London Ambulance Service NHS
NHS Trust

Executive Office
Headquarters
220 Waterloo Road
London
SE1 8SD
Phone 020 7921 5221
Fax 020 7921 5127

www.londonambulance.nhs.uk

Department of Health
Wellington House
133–155 Waterloo Road
London SE1 8UG

29th January 2009

Please find enclose a response to the "No Secrets" consultation on behalf of the London Ambulance Service NHS Trust. This has been compiled by our Safeguarding Group, who have strategic responsibility for these areas of work.

Please note that we have only responded to those matters where we felt confident of our reference and expertise.

We should like to emphasise one consideration in particular. The Trust feels that safeguarding practice in relation to adults has not historically been a priority focus across the NHS. Although there are areas of good practise, not all Trusts have structures in place to comprehensively address this issue. The Trust takes the view that the need for a review of 'No Secrets' is not only to update the current guidance in line with strategic and practice developments which have evolved over the last nine years, but also to provide a definition of best practise to which the NHS can be appraised and monitored. There is a need for this area to be fully included within the inspection regime to achieve improvements in service provision.

The Trust feels it is also important that this issue should not been seen as additional work, to be undertaken by those who have an interest in the subject, but that safeguarding must be embedded throughout the NHS within everyday business. Automatic assessments, supported by robust guidance, should be routinely used within primary care and on emergency admission to identify those individuals' who require additional support. Safeguarding of adults should be regulated, developed and monitored within mainstream governance processes. Safeguarding related structures and mechanisms should be brought into line with existing related similar provision; for example, learning from Serious Case Reviews and the adoption of a cross-agency approach in keeping with the principles of the *Making Experiences Count* reforms. We feel that there are many advantages to adopting the aims and objectives of this programme.

We should also like to highlight the difficulties we can encounter in being involved in safeguarding work. Ambulance staff are often uniquely placed to identify vulnerable adults who are at risk or in need. Although services have systems in place in respect of individuals, partner organisations, including those within the NHS, often fail to appreciate the contribution that ambulance services' can make and how this can be used to improve services and inform investigations. In our experience, there is considerable variation in safeguarding mechanisms and in the awareness of partner agencies to access and use the contribution we can make; the position is exacerbated by the manner in which existing structures inhibit our participation (foe example capacity issues in releasing ambulance staff to attend strategy meetings etc). This has led to less involvement of ambulance services in safeguarding, not assisted by the concomitant lack of funding or recognition.

I do hope that our contribution will be of value and very much look forward to the outcome of the consultation. Please be assured of our commitment to progressing a unified and comprehensive approach towards safeguarding practice.

Yours sincerely

Fionna Moore
Medical Director

Gary Bassett
Head of Patient Experiences
Service Lead, Safeguarding

Consultation No Secrets - Questions & Answers

Chapter 3
Leadership

Q1a	Where should leadership for safeguarding adults lie nationally, and how should the various national organisations work together?	The Department for Health is a potential candidate however, given the responsibilities of Social Services Departments, in terms of investigation of matters which are not necessarily criminal, and their role within commissioning, the Department of Communities and Local Government also has a significant involvement. Any guidance issued should cover all agencies (health, housing, police etc) and be signed up to all relevant departments. It is important that cross agency working be achieved, without building a confusing and conflicting bureaucracy with overlapping mechanisms which duplicate effort. If the intention is to ensure that all areas which impact on the lives of vulnerable people are effectively involved then creating a cross governmental office, not linked specifically to any one department, may be a solution.
Q1b	Where should it lie locally? If within local government, then where in local government?	Local government, and within Social Services – where the expertise lies. However, Local Safeguarding Boards should be chaired if possible by someone independent, not a senior Social Services manager. Using people from outside the statutory agencies provides transparency and accountability. These chairs should however have appropriate officer and administrative support.
Q1c	Do we need a template for 'a local safeguarding job description' and national procedures for use locally?	A greater consistency between areas will increase robustness and consistency. Local Authorities and NHS Strategic Health Authorities and Trusts are not always coterminous, and many NHS Trusts (e.g. Ambulance/Mental Health Trusts) work across several Local Authority boundaries. A national template and procedures would simplify working practices and achieve a greater consistency in service delivery, and facilitate better benchmarking and oversight of services.

Q1d	How do we know if a safeguarding board is working effectively? To whom should it be accountable?	Qualitative as well as quantitative measures are required. These could be monitored by the Care Quality Commission and the Local Government and Health Ombudsmen, working together.
Q1 e	Where should leadership for NHS safeguarding issues lie? Do we want national procedures for the NHS?	Standardised templates/procedures for the NHS, which could be adapted to fit different service providers and local needs, would provide a focus and set standards for consistent principles of safeguarding within the NHS. Guidance on what should be included in job descriptions should also be provided. See also response to Q6c.
Q1 f	Where should leadership for safeguarding in the care home sector lie? What can be done to strengthen this?	Formal accountability and governance systems for the larger organisations (commercial and voluntary sector) should follow the same principles as the statutory sector at a local level. For those small commercial concerns, there should be a requirement for a named individual to be responsible/accountable. This would need to be accompanied by careful guidance on commissioning to ensure that safeguarding principles were built into all contracts, and also integrated into the inspection and licensing regimes for the care home sector. In addition a requirement within future guidance should be a mechanism by which local groups, including the care home sector, meet to discuss issues and facilitate shared training.
Q1 g	Given that there are multiple 'chains of command', how do we ensure that formal leadership roles are accompanied by appropriate authority levels?	Establishment of accountability at Board/Elected Official level within each organisation provides an authority level for action. Beyond that, individual organisations should set the roles as appropriate to them. However, by embedding Safeguarding within normal governance procedures, oversight should be provided through those mechanisms. It might be appropriate to require that, for these organisations where this is applicable, a non executive director is designated to provide additional support to Safeguarding within the organisation.

Prevention

Q2 a	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.	One area would be within primary care. Processes for making preventive checks on potentially vulnerable people who are service users to identify early deterioration in capacity, health and managing skills within the NHS could result in earlier provision of support and, as well as addressing issues around dignity, potentially reduce inappropriate/unnecessary use of emergency access to healthcare and support the "Better Health" agenda.
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?	Interagency alerting for people "in need" would address some of these issues. This would need to be accompanied by training to ensure that Safeguarding issues are recognised. Police and ambulance staff often come into contact with vulnerable people who are in crisis, but this manifests itself as criminal or anti social behaviour. Staff can then identify the individuals as problematic and potentially a risk to staff in those and other organisations. Although these considerations are important, often what can be missed is the vulnerability of the person concerned and the need for intervention within the context of safeguarding. This can be addressed through improved liaison, joint training and local multi-disciplinary boards in each area.
Q3c	Are whistle-blowing policies effective? What can we do to strengthen them?	Training and development to develop and empower staff at the service delivery level would improve and strengthen the effectiveness of whistle blowing policies. In addition, work both locally and nationally, to raise awareness in the public as to what a good service looks like would also increase appropriate challenges to service providers.

Outcomes

Q3b	Should we encourage **local annual reports** to be more evaluative?	Yes. Such reporting would be more likely to identify trends, e.g. changes to the ethnicity of the population, leading to requirements to change the service provision and/or approach.
Q3 c	How can we **learn from people's experiences** of harm and their experiences of the safeguarding process in order to improve safeguarding?	Predominantly, feedback has been historically focussed on 'complaints' This is partial and negates the many differing sources of service-user, stakeholder and staff feedback, including PALS and incident reporting as governance mechanisms. The *Making Experiences Count* programme. enables the drawing together of all of these threads and some Trusts, (the London ambulance Service being an example) have initiated the unification of all of these mechanisms within a single department, including safeguarding activity in relation to both adults and children. This should be encouraged. This type of feedback can provide strong evidence to generate change. There should also be a requirement in the guidance, which can be monitored through service review, for involving service users in driving change and improvement.
Q3 D	Should we review current arrangements for delivery of safeguarding adults **training?** Should we have national occupational training standards across all agencies?	The development of core standards and levels of training across agencies would be useful. However for those staff who work at the operational delivery level, training would need to be specific to their situation and experience. Joint training between agencies is useful as it expands participants understanding of roles as well as constraints and concerns of partner agencies. Although this does take place in some areas, ambulance service staff are often not included in the arrangements. Expansion of existing arrangements to include all partner agencies would be welcomed.

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, but this should include more general shared learning, not just the outcomes of serious case reviews. A mechanism for sharing learning, from any source, as well as best practise would provide a more useful tool, contribute towards consistent standards and provide a broader base for achieving real service improvements. Although STEIS provides some assistance in the dissemination of learning from SUIs this is limited and needs to be improved. It should be possible for increased access across health and social care to access appropriately anonymised reports.
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, it would be appropriate to involve the police, and a wider base for the panels for SCR would also be useful. The involvement of ambulance services should be considered.
Q3G	What are the desired **outcomes** of safeguarding work?	Improvement in cross agency working, learning form previous incidents and reduce the number of people who are subjected to abuse.
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?	The establishment of national guidance would provide a more consistent service and reduce the potential for confusion arising from different organizations having to work with more than one partner agency. This could consist of a framework with principles to be observed and then localised to take account of individual community needs.
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?	In our experience as a pan London organisation, covering 33 Local Authorities, there are significant discrepancies in the resources available to Social Services departments for this work, and in terms of commonality of practise. Ambulance services have received no funding for Safeguarding; all such work has been provided from existing funding streams.

Chapter 4

Q4	**Managing Risks**	
	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.	The LAS has come across several instances where home care service providers have failed to alert their own management or Social Services where a service users care needs have changed and additional resourcing has been required. Better guidance for all domiciliary care providers and a greater onus on companies' providing this type of service is required. This should include better inspection regimes as well as guidelines. Such inspection schemes should also be extended to where the care is provided by family members or self employed individuals providing care to one person only. These safeguards would provide some protection to those who choose to personalise their care. In addition changing the requirements for the provision of domiciliary care, and providing a more formal structure with requirements for vocational training could also address some of these issues.

Chapter 5
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?	Implementation within the NHS is patchy; although some trusts in the acute sector have taken both the specific guidance and the notion of protection/safeguarding on board and put some procedures in place to address those issues, others have not. With the lack of attention to Adult Protection/Safeguarding in the NHS inspection/evaluation regimes there has been little incentive to Trusts to put much effort into developing this area. Safeguarding needs become a central element of the provision of services within the NHS for all organisations and included in all inspection, evaluation, health checks etc. The No Secrets guidance itself must also be updated and expanded to reflect the evolving safeguarding agenda. The current guidance is too tightly focused on prevention of abuse and does not address the safeguarding issues posed by vulnerable people who are "in need".
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?	A framework outlining the principles of safeguarding to be generally adopted by all agencies would work across Health and other departments; however, there is a need for each agency to achieve consistency nationally. This would require specific guidance outlining procedures to be adopted that are specific to professional structures.
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?	Although all NHS organisations should have a safeguarding lead at Board level, safeguarding for vulnerable adults needs to be embedded within all Trusts as part of normal operations. Data collection should be carried out as part of core management information reports and monitored as part of the organisations normal governance and risk management systems. Different professional groups should have identified leads to provide the professional and clinical leadership and development, awareness raising and training should form part of the normal process for training and development within the organisation.

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?	See Q3E – ideally this would be done both regionally and nationally. For large sectors, such as Acute/Primary Care, regional arrangements would be useful, although learning should be shared nationally. For smaller sectors, such Ambulance Trusts, a national forum only would be more appropriate. Local areas should also have forums/boards at the PCT/LA level.
Q6e	How do **procedures for investigating serious untoward incidents** (SUIs) fit into the multi-agency context of safeguarding?	A format similar to that used in Safeguarding Children would be appropriate and has already been adopted in some areas. A Serious Case Review, chaired by an independent partner and ensuring that all relevant partner agencies are involved. We have had recent experience of not being approached to see if we have any relevant information in an SCR. SCR chairs should apply a Root Cause Analysis framework. This requirement would provide a more effective methodology to examine multi agency working and effectiveness in this context.
Q6f	Are adult safeguarding **systems within the NHS effective**? If not, what are the specific challenges that need to be addressed?	Adult safeguarding is still often regarding as Adult Protection, that is, if focuses on abuse, and not the wider safeguarding agenda. The links to “Better Health”, the wider Equality agenda and dignity and respect issues are not well understood. The biggest specific challenge is that Safeguarding principles are not being applied to NHS service themselves. It is necessary to ensure that as part of the “No Secrets” review and a re-launch of the Adult Safeguarding agenda within the NHS, services are asked, at both a corporate and service delivery level, to carry out a self assessment, using a standardised audit tool, to examine the services they provide and to identify areas where institutionalised abuse/service provision which does not meet clients/patients’ needs is occurring and develop plans to address those issues.

Q6g	Are **any parts** of the NHS or healthcare sector **less engaged** and more in need of assistance to get on board with safeguarding?	Ambulance Services are often excluded from investigations and reviews. It can be that ambulance services have valuable information contained within their records relating to safeguarding cases. There is also insufficient appreciation that the nature of emergency care provision places limitations on the availability of ambulance staff to participate in Serious Case Reviews. A greater flexibility of approach is required.
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?	Yes - see response to Q2 a
Q6i	Are there particular issues in relation to safeguarding and **mental health**? If so, how should these be addressed?	Critically, attitudinal; 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. This can only be addressed through better training and leadership. Including mental health trusts on the Safeguarding Boards and other multi disciplinary forums would provide useful links with other agencies and valuable expert input into discussions.
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)?	This should focused on the Healthcare Commission, Monitor and the DH As stated in the response to Q1a, a cross governmental office to co-ordinate the approach to Safeguarding would be valuable.
Q6k	What are the main **drivers for standards** in the NHS that safeguarding should be linked to	“Better Health”, Dignity and respect,, NSFs

Chapter 6
Safeguarding, Housing and Community Empowerment

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?	There need to be better systems in place to establish when vulnerable adults living in social housing need additional support. Situations where someone becomes less able to cope with their living environment, or where that environment is now not meeting their needs should not continue to worsen until a crisis occurs and emergency intervention is required. A more pro-active approach to monitoring and offering support to vulnerable residents would be helpful. Involvement and access to cross disciplinary training for housing workers may assist with this, as would the development of assessment checklists, to identify vulnerable adults, used whenever people moved, and, where potential indicators where present, at regular intervals during residence. Better information sharing protocols would also address some of these issues.

Chapter 7

Access to the criminal justice system

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?	No, given some of those in the client group, and that vulnerable people can have challenging behaviour, there would be potential to further “criminalize” vulnerability.
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?	Yes; the London Ambulance Service is already establishing cross agency working by devising multi disciplinary forums across health and social care in local authority and PCT areas. This is aligned to the *Making Experiences Count* programme and enables a joined up and care plan approach with particular reference to emergency care. This mechanism lends itself very well to safeguarding issues, both in terms of realising the role ambulance services have to play as often being in a position to act as an alert agency and to enable resolution when associated complaints and concerns may be raised. This would also formally enable recognition of safeguarding practice as being a further activity within the totality of staff, service-user and stakeholder feedback.
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?	NHS Trusts also have significant experience in risk assessment and risk management. However, these procedures are often not applied to Safeguarding adults, as this work is often not embedded in the organisations, but the responsibility of a few individuals. Safeguarding needs to be mainstreamed within the NHS, and be a part of the normal governance and inspection and investigation processes.

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?	Yes. As public sector organisations, acting in the interests of a patient, appropriate and proportional information can and should be shared. The provisions of the Data Protection Act should be applied to the level of information shared. Clarification on confidentiality issues, as they appertain to vulnerable people in conjunction with the professional bodies, is required within any guidance issues. A supporting mechanism for staff would be to develop standard NHS alerting/reporting forms. By using a form which clearly indicates the type of information it is appropriate to share by use of tick boxes etc. staff's confidence can be supported in this work. Use of the free form letter should be discouraged. This measure would also address the issue of healthcare workers communicating information in a form that is not understandable by other professionals.
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?	See above. The legitimacy of information sharing is not widely understood, leading to defensiveness, caution and obstruction between different agencies, and, on occasions, within organisations.
Q8h	Should we look at ways of making it easier for people who may be vulnerable to **report abuse**?	Use of information at point of admission to hospital, start of receipt of services, explaining what people should expect and what to do if this is not met would assist in this.
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?	It is supported by us. This would provide transparency and accountability for the sector. Ambulance services will have information that is useful in assessing care/nursing home provision, although this is not generally understood by other agencies. The inclusion of such information in reviews would be potentially useful to such reviews.

Chapter 8

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?	There needs to be an overarching document, setting out the Safeguarding agenda and systems for all agencies to enshrine interagency working. Within the NHS additional guidance is required that addresses the specific circumstances of service provision and organisational complexity. This should provide more specifics, such as requiring Trusts to have similar systems in place as they do for safeguarding children, in terms of embedding safeguarding principles into normal working practise and ensuring that good practice and learning is shared in a useful way.
Q9b	Is new **legislation** necessary and how would it help?	The establishment of principles of safeguarding and the setting of accountability equivalent to that achieved in Safeguarding Children by legislation would be welcome. However, it is not always necessary to have legislative backing for Guidance to be effective. If it is regarding as Best Practice, effective and respected, failure to comply becomes as necessary as with legislation. The involvement of organisations such as the NHSLA and their "buy in" would also support this.
Q9c	Should legislation placing **safeguarding adults boards** on a statutory footing be introduced? Should it include a duty to commission and contribute information to serious case reviews?	This would be useful, as it would reinforce those systems that allow service delivery shortcomings to be addressed more effectively. However, it would not address the attitudinal problems that remain to be overcome in delivering effective safeguarding for vulnerable people.
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?	Yes – this should include the voluntary/commercial care home sector and mental health groups. This would need to be a legislative requirement.

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?	The ability to enter may be useful; however, this would depend on the purpose of that entry. To be able to enter and seize records and notes (during an investigation to preserve/gather evidence) may be helpful, as would the ability to intervene when abuse was occurring. However, to remove someone who is the victim of abuse could then encompass issues of capacity. Assessing capacity can be difficult and not necessarily undertaken within a short timeframe. .
Q9f	Should such a **power apply when an adult has mental capacity** and may be self neglecting or self harming?	Already exists (the National Assistance Act), however the current legislation is dated, and may benefit from a revision. The principal should be that if someone has capacity they can, within the law, decide for themselves how they wish to live, but that some provision must exist for the protection and safety of others and the wider community.
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)?	Magistrate, judge or police officer would be appropriate, however, those tasked with this job should undergo specialist training in Safeguarding, the Mental Capacity and other relevant legislation and areas of expertise. A system similar to that of Approved Social Workers, where a sub set of specialist trained individuals would be able to hear submissions for these powers to be exercised.
Q9h	Should an **offence of ill-treating or neglecting a vulnerable adult with capacity** be introduced?	Yes
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?	In principle no. however, temporary removal to address issues around duress or to be able to properly assess capacity to address the particular issues might be useful in some circumstances.

Q9j	Should **force** be used to remove a person who is self-neglecting or self-harming?	In some circumstances. The right already exists in law where there is lack of capacity (temporary or permanent) – the "doctrine of necessity". It should only be used where the probable outcome of the self harm is potentially extremely serious and where no other option to provide treatment/assistance is possible (refusal to go to hospital, but willing to be treated at home). Where the person has capacity however, this would be problematic in the extreme. Force to remove the person from their home environment would not necessarily address the self harm issue, and what would be defined as self harm – refusal to take nutrition, use of prohibited drugs, alcohol abuse, smoking, poor diet?
Q9k	If a person is **removed, where** should they be taken, for what purpose and for how long?	The Mental Capacity Act addresses these issues around the deprivation of liberty. It would be appropriate to utilise this existing legislation. We would note however that most designated places of safety are inadequate.
Q9l	Is current **care standards legislation sufficient** for closing down poorly performing care homes in a timely and effective manner?	No

Chapter 9
Definitions

Q10a	Should the *No secrets* definition of vulnerable adult be revised? If so, should the revised definition do the following, and if so, how? Should it: • enable practitioners to decide which groups of people they believe require special support? • • provide clarity on what ‘wrongs’ we want the new *No secrets* guidance to put right? • clarify how bad the ‘wrong’ has to be to warrant a response, i.e. define the threshold needed to justify a response? • • take into account those vulnerable by reason of a temporary physical or mental condition? • distinguish between abuses carried out by a person in a position of trust or power in relation to the victim and those committed by a stranger? • make reference to an adult being unlikely to be able to protect himself or herself from harm or exploitation?	Yes; the definition needs to be more focused on needs rather than the current process/status definition. Only to a point – such guidance would be very constraining; effectively it would proscribe action for anything that was not included Potentially useful, however, this would have resource implications, and, inevitably, the threshold set would be resource led, rather than based on need. This issue is covered in the Metal Capacity Act, although some guidance providing a fuller clarification would be useful. Yes, this would provide more opportunity for agencies to address issues where the current definition is unhelpful.

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)?	Use of abuse narrows the focus of work – it excludes many links with the Better Health, Dignity and End of Life Care agendas.
Q10c	How do we enshrine within safeguarding the principles contained within the Mental Capacity Act 2005 and the Human Rights Act 1998?	Multi disciplinary safeguarding boards, including all relevant agencies and the mainstreaming of Safeguarding work in all partner agencies. Would be two key actions to buy into adult safeguarding boards by reps from all areas of safeguarding.