EXTRACT FROM THE DEPARTMENT OF HEALTH DOCUMENT SAFEGUARDING ADULTS – A CONSULTATION ON THE REVIEW OF THE "NO SECRETS" GUIDANCE

SUMMARY OF CONSULTATION QUESTIONS

1. Leadership

Q1a. Where should leadership for safeguarding adults lie nationally, and how should the various national organisations work together?
Q1b. Where should it lie locally? If within local government, then where in local government?
Q1c. Do we need a template for 'a local safeguarding job description' and national procedures for use locally?
Q1d. How do we know if a safeguarding board is working effectively? To whom should it be accountable?
Q1e. Where should leadership for NHS safeguarding issues lie? Do we want national procedures for the NHS?
Q1f. Where should leadership for safeguarding in the care home sector lie? What can be done to strengthen this?
Q1g. Given that there are multiple 'chains of command', how do we ensure that formal leadership roles are accompanied by appropriate authority levels?

2. Prevention

Q2a. Should we be doing more work on prevention? If so, where should we concentrate our efforts? If you are doing effective preventive work, please tell us what it involves.
Q2b. Should we develop a national prevention strategy for adult safeguarding which includes, for example, links with neighbourhood policing, with a human rights agenda, and with Health and Well-Being?
Q2c. Are whistle-blowing policies effective? What can we do to strengthen them?

3. Outcomes

Q3a. Would an **outcomes framework** for safeguarding adults be useful? If so, which indicators should we use within the wider responsibilities of local government, the NHS and the police force?
Q3b. Should we encourage **local annual reports** to be more evaluative?
Q3c. How can we **learn from people's experiences of harm** and their experiences of the safeguarding process in order to improve safeguarding?
Q3d. Should we review current arrangements for delivery of safeguarding adults **training**? Should we have national occupational training standards across all agencies?
Q3e. Should we have a national **database of recommendations** from serious case reviews at a national level? Should we review the effectiveness of serious case reviews as learning tools? What should trigger a serious case review, and how should the conclusions be disseminated?
Q3f. Should we develop **joint inspections** to look at safeguarding systems as a whole? Should this include the police (Her Majesty's Inspectorate of Constabulary) – as for inspecting local children's services?
Q3g. What are the desired **outcomes** of safeguarding work?
Q3h. Should there be **national safeguarding adults guidance** that incorporates training, outcomes and multi-agency procedures? How would this be integrated into the personalisation agenda discussed in chapter 4?
Q3i. How much does adult protection **currently cost**? How is it funded? What evidence

is there, if any, that increased funding would lead to better outcomes?

4. Managing risks

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

5. Managing choice

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

6. Health services and safeguarding

Q6a. How is the ***No secrets*** **guidance being implemented** and applied to ensure that it enables staff in the NHS to recognise, investigate and act on abuse? Are local arrangements effective? What more should be done?
Q6b. Are health organisations able to work with and adopt multi-agency guidance, or is it essential to **develop operational guidance** that adapts procedures into language, culture and structures appropriate to healthcare?
Q6c. What are the **responsibilities of the NHS safeguarding leads** – are they champions, professional leaders, awareness-raisers, data collectors and reporters? Can one person fulfil all these roles? If not, how should these responsibilities be shared?
Q6d. Is there a need for **regional safeguarding forums** where health organisations can share good practice and learning? If so, what would they look like?
Q6e. How do **procedures for investigating serious untoward incidents** (SUIs) fit into the multi-agency context of safeguarding?
Q6f. Are adult safeguarding **systems within the NHS effective**? If not, what are the specific challenges that need to be addressed?
Q6g. Are any parts of the NHS or healthcare sector **less engaged** and more in need of assistance to get on board with safeguarding?
Q6h. Is the **role of GPs** a crucial role for safeguarding in the NHS? Where is the existing good practice and what can be learnt from it?
Q6i. Are there particular issues in relation to safeguarding and **mental health**? If so, how should these be addressed?
Q6j. What **central leadership** role should there be (if any), and what function should it have (Healthcare Commission, Monitor, Department of Health, General Medical Council, Nursing and Midwifery Council, strategic health authorities)?
Q6k. What are the main **drivers for standards** in the NHS that safeguarding should be linked to?

7. Safeguarding, Housing and Community Empowerment

Q7a. Do we need stronger policy links between safeguarding and community development and empowerment? How can this be achieved at the national and the local levels?
Q7b. How can housing providers contribute to safeguarding? What could housing departments, housing associations and supported housing/living providers do to enable their tenants and residents to live safer lives?

8. Access to the criminal justice system

Q8a. How can safeguarding vulnerable adults be **better integrated** into the mainstream criminal justice arena?
Q8b. Are **police units adequately staffed** to respond to the increased reporting of adult protection issues? If not, what changes are needed?
Q8c. Is there a **need to develop a more formal system**, as in MAPPA and MARAC, with regular police-led safeguarding meetings for serious cases?
Q8d. Is there support for **multi-disciplinary teams/joint investigation teams** working together at the same location to assess intelligence, risk assess situations, take decisions on immediate action to safeguard vulnerable adults, decide whether a crime has been committed and whether the allegations should enter the safeguarding adults process? What are the advantages and disadvantages of joint investigations or joint investigation teams? What helps a joint investigation to work well?
Q8e. Police officers have considerable experience of **risk assessment and risk management**. Has that been sufficiently integrated into adult protection work and shared with the multi-agency partners, or should that be further developed? How should this be taken further?
Q8f. Should **information** about the safety of a person **be passed between** health and social care organisations, the ambulance service, GPs, the CSCI and the police? If so, can it happen now or does it need legislation? Should such information include incidents not amounting to abuse, but which may provide early indicators of the likelihood of abuse?
Q8g. Should we have **guidance on** if and when information should be shared, even when the victim expresses a wish that it is not shared?
Q8h. Should we look at ways of making it easier for people who may be vulnerable to **report abuse**?
Q8i. Would the proposal to have an **annual analysis/review** of all information held on each care/nursing home by all relevant agencies be likely to gain support from agencies, the public and the independent sector providers?
Q8j. **Financial abuse** appears to have increased steadily and to have diversified. Is there a need to explore the most common types and most effective responses? Should this include preventive strategies in consultation with the Financial Services Authority and the British Bankers' Association? Should banks, building societies and the Financial Services Authority be encouraged to share information that suggests financial abuse of vulnerable adults?
Q8k. What **strategic links** should there be between homicide reduction strategies, crime reduction partnerships, children's safeguarding boards, adult safeguarding boards, domestic violence forums and disability hate crime?
Q8l. **What else** is needed to increase the ability of the **police** to participate fully in adult protection/safeguarding?
Q8m. What can be done to **improve identification** of vulnerable adults by criminal justice practitioners? For example, could local arrangements be made to provide the police with local groups who might be able to offer advice?
Q8n. What more can be done to raise awareness in local areas of the **availability of intermediaries** to assist vulnerable adults with communication difficulties in criminal investigations and trials?
Q8o. **What else do you think would make a difference?**

9. Guidance and legislation

Q9a. Do we need an updated and refreshed ***No secrets*** **guidance**? If so, should it be one document for all multi-agency partners, or should there be separate documents for: the criminal justice system; the health sector; and local authorities, to include social care, housing and community safety?
Q9b. Is new **legislation** necessary and how would it help?

Q9c. Should legislation place **safeguarding adults boards** on a statutory footing be introduced? Should it include a duty to commission and contribute information to serious case reviews?
Q9d. Should we introduce a **wider duty to cooperate** in relation to safeguarding? Who would this apply to, how would it improve outcomes and how would it be enforced?
Q9e. Should there be a **power to enter premises** where it is suspected that a vulnerable adult is being abused? Should this power apply to: the police only; or social workers and other professionals as well?
Q9f. Should such a **power apply when an adult has mental capacity** and may be self□neglecting or self-harming?
Q9g. If a power of entry is supported, which **means to obtain entry** should be introduced (e.g. authorisation by a senior police officer or magistrate or other means)?
Q9h. Should an **offence of ill-treating or neglecting a vulnerable adult with capacity** be introduced?
Q9i. Should there be a **power to remove an adult** who does have capacity and who does not consent, but who is thought to be being subjected to harm?
Q9j. Should **force** be used to remove a person who is self-neglecting or self-harming?
Q9k. If a person is **removed, where** should they be taken, for what purpose and for how long?
Q9l. Is current **care standards legislation sufficient** for closing down poorly performing care homes in a timely and effective manner?

10. Definitions

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

Should it:

•• enable practitioners to decide which groups of people they believe require special support?
•• provide clarity on what 'wrongs' we want the new *No secrets* guidance to put right?
•• clarify how bad the 'wrong' has to be to warrant a response, i.e. define the threshold needed to justify a response?
•• take into account those vulnerable by reason of a temporary physical or mental condition?
•• distinguish between abuses carried out by a person in a position of trust or power in relation to the victim and those committed by a stranger?
•• make reference to an adult being unlikely to be able to protect himself or herself from harm or exploitation?
Q10b. What language should we use? Is 'abuse' always useful or should we change to 'harm' and 'crime'? Is 'perpetrator' always useful (i.e. for neglect within families)?
Q10c. How do we enshrine within safeguarding the principles contained within the Mental Capacity Act 2005 and the Human Rights Act 1998?