACPO and CSCI already provides a framework for addressing safeguarding concerns. This could be developed into a Code of Practice to support legislation designed to protect people who are vulnerable to abuse.

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

Yes.

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

We must take time to evaluate safeguarding interventions from the perspective of service users and, where appropriate, carers. We must listen to their views not just at the point we close the safeguarding alert but also three/six months on. It would be most valuable if this evaluation could be carried out by a voluntary organisation and

for responses to be anonymised so that clients and carers feel free to express their views. The outcome of the evaluations could be fed into safeguarding committees and operational staff groups to enable responses to influence future practice.

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

Yes this should be reviewed and developments linked to a competency framework for all agencies. This framework needs to be backed by training, supervision and both practical and academic assessment of competency. At a higher level this could be developed into post qualifying modules as part of a Masters degree. A post qualifying award in safeguarding adults would assure employers that a staff member was competent to carry out safeguarding adults work.

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

Yes it would be very useful to have such a data base. Currently publishing executive summaries of SCR's for safeguarding adults cases is not widespread, although practice in Kent and Medway is to publish summaries on their website, and therefore cross authority learning is limited. SCR's should be triggered by death or serious harm to a vulnerable adult, or where systemic abuse is identified within a safeguarding case and where problems were identified about how organisations worked together to address these concerns.

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

Yes this would ensure that criminal justice systems (police and CPS) were accountable in addressing abuse cases. If legislation were to be enacted along with codes of practice this will ensure that all agencies understand their role and responsibilities for safeguarding adults. The lack of legislative backing for safeguarding adults has resulted in lack of capacity within agencies, which limits and delays effective action in some cases.

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

That the vulnerable adult victim is safe from abuse, or the risks are much reduced and that they are able to live their lives free from abuse, empowered and able to protect themselves from further abuse or to raise an alert should this be necessary.

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

There needs to be legislation which is backed up by a Code of Practice which provides requirements for all aspects of the safeguarding work. This has already been demonstrated by No Secrets guidance which has taken 8 years to become integrated within all local authorities and, a CSCI response, there are still problems with engaging with NHS and criminal justice systems in parts of the country. (Not in Kent and Medway) Positive risk assessment and monitoring should be an integral part of the developing personalisation agenda. Reducing risks can be achieved by empowering users of direct payments/ individual budgets through providing them with

information and support to safely recruit and employ staff, as well as to monitor and review outcomes achieved through personal budgets.

Q3i. How much does adult protection **currently cost**? How is it funded? What evidence is there, if any, that increased funding would lead to better outcomes?
The cost of staff solely working in safeguarding for our authority can be calculate, but this does not take account of the lost care management staff and managers throughout the county who assess, investigate and manage safeguarding casework. To this muse be added the costs of safeguarding co-ordinators within the four acute hospital trusts, the three PCT's and the six police areas and their dedicated HQ lead. Currently all the safeguarding staff employed by the local authority are funded by the local authority and the NHS and police employ their own co-ordinators. There are currently three posts funded by the multi agency committee (NHS, LA and Police funding) a multi agency trainer, administrator and the committee administrator. The MA Executive Board have agreed to fund a Board Manager and an additional dedicated trainer in early 2009.

4. Managing risks

Q4. In an environment where an increasing number of people will be taking responsibility for arranging their own support, we need to have a debate on how their interests can be safeguarded. What aspects of safeguarding do we need to build into personalisation? What training, risk assessment and risk management should we use? Please tell us what you are doing locally and what more needs to be done.
Locally we are working with user and carer groups to develop a positive risk assessment process to ensure that our focus is on empowering users to make their own decisions and to protect themselves.

5. Managing choice

Q5. What aspects of personalisation – greater independence, choice and control – can we build into safeguarding? How do we better reflect service users' informed choices? How do we facilitate informed self-determination in risky situations and in the safeguarding process? How can we move forward on this agenda?
It will be important to ensure that there is a balance between promoting opportunities for people making their own choices and arranging their own support and providing advice guidance and where appropriate support to carry out effective recruitment processes. We need to provide information to help people to understand: how to address safeguarding and quality concerns if and when they arise within their home situation, how they can get help if abuse issues arise how to maintain appropriate review and monitoring arrangements and risk assessment in partnership with recipients of a personal budget

6. Health services and safeguarding (this section will be completed in full in partnership with NHS colleagues as part of the multi agency consultation event on 7th January)

Q6a. How is the **No secrets guidance being implemented** and applied to ensure that it enables staff in the NHS to recognise, investigate and act on abuse? Are local arrangements effective? What more should be done?
Although following the publication of No Secrets and the development of the multi-agency adult protection documents in August 2000 most NHS Trusts in Kent had shown some commitment to safeguarding adults, this was often at a local operational

level and very inconsistent. This appeared to be because Trust Boards and Senior NHS managers had not fully engaged with the safeguarding agenda. To address this the safeguarding committee agreed in December 2005 to require each Trust to complete a Board and Senior management safeguarding audit which needed to be signed off by each Trust's Board. This audit report required the Trusts to identify action plans to address areas of concerns and to report progress to the committee on a regular basis. This has been a significant challenge to most Trusts at a time of restructuring. However most Trusts have completed their audit and have presented regular action plan progress reports to the committee. Every Trust now has a safeguarding champion although for some it is still part of their day job. Each PCT and some acute hospitals have dedicated safeguarding leads.

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

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

The NHS safeguarding leads are all the above but their responsibilities should be shared across the various disciplines within the organisation. Everyone within the trust needs to know what their responsibilities are with regard to safeguarding and how these are to be met.

Q6d. Is there a need for **regional safeguarding forums** where health organisations can share good practice and learning? If so, what would they look like? These are beginning to develop across Kent and Medway as all the NHS Trusts with the exception of the Partnership trust have at least one safeguarding lead manager / co-ordinator.

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

This has been the subject of concern within safeguarding and identified as an issue within a recent serious case reviews as SUI processes are used by some NHS organisations to avoid opening up their service to multi agency scrutiny through safeguarding arrangements. In our safeguarding policy and protocols, where serious abuse is alleged within an NHS provision, the recommendation is that the issues should be co-ordinated through safeguarding and SUI processes can be used to determine the facts of the case. The safeguarding arrangements are responsible for assessing the implications for the victim and the risks to any other vulnerable adults and children and for ensuring outcomes for perpetrators are managed in the most appropriate manner. As the SUI process is a statutory responsibility for the NHS there needs to be a nationally agreed interface with safeguarding processes. This should ensure that Serious Case Reviews for adult abuse cases can include information gathered through SUI investigations.

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

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

Currently the number of alerts reported through mental health services remains low, which is the experience elsewhere as well.

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

It continues to be a challenge to engage GP's within safeguarding arrangements.

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

See response for 6g. Mental Health services need to be fully engaged within all aspects of the local safeguarding arrangements, through senior management leadership of the MH Trust and dedicated safeguarding specialist staff, to ensure that safeguarding is integrated within all aspects of the trust's business.

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

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

7. Safeguarding, Housing and Community Empowerment

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

It is clear that housing providers have a key role in safeguarding within the community. Housing providers need to be engaged fully within the local safeguarding arrangements. This is particularly important for sheltered and supported housing project development. Positive risk policies need to encourage and support people to remain in their own homes or in appropriate community housing rather than move into care homes, because they cannot manage alone or fear for their safety. It is vital to develop local community support networks and services to prevent older and disabled people becoming isolated in their own homes.

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

Managers and staff working in the housing sectors need to be committed to the principle of zero tolerance of abuse within the services they manage. They need to empower tenants to understand their rights to live free from abuse / crime and to know how to report abuse / crime concerns safely if these relate to personal issues or concerns they have for fellow tenants.

8. Access to the criminal justice system (Kent police are strongly committed to the safeguarding adults agenda. They have specialist adult abuse officers in each of the public protection units and at headquarters) Officers will be supporting the multi agency No Secrets Review Consultation event on 7th in Kent. They will contribute to a response to the questions in this section).

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

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

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

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

What are the advantages and disadvantages of joint investigations or joint investigation teams? What helps a joint investigation to work well?

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

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

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

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

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

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

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

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

Q8m. What can be done to **improve identification** of vulnerable adults by criminal justice practitioners? For example, could local arrangements be made to provide the

police with local groups who might be able to offer advice?

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

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

9. Guidance and legislation

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

Publishing No Secrets as guidance in March 2000 has served to raise the profile of safeguarding adults. However it has also resulted in inconsistent developments of safeguarding arrangements across the country. It has made it difficult to engage some agencies in any more than a nominal way. This has not been the case in Kent and Medway because of the very strong leadership this has had from the Director of Social Services from the outset. The Safeguarding Adults framework of standards built on No Secrets, as it used the expertise of safeguarding leads across the country to ensure the guidance reflected operational reality. However, without legislative backing and no additional resources, safeguarding adults has remained a junior relation to safeguarding children. For some authorities only the development of the CSCI Safeguarding themed inspections has raised the profile of safeguarding adults. Whatever happens within this review it will be important to ensure that the principles of multi agency, joint working and shared responsibility for safeguarding adults is not diluted within a range of different documents for different agencies. This could fracture what many of us have worked to hard to pull together. There should be one overarching document (hopefully backed up by legislation) that includes Codes of Practice to ensure that engagement of all agencies and services.

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

New Legislation is essential to enable the aspirations of No Secrets to become a reality. Current legislation is disparate and complex. The POVA register is limited and abusers within the NHS and other non registered services cannot be registered. This will change with the ISA but the standard that needs to be reached to get listed as unsuitable has yet to be tested. In reality, accessing suspected victims of abuse can be obstructed by abusers in many ways, which limits agencies from intervening effectively.. Two of our serious case reviews also provide examples where powerful family members were able to obstruct access for community care assessment to be carried out. Both SCR's were carried out following the deaths of the adults concerned. Prosecution did not follow in either case although section 44 of the MCA would now assist as there was evidence of wilful neglect. At the time Section 127 of the 1983 MH Act could have been used but in one case the parent was assessed as lacking capacity and in the other the CPS did not feel that the evidence was strong enough. There are other cases which illustrate the shortcomings of current legislation Legislation is needed to provide a duty to investigate allegations of abuse, carry out assessments in relation to concerns, share information and as last resort to enter premises and where necessary remove a person to a place of safety for an assessment to be carried out. This last element would need to be authorised by a magistrate who has been provided with evidence of why this action is necessary.

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

Safeguarding Adults Boards/Committees should be convened with legislative backing. This will ensure that all agencies have a duty to be part of the Board/Committee and have a statutory to carry out the responsibilities laid out. In Kent and Medway we now have excellent support at both committee and executive board level but this may not be the case elsewhere in the country. The legislation should include a duty to commission and contribute information to SCRs. In Kent and Medway we have long established criteria for carrying out SCRs and we have an independent chair of the SCR panel. It would be useful to have nationally agreed criteria within the code of practice for the legislation.

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

Legislation and a code of practice should include a wider duty to co-operate for all agencies and services that provide or may provide services or support to adults who are vulnerable to abuse due to their inability to protect themselves from harm. It would need to be enforced as part of the Act, failure to co-operate would be a criminal offence.

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

As a last resort there should be a power to enter premises in these circumstances and if necessary remove the suspected victim to a place of safety for an assessment to be carried out. This power should be part of the multi-agency arrangements and should include the most appropriate professional(s) to accompany the police following agreement by a magistrate for the action to be taken.

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

In such cases there would need to be a careful assessment of all the circumstances, especially of the person's mental capacity to understand the consequences of their behaviour. If such action is take, and following assessment it is clear that the adult does have capacity to understand the risks they are running i.e. it is not being intimidated, or mentally ill and has been provided with options and opportunities then the adult should be allowed to continue with their chosen lifestyle.

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

There should be authorisation by a magistrate except in emergency situations where a senior police officer may authorise such action

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

Yes. It is clear from the evidence obtained from safeguarding cases that many vulnerable people with capacity are ill-treated and neglected and are unable to protect themselves or move away from the situation where this abuse occurs. This is usually because of intimidation/bullying/threats or moral blackmail and if they are

given an opportunity to remove themselves or the abuser then they can be free of the abuse. This mirrors the issues in many domestic abuse cases. However in some cases when this occurs within a family setting the victim wants the abuse to stop but does not want the perpetrator to be subject to criminal action. However, as with domestic abuse cases, the police can and will prosecute if there is evidence of crime that does not require the victim to give evidence. Each case needs to be carefully considered to ensure that the outcome of criminal or alternative action provides the best outcome for the victim. There may be occasions where the importance of ?????? family relationships may indicate that legal action is not in the best interest of the victim, although case reviews should ensure that further abuse does not occur.

Q9i. Should there be a **power to remove an adult** who does have capacity and who does not consent, but who is thought to be being subjected to harm?
As with previous responses there needs to be an assessment to determine the views of the adult concerned and to ensure that they have sufficient information to make meaningful decisions and choices. There is also a need to determine if they are really making their own decision or is this based on intimidation.

Q9j. Should **force** be used to remove a person who is self-neglecting or self-harming?
Only if it is considered that they are at risk of significant harm or death and this should only be done under the appropriate section of the Mental Health Act with the support of a psychiatrist and approved mental health practitioner. If it is considered that use of the Mental Capacity Act would be more appropriate and less restrictive then it can be used to provide an assessment and appropriate support. Any detention under the MCA will from April 09 need to be authorised if deprivation of liberty is an issue.

Q9k. If a person is **removed, where** should they be taken, for what purpose and for how long?
The initial sectioning assessment of their needs should dictate where they should be taken but it should never be to a police station. The length of time should be sufficient to carry out a full assessment of needs and for treatment if necessary under the Act. If the MCA has been used the person needs to be taken to an environment (NHS assessment unit) where they can be assessed and provided with support, care and treatment if necessary. Again any detention under the MCA will from April 09 need to be authorised if deprivation of liberty is an issue.

Q9l. Is current **care standards legislation sufficient** for closing down poorly performing care homes in a timely and effective manner?
Current CSL could be effective in these circumstances if the regulatory authority were to fully support multi-agency safeguarding arrangements. Currently limited engagement of CSCI (due to lack of staffing capacity) within local safeguarding planning, review and case conferences restricts access to concerns of professionals at meetings.

10. Definitions

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

- enable practitioners to decide which groups of people they believe require special support?

The current definition of a vulnerable adult has been challenged and is considered to be paternalistic but it does provide a basis from which to determine who may need help and support through the safeguarding arrangements if they are unable to protect themselves. Many elderly, disabled or ill people do not consider themselves to be vulnerable and may be able to live their lives without any assistance from the local authority. Safeguarding arrangements would not be relevant unless their circumstance change and they become victims of abuse and may need help to stop the abuse and to return to their desired lifestyle. The current definition allows for safeguarding support to be provided to a wide range of people including carers and others who do not neatly fit into social care client categories if and when they are unable to protect themselves from significant harm. The definition within the Adult Support and Protection (Scotland) Act 2007 provides the three elements which need to combine for safeguarding support to be used. However this has some limitations. Whatever definition is decided safeguarding arrangements should be available to support those who need help and cannot protect themselves from harm due to their personal characteristics and their circumstances. It should neither include everyone who is elderly, disabled or ill by virtue of their condition or be used to exclude a person in need of safeguarding support due to their not meeting eligibility criteria which are subject to changes.

- provide clarity on what 'wrongs' we want the new No secrets guidance to put right?
The definition within No Secrets is clear and covers abuse which results in significant harm to, or exploitation of the victim. This definition has been helpful in managing local safeguarding arrangements as it is accompanied with examples of types of abuse and the circumstances in which abuse may occur. What we need is clear definitions of which adults should be safeguarded and appropriate consequences for those who abuse.

- clarify how bad the 'wrong' has to be to warrant a response, i.e. define the threshold needed to justify a response?
The difficulty of establishing a threshold for safeguarding intervention is that what may appear on the surface to be a very minor issue may have major life changing implications for the victim(s). There have been examples of the person disclosing a minor abuse initially and, when they feel able to trust a practitioner, disclosing serious criminal offences. If the information received by a social care, health or police representative is believed to constitute abuse then a formal response will be made. However it is important that the response is proportionate to the concerns and flexible. Initially the issues appear minor and one level of response is indicated and this may be subject to change when information or the situation indicates this to be necessary.

- take into account those vulnerable by reason of a temporary physical or mental condition?
Yes there should be a safeguarding response even if the vulnerability of the victim is only temporary. Hopefully with some intervention while they are unable to protect themselves when their condition improves they will be able to return to their desired lifestyle.

- distinguish between abuses carried out by a person in a position of trust or power in relation to the victim and those committed by a stranger?

In general safeguarding arrangements do address abuse within positions of trust or power in relation to the victim. However there are circumstances when safeguarding support is valuable and essential especially when working in partnership with police. Abuse/crime committed by strangers on very vulnerable adults often needs the involvement of social care / health professionals to support joint investigatory action and especially in interviewing the vulnerable victims and in assessing the needs of the victim and providing when necessary appropriate levels of support post abuse. This could include developing witness profiles, supporting the victim through legal processes.

•• make reference to an adult being unlikely to be able to protect himself or herself from harm or exploitation?

Yes this part of the current definition is important because if the person can protect themselves from harm and exploitation then they will probably not need safeguarding support. They may then be referred to police, domestic abuse resources to trading standards etc.

Q10b. What language should we use? Is 'abuse' always useful or should we change to 'harm' and 'crime'? Is 'perpetrator' always useful (i.e. for neglect within families)?
It is vitally import to consider the language we use when addressing adult abuse. Abuse and/or crime are important terms to use in situations where regulated settings and professionals are involved. However it is important to be sensitive within situations where family members may have harmed the person they are caring for through ignorance or stress. There are however situations when relatives are wilfully abusing and neglecting and in these circumstances abuse/crime and perpetrator are important to be used so that the seriousness of the situation is clear.

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

The principles within these Acts must be central to every aspect of the care and support provided to people who are subject to safeguarding arrangements. They must be included within local safeguarding documents as principles underpinning intervention and support. They must also be integral to all aspects of the delivery of health and social care and within the criminal justice system. There are times when the provisions of the HRA appear to protect the perpetrator rather than the victim.

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