Appendix Two

Safeguarding vulnerable adults – a toolkit for General Practitioners

INTRODUCTION & CONTEXT

Card one – About this toolkit

This toolkit is concerned with promoting the wellbeing of adults who may have difficulty in protecting and promoting their own interests. Designed principally with general practitioners in mind, it will nonetheless be useful for any professional working in a healthcare setting who encounters adults whose ability to promote their own rights and interests may be challenged, either directly by an abuser or because they are in a situation of dependency, or through institutional neglect or disempowerment.

Safeguarding adults is a challenging area of practice. As discussed in more detail in card three, the group of adults involved is extremely diverse, making a one-size-fits-all approach clearly inappropriate. Adults who may be the focus of safeguarding range from those whose decision-making capacity is severely impaired and on whose behalf decisions have to be made, to adults with no underlying cognitive impairment but for whom their physical situation or a brief period of illness has temporarily affected their ability to protect their own interests. The nature of the abusive behaviours involved can also range from violent physical and psychological abuse through varieties of personal, financial or institutional abuse or neglect to a failure to provide timely access to key services such as dentistry or prostheses. Abuse or neglect of vulnerable adults can also take place in a wide variety of contexts, including private homes, nursing or residential care units,
hospitals and custodial settings. Perpetrators of abuse can be family members, professionals, paid care workers, volunteers or other service users. This diversity of contexts and relationships reinforces the complex, multi-agency nature of safeguarding and the extent to which opportunities to promote the welfare of adults who may be vulnerable permeate all aspects of health care.

Just as the nature, and context, of harm can vary, so to can the nature of the response. An important distinction to be made in relation to safeguarding is between meeting the needs of vulnerable adults as part of ordinary care, and the recognition of vulnerable adults who are at risk of significant harm and require intervention from adult safeguarding services provided by local authorities. Both aspects are set out in this toolkit.

Although the phrase ‘vulnerable adult’ is widely used, it is not without its problems. It is a fundamental principle of medical ethics and law that competent adults have a right to make decisions that affect their lives, even where this may result in exposure to risk. Labelling adults ‘vulnerable’ can be stigmatising and lead to unfounded assumptions that individuals lack the ability to direct their own lives. This can lead to unacceptably paternalistic interventions and result in the kinds of disempowerment that this guidance is designed to avoid. Alternatively, drawing too narrow a definition of vulnerability could mean that opportunities to identify adults who may benefit from additional consensual support can be lost. Recognising the wide range of circumstances in which safeguarding issues can arise, a key message in this toolkit, is the need for an approach that addresses the specific needs of individuals. Such a person-centred approach, rooted in good communication skills and respectful of each individual’s dignity and independence is likely to lead to optimal outcomes.

In 2005 the Department of Health published the findings of an inquiry into how the NHS handled allegations about the performance and conduct of two consultant psychiatrists, William Kerr and Michael Haslam. Both had been convicted of indecent assault involving their female patients. Although such high profile
cases are fortunately exceedingly rare, they have nevertheless placed adult safeguarding at the centre of debate around health care. Involving vulnerable female psychiatric patients, they raised key questions about trust, differences in power between doctors and patients, and the extent to which monitoring, audit and complaints systems were sufficiently robust to prevent abuse. Despite this increased awareness, a 2009 DH consultation on safeguarding adults reported a pervasive sense from professionals that the NHS was failing to ‘own’ the concept of safeguarding adults. The aim of this toolkit is to set out in straightforward terms key concepts and responsibilities in relation to safeguarding adults in England. It is not designed to be comprehensive or to provide definitive answers for every situation. The toolkit contains a series of cards that address specific areas of practice, including adults lacking capacity, definitions of abuse and neglect and approaches to multi-agency working. As each card is designed to be read separately, there is some deliberate repetition.

**Card two – what is adult safeguarding?**

General Practitioners and other qualified health professionals have considerable experience of promoting the interests of their adult patients, including those adults who may, in varying degrees, be vulnerable. The majority of GPs will have experience, for example, of women who may be victims of domestic abuse, of patients whose mental and physical health problems can mean that they have difficulty protecting and promoting their interests and of adults who may be experiencing difficulties in their relationships with partners, family members or carers. The role of doctors is to act as advocates for their patients, and the support that GPs in particular offer their patients often extends beyond narrowly defined health needs to wider welfare considerations. Safeguarding has been defined as that range of activities aimed at respecting an adult’s fundamental right to be safe. It follows therefore that although the word ‘safeguarding’ may suggest a new approach, many of the associated activities will already be very familiar to doctors as part of good practice. Although not immediately associated with safeguarding, the question of maintaining professional standards for example has a direct impact
on the welfare of patients, and, in particular patients who may have difficulty promoting their own interests. In this context, clinical governance procedures, including adverse incident reporting, peer review and revalidation that are aimed at ensuring that poor practice is identified and that the highest standards of clinical practice are maintained are central to safeguarding.

Where safeguarding does continue to present challenges is in relation both to the sheer variety of circumstances in which adults can be vulnerable, the complexity of individual needs, which can bring together physical, psychological, social and interpersonal factors and the wide range of agencies with safeguarding responsibilities. Identifying the scope of each agency’s responsibility and the limits of its authority to intervene can be problematic. Authority boundaries are not always coterminous, and appropriate support for a vulnerable adult can require co-operation between agencies that have not always worked together successfully. There is always a risk that vulnerable adults will fall between services, particularly where there is confusion about responsibility and ‘ownership’ of the safeguarding process. (Practical advice on ensuring continued care for vulnerable adults is given in card eleven, safeguarding adults as part of ordinary care).

Law enforcement agencies, social care practitioners and health professionals also have different obligations, professional priorities and cultural expectations, and this can present challenges in relation, for example, to information sharing. In addition, while guidance stresses that adults have a right to be safe, competent adults also have a right to manage their own affairs, and this obviously extends to the right to make choices that involve some, even at times considerable, degree of risk. Where adults have decision-making capacity, interventions or measures designed to reduce risk, but which also restrict liberties, such as the use of bed rails, should be offered, but decisions about their use should rest with the competent adult.

Where an adult lacks decision-making capacity, professionals have a different set of legal and ethical responsibilities, and decisions will ordinary have to be made on his or her behalf, based on an assessment of his or her best interests. (See cards seven and
eight). Where adults have capacity they nevertheless require information about the nature and scope of the risks they are exposing themselves to. In relation to health care, professionals have a key role to play in communicating the nature of the risks involved, either in episodes of health care, or, where appropriate in other life choices involving risk. In this way competent adults can make more informed choices, and also identify ways of mitigating or managing the harms to which they may be exposed.

Although systems and procedures for protecting vulnerable adults are not yet uniform across England and Wales the following key points apply to all health professionals who may encounter vulnerable adults:

- Health professionals should be able to identify adults whose physical, psychological or social conditions are likely to render them vulnerable (see card three – Which adults may be vulnerable?)
- Health professionals should be able to recognise signs of abuse and neglect, including institutional neglect (see card fourteen – the structure of adult safeguarding services)
- Health professionals need to familiarise themselves with local procedures and protocols for supporting and protecting vulnerable adults

Card three – Which adults may be vulnerable?

The term ‘vulnerable adult’ is contentious. By labelling adults ‘vulnerable’ there is always a danger that they will be treated differently. The label can be stigmatising and can result in assumptions that an individual is less able than others to make decisions and to determine the course of his or her life. In this way the term can lead to subtle forms of inappropriate discrimination. Throughout this toolkit, the distinction between adults with the capacity to make decisions and adults lacking capacity is
emphasised. Adults who have capacity retain the right to make their own decisions and to direct their own lives. Adults lacking capacity to make decisions, though they retain the right to be involved in decision-making as far as possible, nevertheless require decisions to be made on their own behalf, and the overall approach shifts to promoting their best interests. The judgement that an adult is vulnerable should not be confused with a decision about his or her capacity. They are distinct questions, although a lack of capacity will ordinarily contribute to an adult’s vulnerability.

The Safeguarding Vulnerable Groups Act 2006 gives a very wide-ranging definition of a vulnerable adult. From a health care perspective this involves anyone aged 18 or over who is in receipt of ‘any form of health care.’ The difficulty with this definition is that it is too inclusive to enable appropriate distinctions to be made between the needs or vulnerabilities of adults. The overwhelming majority of adults who are in receipt of health care are able to look after their own interests and to label them vulnerable can be patronising and pejorative. Too much attention to the definition of a vulnerable adult could also lead to a failure to recognise that systems can also play a part in neglect and abuse. Systemic failures in health care can render adults vulnerable where in all other aspects of their life they are competent and in control. As emphasised throughout this toolkit, neither capacity, nor vulnerability, is an all-or-nothing state, but is subject to degrees of variation.

The most widely-used current definition of vulnerable adult is taken from the 1997 consultation paper Who Decides, issued by the then Lord Chancellor’s Department. According to this definition a vulnerable adult is a person aged 18 or over:

**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.**
There are a very wide number of factors that can contribute to an adult being vulnerable, although their presence is by no means determinative and each individual will vary according to their circumstances and needs. It is nevertheless broadly accepted that the following groups are at enhanced risk of being vulnerable to neglect or abuse:

- An older person who is particularly frail
- An individual with a mental disorder, including dementia or a personality disorder
- A person with a significant and impairing physical or sensory disability
- Someone with a learning disability
- A person with a severe physical illness
- An unpaid carer who may be overburdened, under severe stress or isolated
- A homeless person
- Any person living with someone who abuses drugs or alcohol
- Women who may be particularly vulnerable as a result of isolating cultural factors

The presence of one or other of these factors does not necessarily mean that the adult is vulnerable – age, disability or the presence of a physical illness for example should not lead to the automatic assumption that the individual is vulnerable. A key factor in each case will be whether or not the individual is able to take steps to protect and promote his or her interests.

The Government’s 2009 review of its *No Secrets* guidance accepted that there were some concerns about the current definition of ‘vulnerable adult’. The definition outlined above may therefore be liable to change. The web version of this guidance will be updated as appropriate.

**Card four – What constitutes abuse and neglect?**
The term ‘abuse’ can be subject to a variety of definitions, and the distinction between abuse and neglect is unlikely to be a clear one. In certain circumstances, neglect can lead to harm that is as significant as direct abuse. The Government’s 2009 review of *No Secrets* also identified that within healthcare, neglect is the most serious form of abuse and that in some care settings, poor levels of services that could amount to neglect were accepted as a result of staff and other resource shortages. In practical terms this toolkit therefore treats neglect as one category of abuse. Abuse can occur in any relationship and in a very wide range of circumstances. The *No Secrets* guidance identifies a number of factors that can categorise abuse:

- *It may consist of a single act or repeated acts*
- *It may be physical, verbal or psychological*
- *It may be an act of neglect or an omission to act including an unintended lack of attention to someone who requires it*
- *It may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent*
- *It can occur in any relationships and may result in significant harm to, or exploitation of, the person subject to it.*

Abuse and neglect can amount to serious violations of an individual’s human and civil rights. Many acts of abuse constitute criminal offences and vulnerable adults are entitled to the full protection of the law. Where a crime has been committed, or is likely to be committed, it may be necessary to involve law enforcement agencies. In addition, abuse and neglect are often characterised by a lack of respect for, or a violation of, the respect for individual dignity, agency and integrity that are at the core of both good patient care, and of fundamental social norms.

Although abuse can take many forms, there is broad agreement that the following are among the most significant:
Card five – What basic principles underpin safeguarding?

Safeguarding adults is a complex area of practice, and no two adults will be in identical situations or have identical needs. This toolkit cannot provide answers to all the problems and dilemmas in this area. There are however a number of key considerations that will need to be taken into account whenever health professionals are working with adults who may be vulnerable. These are given below.

- Legally and ethically, adults with capacity have the right to make decisions about their care and treatment, even where those decisions may not be thought to be in their best interests

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- **Physical abuse** including hitting, the misuse of medication, inappropriate or unlawful restraint or other sanctions
- **Sexual abuse** including any sexual act to which the person did not or could not consent
- **Psychological abuse** including coercion, emotional abuse, humiliation, harassment, bullying, verbal abuse, enforced isolation or withdrawal from services
- **Financial abuse** including theft, fraud, the misuse of property, finances and benefits, including coercion in relation to wills and other forms of inheritance
- **Neglect and acts of omission** including deliberate or neglectful failure to meet health or physical care needs or to provide the necessaries of life including food and appropriate shelter. It can also include thoughtless forms of neglect such as leaving food or drink out of reach, the removing of spectacles, hearing aids or false teeth and the placing of them out of reach.
- **Discriminatory abuse** including racial, religious, gender-based abuse or abuse based upon an enduring condition or disability, or a person’s age.
The interests and wishes of the vulnerable adult must be at the centre of the decision-making processes.

All adults are presumed to have decision-making capacity, unless there is evidence to the contrary.

All adults, irrespective of their capacity, have rights to privacy and confidentiality although in exceptional circumstances, such as where there is a serious risk of harm to a third party, those rights may be set to one side.

Where an adult is assessed as lacking capacity, he or she must be helped to participate in decisions affecting his or her life to the maximum of his or her ability.

All adults have a right to holistic care that is focused on their individual needs and is respectful of their dignity and privacy.

Safeguarding adults must involve promoting the independence and quality of life of adults and must maximise the ability of adults to control their own lives.

Care providers must avoid discriminating unfairly between groups of patients.

Care and treatment decisions must be made on the basis of a fair and objective assessment of individual needs and not on assumptions about age or disability.

Good communication is at the centre of safeguarding. This includes the requirement to meet the communication needs of non-English speakers and those who may have communication difficulties.

Card six – What part does mental capacity play in safeguarding?

Capacity is a vital concept in relation to the care and treatment of adults who may be vulnerable. Many of the respondents to the Government’s consultation on the review of the No Secrets guidance expressed frustration that the voices of adults were insufficiently listened to in relation to safeguarding. Although people wanted to be informed of options for care and support, they wanted to retain control. There was also a clear message from the consultation responses that comparisons with child
protection were inappropriate: adults quite obviously have very different needs and capacities to children. Retaining control means that competent adults have the right to assess and manage the risks to which they are exposed, and in this context support will normally involve talking through those risks and offering support where appropriate. In the absence of serious crime, and of significant risks to third parties, competent adults retain the right to make decisions about how they wish to direct their lives. Neglecting or violating these decision-making rights, even where the intentions are to protect the individual, can itself amount to a form of abuse.

It is a central message of this toolkit that vulnerability is not the same as incapacity and care must be taken to avoid confusing the two. For many adults, however, vulnerability can develop over time. Deteriorating health, for example, declining alertness, or a change to an unfamiliar residence or care regime can all exacerbate vulnerability, and can present challenges to the ability of adults to take steps to manage risk. Vulnerability is not a static or absolute state, and may vary according to the nature of the individual’s circumstances. It follows therefore that assessments of an individual’s needs must be made on a case-by-case basis and be subject to regular review. A key feature of adult safeguarding for health professionals will therefore be to consider how best to balance an appropriate respect for agency, or the ability of adults to make informed choices about their lives, with the requirement to provide appropriate support to help people manage risks. In ethical terms the challenge is managing a respect for autonomy with the requirement to act to prevent avoidable harms. In assessing the balance between these factors, the decision-making capacity of the individual will be central. In the absence of crime, or of serious risks to third parties, adults with capacity have the right to direct their own affairs. Support and advice should be offered as appropriate, but basic freedoms cannot be infringed.

In England, decisions relating to adults who lack capacity are regulated by the Mental Capacity Act 2008. The Act sets out a number of basic principles that must govern all decisions taken in relation to adults lacking capacity. A brief list is given below. The
concept of ‘best interests’ is discussed in slightly more detail in card eight.

- **A presumption of capacity.** Adults are assumed to have the capacity to make decisions on their own behalf unless it is proven otherwise
- **Maximising decision-making capacity.** Everything practicable must be done to support individuals to make their own decisions, before it is decided that they lack capacity
- **The freedom to make unwise decisions.** The fact that an adult makes a rash, unwise or impulsive decision is not in itself evidence of lack of capacity
- **Best interests.** Where it is determined that an adult lacks capacity, any decision or action taken on his or her behalf must be in his or her best interests
- **Less restrictive alternative.** Whenever a person is making a decision on behalf of an adult who lacks capacity, he or she must consider if it is possible to make the decision in a way that is less restrictive of that person’s fundamental rights or freedoms.

Card seven – adults with capacity

It is a fundamental principle of English law that adults have the right to make decisions on their own behalf, and are assumed to have the capacity to do so. This is known as the ‘presumption of capacity’ and extends to decisions that may entail personal risks and that may not be in accordance with an objective view of their best interests. Where there are doubts about an individual’s capacity the responsibility for demonstrating that he or she lacks capacity falls upon the person that challenges it. The fact that an adult is regarded as ‘vulnerable’ is not by itself evidence that he or she lacks capacity and great care must be taken to avoid any such assumption.

Where an adult has capacity in relation to a specific decision, such as a health intervention, consent is required and his or her decision must be respected unless treatment is being provided
under mental health legislation. Where a health professional believes an adult with relevant capacity may be both vulnerable and at risk of harm, but he or she refuses the offer of assistance, this decision should ordinarily be respected although health professionals should keep an accurate and contemporaneous record of the support offered and the reasons for the adult’s refusal. Such decisions should also be kept under review and ongoing support should be offered. Examples here might be where an adult is offered a protective measure, such as a bed rail, but refuses. Such a situation is likely to be challenging to health professionals, and where possible, the options available to the individual, and the nature of the professional’s concerns should be discussed in detail, including presenting, where possible, a range of options to manage risk. Having said this, where a competent adult explicitly refuses any supporting intervention, this should normally be respected. Exceptions to this may be where a criminal offence may have taken place or where there may be a significant risk of harm to a third party. Where a criminal offence is suspected it may also be necessary to take legal advice. Ongoing support should also be offered. Because an adult initially refuses the offer of assistance he or she should not therefore be lost to or abandoned by relevant services. The situation should be monitored and the individual informed that she or he can take up the offer of assistance at any time.

Although a vulnerable adult with relevant capacity is entitled to refuse assistance and to remain in a situation of risk, it is vital in such circumstances to identify whether there are other people who may also be at risk of harm. If, for example, there may be an abusive adult in a position of authority in relation to other vulnerable adults, it may be appropriate to breach confidentiality and disclose information to an appropriate authority.

**What is decision-making capacity?**

In England and Wales, decisions relating to adults who lack capacity are regulated by the Mental Capacity Act 2005 (MCA). The Act starts with the presumption that all adults have the capacity to make decisions on their own behalf unless it can be
demonstrated otherwise. The Act makes use of a ‘functional’ test of capacity that focuses on the decision-making process itself. It must first be established that the individual being assessed has ‘an impairment of, or a disturbance in the functioning of, the mind or brain’ which may affect their ability to make the decision in question. Under the Act, a person is regarded as being unable to make a decision if, at the time the decision needs to be made, he or she is unable:

- To understand the information relevant to the decision
- To retain the information relevant to the decision
- To use or weigh the information; or
- To communicate the information (by any means).

Where an individual fails one or more parts of this test, then they do not have the relevant capacity and the entire test is failed.

An assessment that a person lacks the capacity to make a decision must not be inappropriately discriminatory. It must not be based simply on a person’s age or appearance or any unfounded assumptions about their condition, their behaviour or their ‘vulnerability.’

An assessment of mental capacity is decision-specific. This means that the question that needs to be asked is whether the individual has the capacity to make a specific decision at a specific time. Although some patients, such as those who may be unconscious, will not be able to make any decisions, most individuals will be able to participate in at least some decisions, even very straightforward ones such as what to wear.

**Where there are doubts about a person’s capacity**

Although, as discussed above, where an adult has relevant capacity, he or she has the right to make decisions that affect his or her life, including decisions that involve risk, particular difficulties arise where some capacity exists but its extent is uncertain. In these circumstances very difficult decisions may need to be made involving a balance between respecting the decision-
making freedom of adults and the requirement to intervene. Where there is doubt about an adult’s capacity a formal assessment should be undertaken. The more serious the decision – and this will include identifying the scale and seriousness of any risks the adult’s decision may expose him or herself to – the more formal the assessment of capacity is likely to be. Depending upon the circumstances it may be appropriate to refer the patient to a psychiatrist or psychologist with particular experience in assessing capacity. Where there are doubts about a person’s capacity that cannot be resolved using more informal methods, the Court of Protection can be asked for a judgement.

What do you do when an individual refuses to be assessed?

Occasionally an individual whose capacity is in doubt may refuse to be assessed. In most cases, a sensitive exploration of the consequences of such a refusal, such as the possibility that decisions may be challenged at a later date, will be sufficient for people to agree. In the case of an assessment for testamentary capacity, for example, pointing out that a person’s wishes may be contested in the absence of such an assessment can be persuasive. If the individual flatly refuses, however, in most cases no one can be required to undergo an assessment.

Card eight – adults lacking capacity

Decision making in relation to adults who lack capacity is regulated in England and Wales by the Mental Capacity Act 2005. The BMA provides extensive guidance on the Act which is available on its website. Links are provided at the bottom of this card. This section contains a very brief outline of the main features of the legislation emphasising those aspects most relevant to a safeguarding approach. Professionals are strongly advised to refer to this more detailed guidance.

Adults lacking capacity to make decisions that would protect and promote their own interests are potentially extremely vulnerable. Although, in accordance with the principles of the Act given in card
eleven, adults lacking capacity should be at liberty to participate as far as possible in decision-making, and express their views, emphasis should shift to ensuring that decisions promote their overall best interests.

**Best interests**

Under the Act, all decisions taken on behalf of someone who lacks capacity must be taken in his or her best interests. A best interest’s judgement is not an attempt to determine what the person would have wanted, although this must be taken into account. It is as objective a test as possible of what would be in the person’s actual best interests taking into account all relevant factors including:

- The likelihood that the person will regain capacity, and if so, when
- Whether the decision can be delayed until the person might regain capacity
- The person’s past and present wishes and feelings, including any relevant written statement
- His or her beliefs or values where these would have an impact on the decision
- Other factors the person would have considered if able to do so, such as the effect of the decision on other people

A crucial part of any best interests decision will involve a discussion with those close to the individual, including, where appropriate, family, friends or carers, bearing in mind both the duty of confidentiality (see card nine) and the caution that would be required if the adult was believed to be in an abusive relationship.

**Lasting Powers of Attorney (LPA)**

The MCA allows an individual who is aged 18 or over and who has capacity to appoint an attorney under a personal welfare LPA, to make health and welfare decisions on their behalf once they lose capacity. Where an incapacitated adult has earlier appointed an
attorney, he or she has the right to consent or refuse health and welfare decisions. Unless it is an emergency, consent from the attorney is required for all decisions that would have required consent from the adult had he or she retained capacity. Attorneys are under a duty to act in the incapacitated adult’s best interests.

**Independent Mental Capacity Advocates (IMCAs)**

The MCA has introduced a new role of Independent Mental Capacity Advocates. Under the Act, an IMCA must be instructed in relation to individuals who lack capacity and who no family or friends whom it is appropriate to consult when:

- An NHS body is proposing to provide, withhold or withdraw ‘serious medical treatment’; or
- An NHS body or local authority is proposing to arrange accommodation, or a change in accommodation, in a hospital or care home, and the stay in hospital will be more than 28 days, or the stay in the care home more than eight weeks

Responsibility for instructing an IMCA lies with the NHS body or local authority providing the treatment or accommodation.

**Card nine – When can information be shared about vulnerable adults?**

Health professionals owe the same duty of confidentiality to all their patients regardless of age, vulnerability or the presence of disability. The existence of a mental disorder, a serious physical illness or a learning disability should not lead to an assumption that the individual lacks capacity to make decisions relating to the disclosure of confidential information. Competent adults have considerable rights about the extent to which their information is used and shared and these are protected both by law, and by professional and ethical standards. Although, for example, there is a presumption that information will be shared between health
professionals involved in providing care to a patient, where a competent adult explicitly states that this information should not be shared, this should ordinarily be respected.

Having said this, the multi-agency approach to safeguarding vulnerable adults means that, where it is lawful and ethical to do so, appropriate information should be exchanged between relevant agencies in order to ensure that support that is right for the individual can be provided. Abuse thrives upon secrecy, a lack of transparency and closed lines of communication. Wherever possible, information should be shared on a need to know basis. Health professionals can sometimes feel challenged when a competent adult refuses to agree to the sharing of information that would seem to be in their best interests. Where a health professional is in this position, and believes that information should be exchanged, the reasons for this should be carefully explained. They should also detail the benefits that are likely to accrue, and the duty of confidentiality that the various agencies are subject to. The reasons for the refusal should also be sensitively explored, and, where appropriate, options that might prove more amenable to the patient offered. At the end of the day, however, where a competent patient refuses to permit disclosure, this should be respected. The only exceptions to this are where confidentiality can be overridden either by a court order or other legal authority, or in the public interest. Public interest justifications usually relate to disclosures to prevent significant harm to third parties or to prevent or to prosecute a serious crime. The vulnerable adult maybe also be unaware of options available to reduce the risk of further harm.

Where an adult lacks capacity, information can be disclosed in accordance with the Mental Capacity Act, where, in the opinion of the relevant health professional, it would be in the incapacitated person’s best interests. Where an adult lacks capacity to consent to disclosure it is usually reasonable to assume that they would want people close to them, or directly involved in their care to be given information about their illness, prognosis and treatment, unless there is evidence to the contrary.
Card ten – What part does good communication play in safeguarding?

Good communication is a fundamental medical skill, and much of what appears in this card will be common to all discussions between doctors and patients. Good communication can, however, take time, particularly where there may be language difficulties, or some degree of cognitive impairment. There can often be time constraints in hospitals and care homes which can present challenges to the delivery of personalised health care. The basic principle however is that all individuals should be offered information about their condition and about options for treatment or support in a manner appropriate to their needs. This includes adults who may lack capacity but who have some ability to participate in decision-making. Listed below are key aspects of good communication.

- Good communication involves an honest and sensitive exploration with the patient of health conditions, treatment options, prognosis, risks and side-effects. Euphemism should be avoided, and thought should be given to timing of discussions and to the use of communication aids where appropriate.
- Information should be tailored to the individual’s needs. This may, for example, involve the use of pictures, or, where English is not a first language, translators.
- Consideration should be given to the use of fact sheets and other written communication supports.
- All patients should be encouraged to participate as far as possible in decision-making.
- Most patients will want those close to them to be involved in communication and decision-making, but all patients have a right to confidentiality and where an individual has indicated
that information should not be shared this should be respected

- Health professionals must avoid the use of communication styles that inadvertently imply that patients lack autonomy, dignity or competence
- Good communication is about more than conveying information, it is also about establishing positive professional relationships
- Time should be taken to identify the patient’s underlying values and beliefs that may have a bearing on decisions that need to be made.
- Where the criteria in the Mental Capacity Act are met, consideration should be given to involving an advocate, such as an Independent Mental Capacity Advocate (IMCA) to facilitate good communication
- Discussion with vulnerable adults can involve broaching sensitive subjects and this requires good communication skills. Where health professionals are likely to be working with adults who may be vulnerable appropriate training should be provided.

Card eleven – How can safeguarding adults be made part of ordinary care?

High profile cases where adults have been subject to violent or serious abuse or even murdered by those in a position of trust have put adult safeguarding within health services into sharp focus. There is a danger however that a minority of horrific cases, which must be dealt with by criminal justice procedures, detract attention from the work of committed health professionals in the provision of health care and support to vulnerable adults. While abuse of any sort cannot be tolerated, the overwhelming concern of the majority of doctors and other health professionals is with meeting the health and care needs of their patients. It is in this day to day work that the majority of support is provided to vulnerable adults.
A central feature of safeguarding adults in the context of ordinary care is the need for sensitive and supportive communication, particularly where factors such as poor health and problems with understanding or retaining complex or challenging information may lead to difficulties in decision-making. In addition to taking a normal medical history, it may also be helpful for doctors to think more laterally, to look beyond specifically medical concerns and to explore wider aspects of the patient’s experience, such as social, financial and emotional factors that may be contributing to a loss of overall wellbeing. This can help to establish a richer understanding of the needs of vulnerable adults. Time spent in this way can be vital in identifying those adults for whom a multiplicity of factors – mobility issues, financial or other difficulties in providing for the necessaries of life, health deficits, and the presence of domestic or other abuse – can combine to put adults at risk of serious harm.

Another source of possible harm to vulnerable adults can result from family carers who may be under severe and long term stress. Good practice can also therefore involve discussion with those who are in a long-term non-professional care role with a vulnerable adult, including partners and family members. Respite care and the provision of some professional care support can be important contributors to supporting both the carer and the vulnerable adult.

Tragically, every winter older people die from hypothermia. Such deaths are avoidable. The majority of these older people will have been in receipt of health and social care services. Some will have been living in social housing or will otherwise have been known to supporting services. Such appalling deaths are often the result of failures within – and between – systems, often where adults who are unable actively to promote their own interests, and have no family or friends who can offer support and assistance, become lost to the services that are geared to support them. Many GP practices have developed innovative methods for ensuring continuity of contact with vulnerable adults, including appropriate use of flags in electronic notes, regular practice meetings to discuss vulnerable adults, or, where required, the use of successive appointments, home visits or other reminders.
practices allocate lists of vulnerable patients to specific doctors. In this way, doctors, who are extremely busy, can be supported by a system that helps them look out for vulnerable adults. Such approaches are obviously not limited to those who may be at risk of hypothermia or malnutrition, but can be used wherever doctors have concerns that adults may be at risk.

Card twelve – When should GPs contact local authority adult safeguarding services?

Doctors and other health professionals will routinely offer support and advice to adults in their care and much of this will be designed to have an impact on factors contributing to their vulnerability. Where adult patients may be at risk of harm due to a lack of appropriate health resources, or poor clinical performance, doctors have clear responsibilities, outlined by the General Medical Council, to take appropriate action via established channels to protect patients (see card thirteen below). There will be occasions, however, where health professionals identify vulnerable adults at risk of abuse that is unrelated to health services. A key question is at what point should health professionals consider involving local authority adult protection procedures?

It is widely accepted that a useful starting point here is the concept of ‘significant’ harm. This is likely to include not only violent and unlawful acts including hitting, sexual abuse and harmful psychological coercion, but also any acts, or omissions, likely to lead to a serious impairment of physical or mental health. Factors that should be taken into account when considering the involvement of adult protection services will include:

- The vulnerability of the individual
- The nature and extent of the abuse
- The length of time is has been occurring
- The effect of the abuse on the individual
- The risk of repeated or increasingly serious abuse
The likelihood that other vulnerable individuals may also be put at risk
The risk of serious harm
Whether criminal offences are involved

Although these factors are important considerations, the nature of the response, and the agencies who may be contacted, will vary according to circumstances and to local procedures and protocols. It is therefore important that doctors and other health professionals ensure they are familiar with local procedures, in particular how to make a safeguarding referral to the Local Authority and the content of relevant multi-agency adult safeguarding policy and procedures.

Where doctors or other health professionals suspect that a serious crime may have been, or maybe about to be, committed, action should be taken as a matter of urgency. Although health professionals owe a duty of confidentiality to all their patients, this duty is not absolute (see card nine, information sharing). In these circumstances health professionals should discuss the matter with the social services adult safeguarding team or the police as a matter of urgency.

_Card thirteen – When should concerns about patient safety be reported?_

A key component of safeguarding is ensuring that vulnerable adults are kept as safe as possible. While this may mean identifying abusers and working to ensure that adults are protected from them, it can also mean identifying both systemic failures and poor professional performance that can lead to harm. Where systemic problems or poor performance are identified, early intervention is important, leading to better outcomes for vulnerable adults, and for health professionals. There are currently a range of safeguards in place, such as regular inspection of nursing and care homes, and strict licensing specifying what kinds of patients certain homes can admit. Properly implemented, these safeguards can be very effective at safeguarding. In terms of
medical regulation, in its guidance, *Good Medical Practice* the GMC states that, in relation to concerns about patient safety:

**If you have good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems, you should put the matter right if that is possible. In all other cases you should draw the matter to the attention of your employing or contracting body. If they do not take adequate action, you should take independent advice on how to take the matter further.**

In relation to concerns about the conduct and performance of colleagues, the GMC states:

**You must protect patients from risk of harm posed by another colleague’s conduct, performance or health. The safety of patients must come first at all times. If you have concerns that a colleague may not be fit to practise, you must take appropriate steps without delay, so that concerns are investigated and patients protected where necessary.**

Where doctors or other health professionals have concerns about colleagues or about the impact of services on vulnerable adults, they may first need to gather information to establish the facts, taking into consideration patient confidentiality as appropriate. Where patients are at risk, health professionals have a responsibility to act. In many instances, where there are concerns about health systems, or individual practitioners, these can be appropriately dealt with through informal discussion, or through relevant local procedures. This enables problems to be dealt with quickly and as close to the source as possible. Although local policies and procedures will differ, every practice and primary care trust should have procedures in place to deal with concerns about health services, and individual performance.
In relation to the performance of doctors, final responsibility lies with the GMC. In the first instance, concerns can be discussed with the GMC without necessarily revealing the identity of the doctor concerned, and advice on how to proceed can be sought. Where patients are at risk, however, it may be necessary formally to refer the matter to the GMC for further action.

Where these remedies are exhausted, and patients are still at risk, it may be necessary to consider raising the issue more widely – by ‘whistle blowing’, for example, which may involve providing information to media or MPs. The Public Interest Disclosure Act protects whistleblowers who disclose information ‘in good faith’ to a manager or employer. Within the NHS, disclosure in good faith to the Department of Health is protected in the same way. Wider dissemination of information is protected, as long as it is reasonable, not made for gain and meets the following conditions:

- Whistle blowers reasonably believe they would be victimised if they raised the matter internally or with a prescribed regulator
- They believe a cover-up is likely and there is no prescribed regulator
- They have already raised the matter internally or with a prescribed regulator

Further advice on whistle blowing can be obtained from the BMA or from support organisations such as Public Concern at Work.

Card fourteen – What is the structure of adult safeguarding services?

Throughout this toolkit a distinction has been maintained between ordinary health services provided to adults who may be vulnerable, and the systems designed to ensure the quality of those services, and dedicated local authority adult safeguarding services designed to protect vulnerable adults from a risk of serious abuse. In regard to the latter, all local authorities have dedicated services designed to protect vulnerable adults from abuse. Such protection is
delivered by a wide range of services and these can vary from
authority to authority. The following service providers are all likely
to have some input into safeguarding, although they will often vary depending upon the needs of their client:

- Local authority safeguarding adults services
- Adult community social work teams
- Community mental health teams
- Community services for adults with learning disabilities
- The police and criminal justice service

Although all professionals have safeguarding responsibilities in relation to adults in their care, the lead role in co-ordinating dedicated adult protection services rests with the Local Authority (LA). Each LA will have local procedures for safeguarding adults, jointly agreed with their PCT and other local partners. Most will have a website with information about what to do if health professionals suspect that a vulnerable adult is being abused, including a telephone number for direct referrals to local authority adult protection services. The LA safeguarding team will contact the referrer as soon as possible to discuss the concern and next steps. Referral forms can generally be downloaded from their website.

In addition to these there may be other local agencies with whom health professionals might need to work in relation to vulnerable adults. These can include, but are not limited to:

- Multi-agency risk assessment conference (MARAC). MARACs main focus of concern is to identify individuals at risk of domestic violence and to reduce the risk to victims.
- Multi-agency public protection arrangements (MAPPA). MAPPAs support the assessment and management of violent and sexual community based offenders

Card fifteen – A stepped approach to safeguarding?
This toolkit has repeatedly emphasised the complex nature of safeguarding vulnerable adults. The potential client group is extremely wide, ranging from adults who are incapable of looking after any aspect of their lives, to individuals experiencing a short period of illness or disability. A wide range of services and service providers can also be involved, making it difficult to identify those with responsibility to act. Another key distinction is between adults who have decision-making capacity and those on whose behalf decisions have to be made. There is also the question of whether the adult can best be safeguarded through ordinary care routes, or whether the risks require the involvement of dedicated local authority adult protection services. This card sets out a stepped approach to safeguarding that highlights key points in decision making in relation to vulnerable adults.

**Step one: Identifying adults who may be vulnerable**

GPs should be able to identify those adults in their care who may be vulnerable, using where appropriate the criteria laid out in cards three and four above. Identifying and recording factors that may contribute to a patient’s vulnerability can be a vital first step in ensuring that he or she receives necessary support.

**Step two: Assessing the individual’s needs**

Once an individual has been identified as vulnerable, the next step is to assess his or her needs. At this stage it is also essential to identify whether the individual is at risk of immediate harm and to consider whether the local authority adult safeguarding procedures should be engaged.

**Step three: Assessing competence**

In accordance with the cards six to nine on mental capacity, where there are any doubts about an adult’s decision-making capacity this should be assessed at the earliest opportunity. Adults with capacity have the right to make decisions about their own care
and treatment. Treatment decisions made on behalf of adults lacking capacity should be made on the basis of an assessment of his or her best interests?

**Step four: Identify relevant services**

Following discussion with the patient, taking into consideration the need to look laterally beyond direct health needs to wider personal and social factors, relevant supporting services should be identified and offered. This could involve referral to social care, or to other sources of support such as citizens’ advisors or to charitable organisations offering support and advice for individuals suffering from specific disorders or with particular social needs.

**Step five: A consensual approach**

The majority of adults with capacity take up the offer of support services. Where adults with capacity decline services, the reasons should be explored and alternatives offered where appropriate. Ultimately the decision about accepting treatment rests with the competent adult. Where adults lack capacity, they should be involved in decision-making as far as possible. Those close to the adult, including specifically anyone with the power of a welfare attorney should be involved as appropriate.

**Card sixteen – the vetting and barring scheme**

The Safeguarding Vulnerable Groups Act (SVGA) was introduced in 2006 following the Bichard Inquiry into the deaths of Holly Wells and Jessica Chapman. The Inquiry called for the development of a single agency to vet all individuals who seek either paid or voluntary work with children and vulnerable adults and to bar unsuitable people from doing so. The Act led to the creation of a new Independent Safeguarding Authority (ISA) charged with the development of a new Vetting and Barring scheme designed to prevent people who may present a risk from working with children
and vulnerable adults. Under the scheme, anyone working in a ‘regulated’ activity, which includes the provision of any form of healthcare, to children or vulnerable adults will need to register with the newly established Independent Safeguarding Authority (ISA). In the terms of the SVGA, any adult in receipt of any form of healthcare is deemed to be vulnerable.

The role of the ISA is to make decisions as to who should be barred from working with vulnerable groups. The ISA will oversee the development of two new lists: the ISA Adults’ Barred List and the ISA Children’s Barred List that replace those on the Protection of Vulnerable Adults List and the Protection of Children Act List. Initially, anyone seeking to take up a new role working with children or vulnerable adults will have to register with the ISA and by November 2010 it will be mandatory for all those starting a new post. By 2015, those in existing posts will also have to be registered.

From November 2010, employers must check, before work commences, whether any new recruit is registered with the ISA. Failure to do so will be a criminal offence. It is also a criminal offence to appoint a person into a regulated activity role if the employer knows, or has reason to believe, the individual is on a barred list.

Further information is available from the Independent Safeguarding Authority: http://www.isa-gov.org.uk/

The British Medical Association also provides information to GP members about their specific legal and contractual responsibilities in relation to the Vetting and Barring Scheme http://www.bma.org.uk/employmentandcontracts/employmentcontracts/salaried_gps/vettbarringscheme.jsp.
Card seventeen – Guidance on protecting vulnerable adults


No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from


Card eighteen – Adult safeguarding legislation

The law surrounding the protection of vulnerable adults is complex and wide-ranging. Key pieces of legislation and statutory provisions in this area are outlined below.

The NHS Constitution. The NHS constitution sets out a number of core values and patient rights, including the commitment to promote a comprehensive service available to all irrespective of age, gender, disability, race, sexual orientation, religion or belief.


Mental Health Act 1983 (Amended). Renders lawful compulsory treatment of mentally disordered individuals in certain circumstances and puts in place statutory safeguards.
Mental Capacity Act 2005. Provides a comprehensive framework for making decisions on behalf of adults lacking capacity.

Safeguarding Vulnerable Groups Act 2006. Provides a statutory framework for a vetting and barring scheme. It includes the development of a list of individuals barred from working with vulnerable adults. Individuals will be checked against the list before they will be able to start working with vulnerable adults.

Public Interest Disclosure Act 1998. Sets out a framework for public interest whistle blowing that provides protection from reprisal for the whistleblower.

Card nineteen – useful names and addresses

British Medical Association
Medical Ethics Department
BMA House, Tavistock Square, London, WC1H 9JP.
Tel: 020 7383 6286, Fax: 020 7383 6233
Web: www.bma.org.uk/ethics

Ministry of Justice
Selborne House, 54 Victoria Street
London, SW1E 6QW.
Tel: 020 7 210 8500, Web: www.gsi.gov.uk

Department of Health
Wellington House
133-55 Waterloo Road, London, SE1 8UG.
Tel: 020 7972 2000, Web: www.doh.gov.uk

General Medical Council
Regents Place, 350 Euston Road
London, NW1 3JN.
Tel: 020 7189 5404, Fax: 020 7189 5401
Web: www.gmc-uk.org
Office of the Public Guardian
PO Box 15118
Birmingham
B16 6GX
Phone number: 0300 456 0300
Fax number: 0870 739 5780
http://www.publicguardian.gov.uk/.