

Safeguarding  
vulnerable adults  
– a tool kit for  
general practitioners



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## ***Introduction – About this tool kit***

This tool kit is about promoting the wellbeing of adults who may have difficulty in protecting themselves from harm and abuse and in promoting their own interests. Designed principally with general practitioners (GPs) in mind, it will nonetheless be useful for any professional working in a health care 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. Although GP consortia will have a critical role in ensuring that adults are appropriately safeguarded throughout the care they commission, the focus of this tool kit is on GPs as practitioners.

In 2005 the Department of Health (DH) 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 who had been convicted of indecent assault involving their female patients. Although such high profile cases are 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 tool

**Introduction – About this tool kit**

kit is to set out in straightforward terms key concepts and responsibilities in relation to safeguarding adults in England. It 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 1

## A stepped approach to safeguarding

Safeguarding vulnerable adults is a complex area of practice. 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: Prevention – 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 4 and 5 below. 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.

**A stepped approach to safeguarding**

***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. Where harm or abuse has occurred, or where an individual is at immediate risk, it is important to consider whether the local authority adult safeguarding procedures should be engaged.

***Step three: Responding to harm or abuse – assessing competence***

In accordance with Cards 6 and 7 on mental capacity, where there are any doubts about an adult's decision-making capacity this should be assessed. 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 their best interests.

***Step four: Responding to harm or abuse: identifying 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.

**A stepped approach to safeguarding**

***Step five: Responding to harm or abuse – taking 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 care and treatment rests with the competent. 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 health and personal welfare attorney should be involved as appropriate. Information may need to be shared without consent where others are at risk of significant harm.

***Step six: Safeguarding***

Where significant incidents have taken place involving vulnerable adults, GPs will frequently be key contributors, both to any investigation process and in terms of the post-incident care of patients and the development of the protection plan. Although the local authority will have a coordinating role in any multi-agency response, it may also include the individual's GP taking a key role in the patient's protection.

## CARD 2

### Safeguarding vulnerable adults: basic principles

The DH has developed a list of key principles that should articulate and inform good practice in relation to safeguarding vulnerable adults. These are given below and are reflected throughout the following guidance.

#### **Principle 1 – Empowerment**

This foregrounds the strong presumption that adults should be in charge of their care and of any decisions that affect their lives. Safeguarding must involve promoting the independence and quality of life of adults and must maximise their ability to control their own lives. Where adults cannot make decisions, as a result for example of a lack of capacity to make the specified decision, they should still be involved in the decision as far as possible. Legally and ethically, however, 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.

#### **Principle 2 – Protection**

Patients should be offered the support necessary for them to protect themselves. Where adults are less able to protect or promote their own interests, health professionals should take reasonable and appropriate measures to ensure their protection. This also involves assessing whether more proactive measures may be

required to protect a person, such as where, for example, an adult may lack the capacity to make a specified decision.

### **Principle 3 – Prevention**

Prevention of harm or abuse is the primary goal. Prevention involves working with individuals to reduce risks of harm or abuse that they find unacceptable. Prevention involves delivering high quality person-centred services in safe environments. All adults have a right to holistic care that is focused on their individual needs, including their need to be kept safe.

### **Principle 4 – Proportionality**

In addition to respecting the informed choices of competent adults, safeguarding responses should be proportional to the nature and seriousness of the concern. Options should be presented that are the least restrictive of individual rights and choices while remaining commensurate with the desired goals.

### **Principle 5 – Partnership**

Safeguarding adults is most effective where individuals, professionals and communities work together to prevent, detect and respond to harm and abuse.

### **Principle 6 – Transparency and accountability**

As with all other areas of health care delivery, responsibilities for safeguarding should form part of ongoing assessment and clinical audit in order to identify areas of concern and to improve delivery. Good safeguarding requires collaboration and transparency with partner agencies.

**Safeguarding vulnerable adults: basic principles**

In addition to these principles, 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.

## CARD 3

### What is safeguarding?

Safeguarding is about keeping vulnerable adults safe from harm. It involves identifying adults who may be vulnerable, assessing their needs and working with them and with other agencies in order to protect them from avoidable harms. It is a challenging area of practice. The group of adults involved is extremely diverse, making a one-size-fits-all approach inappropriate. Adults who may be the focus of safeguarding range from those whose decision-making capacity is severely impaired, to adults with no underlying cognitive impairment but whose physical situation, or a brief period of illness, has temporarily affected their ability to protect their own interests. The nature of the harms 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.

## What is safeguarding?

Just as the nature and context of harms can vary, so 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 protection services provided by local authorities. Both aspects are set out in this tool kit.

### ***A person-centred approach***

Although the phrase ‘vulnerable adult’ is widely used, it is not without its problems. 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 tool kit 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.

**What is safeguarding?**

***GPs and safeguarding – promoting professional standards***

GPs and other 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 victims of domestic abuse, of patients whose mental and physical health problems lead to difficulties protecting and promoting their interests and of adults experiencing difficulties in their relationships with partners, family members or carers. Doctors are 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. Many of the activities associated with safeguarding will therefore already be familiar to doctors as part of good practice. The maintenance of 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. 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.

## **What is safeguarding?**

### ***Identifying vulnerable adults***

In addition to promoting professional standards, the ability to identify those adults who are at risk of either abuse or neglect, is critical. Card 4 in this guidance gives some indication of those adults who may be at risk, either from individuals or from health care systems that may be failing them, while Card 5 looks at what constitutes abuse. Protecting and supporting these adults will ordinarily entail both the identification of risk factors, assessing the nature and extent of those risks and the provision, or at least the offer, of targeted and proportionate services. Where an adult lacks capacity in relation to a specific decision, for example, this will involve making an appropriate decision on his or her behalf. It will also frequently involve the identification of care partners in order to provide, where appropriate, a comprehensive, multi-agency approach.

### ***Meeting the challenges to safeguarding – multi-agency working***

In addition to the variety of circumstances in which adults can be vulnerable and the complexity of individual needs, which can bring together physical, psychological, social and interpersonal factors, safeguarding presents challenges in relation to the wide range of agencies with safeguarding responsibilities. It is important therefore that where multi-agency support is required, health practitioners identify the lead agency with overall responsibility. It is also important to understand the scope of each agency's responsibility and the limits of its authority to intervene. Authority boundaries are not always coterminous, and appropriate support for a vulnerable adult can require

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cooperation between agencies that have not always worked together successfully. It is vital that agencies work cooperatively to ensure that vulnerable adults do not 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 11, safeguarding adults as part of ordinary care.)

#### **Checklist of key points**

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 4)
- Health professionals should be able to recognise signs of abuse and neglect, including institutional neglect (see Card 14)
- Health professionals need to familiarise themselves with local procedures and protocols for supporting and protecting vulnerable adults

## What is safeguarding?

### Good practice example: managing risk to patients

Mr Hart was recovering from a stroke in a nursing home. As he began slowly to recover he remained quite confused. When he regained the ability to walk he started to wander beyond the confines of the building. The home was fronted by a busy road and the carers in the home became concerned about his wellbeing. Although they did not want to restrict his freedom of movement they were concerned both that he might come to harm and also that they might be found negligent.

Discussing his care with the nursing staff the GP heard that although Mr Hart could be confused, when they talked about the potential risks that he was exposing himself to, he seemed to understand what he was doing. Mr Hart had always worked outdoors and been active and he at times felt constrained and uncomfortable in his room. Following further discussion with Mr Hart and the care staff it became clear that he understood the risks involved and that his ability to walk and to get fresh air was important to his wellbeing. As, in the GP's view, Mr Hart retained capacity, and was aware of the risks, it would be inappropriate, as well as unlawful, to introduce restrictions beyond the ordinary security measures required to keep all the residents safe.

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After careful discussion Mr Hart acknowledged the concerns of staff and agreed that he would try to avoid the road in front of the building, confining himself to the gardens. If he did want to leave the building he would inform the care staff and wait until somebody was able to accompany him. A written record of the discussions, and of the assessment of Mr Hart's capacity to manage the risks, was made.

## CARD 4

### Which adults may be vulnerable?

#### **Definition of 'vulnerable adult'**

The term 'vulnerable adult' is contentious. By labelling adults 'vulnerable' there is a danger that they will be treated differently. The label can be stigmatising and 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 tool kit, 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 wide-ranging definition of a vulnerable adult. This includes anyone aged 18 or over who is in receipt of 'any form of health care.' This definition is too inclusive to enable appropriate distinctions to be made between the needs or vulnerabilities of adults. The overwhelming majority of adults in receipt of

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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 tool kit, neither capacity, nor vulnerability is an all-or-nothing state, but is subject to degrees of variation. A concern with definitions should not interfere with an objective assessment of an individual's needs.

The most widely-used current definition of vulnerable adult is set out in the Government's *No Secrets* guidance. It 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.*

**Which adults may be vulnerable?**

**Factors contributing to vulnerability**

There are a number of factors that can contribute to vulnerability, although their presence is by no means determinative and individuals 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 more of these factors does not necessarily mean that the adult is vulnerable – age, disability or physical illness for example should not lead to the automatic assumption that the individual is vulnerable. A key factor in each case is whether the individual is able to take steps to protect and promote his or her interests.

## Which adults may be vulnerable?

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 change. The web version of this guidance will be updated as appropriate.

### **Good practice example – identifying and responding to vulnerability**

Mrs Granger was a wealthy elderly lady living on her own in a large town house. She had no family or close friends and was supported by a paid carer. She visited her GP complaining that she was losing things and becoming slightly forgetful. It was clear to the doctor that although her decision-making capacity was currently unimpaired, investigation would be useful and together they agreed that it would be a good idea to refer her to a consultant for assessment. She was diagnosed as being in the early stages of Alzheimer's and at her next visit to the GP she became distressed. She had always been fiercely independent and had taken good care of her financial assets. The diagnosis had left her very concerned for the future. During the consultation her GP spent some time discussing options for the future with her, including the possibility of nominating a property and affairs attorney. Although Mrs Granger felt confident in looking after herself, they also discussed the possibility of social services support should the need arise. Although the GP recognised that there were aspects of vulnerability, Mrs Granger clearly

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retained the right to make decisions about her life. They both decided that it would be in Mrs Granger's interests for her to make quarterly appointments with the GP so they could review her needs on a reasonably regular basis.

**Checklist of key points**

The term 'vulnerable' adult is contentious and care must be taken to avoid using it pejoratively or in ways that undermine fundamental rights, interests or freedoms

- A clear distinction must be drawn between adults who retain capacity to make decisions and those whose capacity has been lost or impaired
- Attention must be paid to systemic sources of vulnerability
- A key factor in assessing vulnerability is whether individuals are able to protect or promote their interests

## CARD 5

### What constitutes abuse and neglect?

The term 'abuse' is subject to a variety of definitions, and the distinction between abuse and neglect is not always clear. Neglect can also lead to harms as significant as direct abuse. The 2009 review of *No Secrets* identified that within health care, neglect is the most serious form of abuse and that in some care settings, poor levels of services amounting to neglect were accepted as a result of staff and other resource shortages. In practical terms this tool kit therefore treats neglect as a category of abuse. Abuse can occur in any relationship and in a wide range of circumstances. The *No Secrets* guidance identifies a number of factors that 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.*

### What constitutes abuse and neglect?

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:

- **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

**What constitutes abuse and neglect?**

- **neglect and acts of omission** including deliberate or neglectful failure to meet health or physical care needs or to provide the necessities 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.

## CARD 6

### 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. Although people wanted to be informed of options for care and support, they wanted to retain control. There was also a clear message 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 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.

For many adults vulnerability can develop over time. Deteriorating health, declining alertness or a change in residence or care regime can exacerbate vulnerability and present challenges to the ability of adults to manage risk. Vulnerability is not therefore static, and may vary according to the individual's circumstances. Assessments of an individual's needs

**What part does mental capacity play in safeguarding?**

must therefore be made on a case-by-case basis and be subject to regular review. A key feature of adult safeguarding is 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. Support and advice should be offered as appropriate, but basic freedoms cannot be infringed.

***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 capacity the responsibility for demonstrating that an individual lacks capacity falls upon the person challenging 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 refuses the offer of assistance, this decision should ordinarily be

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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. 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. 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.

**What part does mental capacity play in safeguarding?**

**Good practice example  
– assessing capacity**

Mrs Jones' relatives were concerned that she was sliding into dementia as she seemed increasingly confused, acted out of character, dressed strangely and appeared rude, giving bizarre answers to questions. The family also reported that her confusion had also led to her being exploited by a door-to-door salesman who had talked her into agreeing to 10,000 pounds worth of unnecessary building work. Her GP was asked to carry out an assessment of mental capacity with a view to admission in a specialist care home. The GP had known her for years and was familiar with her reluctance to admit to health problems or ask for help.

After careful discussion with Mrs Jones, she concluded that her declining hearing was behind her bizarre answers as she often misheard the question. Macular degeneration was affecting her eyesight and led to her making unusual clothing choices, ignoring friends and greeting strangers. Fear of incontinence had also led her to start refusing liquids, resulting in dehydration and some mental confusion. Although appropriate treatment rectified her confusion, her failing eyesight meant that she required a higher level of support than she could receive in her home. Rather than being diagnosed with dementia she was instead assessed as being partially sighted. Given her needs, she agreed to move to a supported care environment near to her

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relatives. Safeguarding in this context involved a careful clinical assessment and an identification and treatment of factors that were impairing capacity. This reduced the risk of further exploitation. Following appropriate clinical support, Mrs Jones was identified as having decision-making capacity in relation to the decision to move to a care home. The provision of additional social support enabled Mrs Jones to regain a high level of independence.

### *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

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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.

#### **Good practice example: managing a potentially abusive situation**

Mr Carmichael's wife was experiencing an episode of mental illness. Although she had briefly been an in-patient she was now being treated at home. Largely as a result of her mental illness, there were times when she was verbally aggressive to her husband to an extent that at times amounted to psychological abuse. On one or two occasions she had also struck him. Mr Carmichael was in his 80s, and although physically not strong he had only experienced some minor decline in his cognitive abilities. During a routine visit to his GP, Mr Carmichael discussed the problems he was experiencing with his wife. Although distressed, he was very clear that he wanted to

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continue living with and supporting his wife, despite recognising that there were abusive aspects to his wife's behaviour. Mr Carmichael clearly had the capacity to make decisions about the kind of behaviour he could manage and the risks he was willing to accept. After some discussion, Mr Carmichael agreed that the GP would contact social services on his behalf to look into the possibility of providing

Mr Carmichael with some support, such as respite care. In this way, Mr Carmichael's decision-making freedom was respected, but help was offered in order to mitigate some of the potential harms.

### Checklist of key points

- All adults are presumed to have the capacity to make decisions on their own behalf
- Exceptions to the obligation to respect the informed decisions of adults include where the decision or action results in a threat of significant harm to a third party
- An assessment of mental capacity is decision-specific – it relates to the specific decision that needs to be made at the time it needs to be made
- Where there is doubt about an adult's capacity, a more formal assessment should be made

# CARD 7

## Adults lacking capacity

Decision-making in relation to adults who lack capacity is regulated in England and Wales by the Mental Capacity Act 2005 (MCA). The BMA provides extensive guidance on the Act which is available on its website. A link is given at the bottom of this card. This section contains a very brief outline of the legislation emphasising those aspects most relevant to a safeguarding approach. Professionals are strongly advised to refer to 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, 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 made on patients' behalf promote their overall best interests.

### **Mental Capacity Act 2005**

The MCA 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.

- *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

**Adults lacking capacity**

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.

An assessment of mental capacity is decision-specific. The question 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.

**Adults lacking capacity**

*Best interests*

Under the MCA, all decisions taken on behalf of someone who lacks capacity must be taken in his or her best interests. A best interests 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 whether the decision can be delayed until that time
- 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 9) and the caution that would be required if the adult was believed to be in an abusive relationship.

**Adults lacking capacity**

*Lasting Powers of Attorney (LPA)*

The MCA allows individuals aged 18 or over and who have capacity to appoint an attorney under a personal welfare LPA, to make health and welfare decisions on their behalf once they lose capacity. 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*

The MCA has introduced a new role of Independent Mental Capacity Advocates (IMCA). Under the Act, an IMCA must be instructed in relation to individuals who lack capacity and who have 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. In some situations where adults require safeguarding local authorities are also able to instruct IMCAs.

**Adults lacking capacity**

**Checklist of key points**

- Decision-making in relation to adults who lack capacity is regulated in England and Wales by the Mental Capacity Act 2005
- Adults lacking capacity to make decisions that would protect or promote their own interests are potentially extremely vulnerable
- All decisions made on behalf of individuals lacking capacity must be made in their best interests
- Where appointed, welfare attorneys are under a duty to act in an incapacitated adult's best interests

**BMA guidance on the Mental Capacity Act**

[www.bma.org.uk/images/MentalCapacityToolKit%20July2008\\_tcm41-175571.pdf](http://www.bma.org.uk/images/MentalCapacityToolKit%20July2008_tcm41-175571.pdf)

## CARD 8

### Care and treatment amounting to deprivation of liberty – the deprivation of liberty safeguards (DOLS)

Where adults lack the capacity to consent to treatment, the Mental Capacity Act, as indicated in Card 7, makes it clear that they should be cared for using the less restrictive of the available options. There will be occasions however where adults lacking capacity will need to be cared for in a manner that amounts to a 'deprivation of liberty'. In April 2009 the deprivation of liberty safeguards (DOLS) were introduced to provide protection for this particularly vulnerable group of adults. A brief outline of what factors might amount to a deprivation of liberty, and the safeguards are given below.

#### **What is deprivation of liberty?**

Although the concept of 'deprivation of liberty' is not straightforward, the courts have identified that the following factors are likely to result in deprivation of liberty:

- restraint is used, including sedation, to admit a person who is resisting
- professionals exercise complete and effective control over assessments, treatment, contacts and residence
- the person would be prevented from leaving if they made a meaningful attempt to do so
- a request by carers for the person to be discharged to their care is likely to be refused

**Care and treatment amounting to deprivation of liberty – the deprivation of liberty safeguards (DOLS)**

- the person is unable to maintain social contacts because of the restrictions placed on access to other people
- the person loses autonomy because they are under continuous supervision and control.

**How can deprivation of liberty be authorised?**

Under the MCA, the deprivation of liberty of a person lacking capacity to consent to treatment can be authorised in one of three ways:

- by the Court of Protection exercising its powers to make personal welfare decisions under the MCA
- where it is necessary in order to give life-sustaining treatment or do any 'vital act' while a decision is sought from the court
- in accordance with the DOLS scheme as outlined below.

In addition, it remains possible to authorise deprivation of liberty where a person falls under the provisions of the Mental Health Act 1983.

**Deprivation of Liberty Safeguards (DOLS)**

Where health professionals identify that an individual lacking capacity is at risk of being deprived of his or her liberty in a hospital or care home setting, the 'managing authority' of the hospital or care home has to make an application to a 'supervisory body' to request an authorisation of the deprivation. In the case of an NHS hospital, the managing authority will be the NHS body responsible for its running. In the case of a private hospital or care home, the managing authority will be the person registered, or required to be

**Care and treatment amounting to deprivation of liberty –  
the deprivation of liberty safeguards (DOLS)**

registered, under Part 2 of the Care Standards Act 2000. In England, the supervisory body will be either the body responsible for commissioning or the local authority, in Wales it is either the National Assembly for Wales or a Local Health Board. If the supervisory body agrees that the application should be made, it will commission an assessment to determine whether the qualifying criteria are met, and if appropriate, will grant an authorisation. In an emergency, the managing authority of the hospital or care home can grant an urgent authorisation, but must simultaneously apply for a standard authorisation. This urgent authorisation is usually valid for seven days, although the supervisory body may extend this for up to another seven days.

# CARD 9

## When can information be shared about vulnerable adults?

### **Duty of confidentiality**

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 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.

### **Sharing information**

The multi-agency approach to safeguarding vulnerable adults nevertheless 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. 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, or that could help mitigate a potential

**When can information be shared about vulnerable adults?**

harm. Where a health professional is in this position and believes that information should be exchanged, the reasons for this should be carefully explained, 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.

**Adults lacking capacity**

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 appropriate information about their illness, prognosis and treatment, unless there is evidence to the contrary.

**When can information be shared about vulnerable adults?**

**Checklist of key points**

- Health professionals owe the same duty of confidentiality to all their patients
- Competent adults have the right to determine how their information is used, although this right is not absolute and confidentiality may be overridden by legal authority or where there is a significant risk of harm to others, or to prevent or prosecute a serious crime
- Where an adult lacks capacity relevant information can be disclosed where it is in his or her best interests
- The principle of proportionality entails making balanced decisions about whether to share information without consent

**Good practice example: disclosure of information in an individual's best interests**

Mr Atjit is an elderly man living in residential care. His son is concerned about the care home's ability to meet Mr Atjit's needs as he is becoming increasingly confused. The son contacted Mr Atjit's GP requesting sight of his father's medical records. After a routine visit to Mr Atjit at the care home, the GP felt he was unable to consent to disclosure because of Mr Atjit's deteriorating mental ability. Given that the son was so concerned about the support being offered to his father, in the GP's view it was clearly in the father's

**When can information be shared about vulnerable adults?**

best interests for the son to have access to relevant information about the support he was receiving.

The GP decided, however, that it would not be appropriate to disclose the entire medical record as some of it contained sensitive information not relevant to the current episode of care. The GP therefore gave the son access to current and relevant information but not the entire record.

## CARD 10

### What part does good communication play in safeguarding?

Good communication is a basic 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, surgeries and care homes, which can present challenges to the delivery of personalised health care. In these circumstances, it is important that professionals are sensitive to the potentially coercive effects of pressurised decision-making.

The basic principle 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 should extend to the offer of information about their wider care. Vulnerable adults should be supported to explore choices about their safety and wellbeing. 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.

**What part does good communication play in safeguarding?**

- Good communication involves an honest and sensitive exploration 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.

**What part does good communication play in safeguarding?**

- 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, including discussion of concerns about harm or abuse, 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 11

### 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 protection in 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.

#### *Exploring the needs of 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, or 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 necessities of life, health deficits, the presence of domestic or other abuse – can combine to put adults at risk of serious harm.

### *Working with carers*

Another source of possible harms to vulnerable adults can result from 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.

### *Prevention as part of ordinary care*

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.

Prevention is clearly critical to safeguarding and 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. In this way, targeted support can be offered to patients with the highest levels of need. Some 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. Some practices have also introduced early warning systems in relation to developing trends or where, for example, concerns are emerging about the standards of care in particular care homes.

**Good practice example – effective communication as part of ordinary care**

Mrs Edgman had been active well into her 80s, but as a result of a faulty heart valve, her health began to deteriorate and she began to neglect herself. She lived on her own and had become gradually more self-neglectful. Her neighbours were concerned as she seemed confused and disorientated. Following a collapse she was admitted to hospital where she was diagnosed as suffering from malnutrition and dehydration. After emergency treatment she was started on anti-depressants

and when she had recovered sufficiently she returned home. After receipt of the discharge letter, her GP arranged for a consultation. Although dehydration had temporarily affected her capacity, following treatment there was no evidence of any decline in her cognitive abilities. The GP discussed Mrs Edgman's circumstances and needs and together they explored the way her depression had led her into a downward spiral of self-neglect. Although antidepressants would probably improve her mood, they nevertheless agreed that it was important that they worked together to develop a care plan to ensure that any early signs of deterioration would be acted upon. Mrs Edgman agreed to a referral to social services. Her GP discussed with her the practice scheme whereby individuals in need of support were identified and ongoing follow-up was offered. This would include regular check-ups and, where necessary, home visits. Identified as being at-risk, Mrs Edgman's case was subject to ongoing review at the practice's weekly meeting designed to discuss vulnerable patients.

## CARD 12

### When should GPs refer through multi-agency safeguarding adults service?

Overall responsibility for coordinating multi-agency responses to the harm or abuse of vulnerable adults rests with the local authority, and it is important that GPs are familiar with the relevant local contacts. Where adult patients are 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 (GMC), to take appropriate action via established channels to protect patients (see Card 13). This will include engaging multi-agency safeguarding services. Through multi-agency procedures, agreement can best be reached about how to support vulnerable adults and how to investigate the concerns of abuse or neglect. Although, for example, health services might lead any investigation into allegations of misconduct about a health professional, a multi-agency approach can ensure openness and accountability, as well as a multi-agency approach to supporting the vulnerable adult.

#### *Significant harm*

A key question for health professionals is the point at which they should consider involving local authority adult protection procedures. 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

**When should GPs refer through multi-agency safeguarding adults service?**

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 it 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 that 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 the local authority adult protection leads, and the relevant multi-agency adult protection panels.

*Serious crime*

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 9). Where an adult has the relevant decision-making capacity, they retain the freedom to decide how best to manage the risks to which they may be exposed, including whether a referral through multi-agency procedures would help them. Where other individuals may be at

**When should GPs refer through multi-agency safeguarding adults service?**

harm, however, or where there is concern that a serious crime may be, or may have been committed, referral must be made through appropriate procedures. In these circumstances health professionals should discuss the matter with the social services adult protection team as a matter of urgency. It may also be necessary directly to contact the police.

**Checklist of key points**

- Where harm or abuse has occurred or there is significant risk, multi-agency procedures provide a means of investigating and protecting the person
- Where adults have relevant mental capacity they have the right to decide how to manage risks, including whether a referral through multi-agency procedures would assist them
- Where other individuals are at risk of harm information may need to be shared without consent
- Where adult patients are at risk of harm due to a lack of appropriate health resources, or poor clinical performance, doctors have clear responsibilities to take appropriate action via established channels, including multi-agency safeguarding procedures, in order to protect patients
- 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

## CARD 13

### 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.

#### *Health systems and poor resources*

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 minimising harms. 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*

**When should concerns about patient safety be reported?**

*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.*

### *Information gathering*

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 commissioning body should have procedures in place to deal with concerns about health services, and individual performance.

**When should concerns about patient safety be reported?**

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.

*Whistle-blowing*

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 whistle-blowers who disclose information ‘in good faith’ to a manager or employer. Within the NHS, disclosure in good faith to the DH 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.

**When should concerns about patient safety be reported?**

**Checklist of key points**

- Where patients are at risk of harm from substandard services or poor clinical performance, health professionals have a responsibility to act and this will usually involve liaising with local multi-agency procedures
- Initial concerns about the performance of colleagues can be discussed with the GMC without necessarily revealing the identity of the doctor concerned
- The Public Interest Disclosure Act protects whistle-blowers who disclose information 'in good faith' to a manager or employer

## CARD 14

### What is the structure of adult protection services?

Throughout this tool kit a distinction has been made between ordinary health services provided to adults who may be vulnerable, the systems designed to ensure the quality of those services, and dedicated adult protection 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. Protection is delivered by a wide range of agencies and these can vary from authority to authority.

Although all professionals have safeguarding responsibilities in relation to adults in their care, the lead role in coordinating dedicated adult protection services rests with the local authority. Each LA will have local procedures for safeguarding adults, jointly agreed with their commissioning body and other local partners. Most will have a website with information about what do to 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 local authority 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.

**What is the structure of adult protection services?**

In addition to these there may be other local agencies with which 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 offenders.

# CARD 15

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**Guidance on protecting vulnerable adults**

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*Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice.*  
[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_085476](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476)

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[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4008486](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4008486)

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Department of Health (2009) *Safeguarding adults: report on the consultation on the review of 'No Secrets'.*

# CARD 16

## Adult protection 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.

*The Human Rights Act (1998).* The Human Rights Act incorporates the rights set out in the European Convention on Human Rights. It embeds the values of fairness, non-discrimination and dignity into public services.

*Equalities Act (2010).* This links equality with duties to take positive action in relation to groups with defined protected characteristics.

*Disability and Discrimination Act (DDA 1995).* Prohibits unlawful discrimination against disabled people in relation to access to health care.

*Mental Health Act 1983 (Amended).* Renders lawful compulsory treatment of mentally disordered individuals in certain circumstances and puts in place statutory safeguards.

**Adult protection legislation**

*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 whistle-blower.

# CARD 17

## 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](http://www.bma.org.uk/ethics)

### **Ministry of Justice**

Selborne House, 54 Victoria Street  
London, SW1E 6QW.  
*Tel:* 020 7210 8500  
*Web:* [www.gsi.gov.uk](http://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](http://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](http://www.gmc-uk.org)

### **Office of the Public Guardian**

PO Box 15118  
Birmingham  
B16 6GX  
*Tel:* 0300 456 0300  
*Fax:* 0870 739 5780  
*Web:* [www.publicguardian.gov.uk/](http://www.publicguardian.gov.uk/)

**British Medical Association**

BMA House  
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