Safeguarding adults in primary care:

making a safeguarding adults referral

Clinical Question

When and how to make a safeguarding adults referral in primary care

INTRODUCTION

Safeguarding adults is about ‘...protecting an adult’s rights to live in safety, free from abuse and neglect’;¹ which can take many forms (Box 1). Although it is estimated that one in four vulnerable older people are at risk of abuse,² abuse is not limited to older people. Section 42 of the 2014 Care Act — the most significant reform to adult social care for more than 60 years, which has brought a clear legal framework to bear on safeguarding adults — states that

*‘...where a local authority has reasonable cause to suspect that an adult in its area ... a) has needs for care and support ... b) is experiencing, or is at risk of, abuse or neglect, and c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it ... the local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult’s case ...’*³

The Care Act has, therefore, given huge responsibilities to local authorities regarding safeguarding adults. Given the many issues which can present in primary care regarding safeguarding adults, it is also essential for GPs to respond appropriately. This paper presents a straightforward approach to safeguarding adults for GPs.

COMPLEXITY IN SAFEGUARDING ADULTS

The following fictional case scenarios exhibit some of the complexities arising from safeguarding adults that can present to GPs:

- The case of an older female with dementia in a nursing home, whose GP notices she is dirty, poorly dressed and faecally soiled, but whose daughter resists reporting the issue of possible organisational abuse, neglect and acts of omission, shows that public interest disclosure may outweigh individual patient confidentiality, if others are at risk of abuse or neglect.

- The case of a 55-year-old female with learning difficulties, who is off her legs and confused because of constipation, but refuses an enema, highlights the predicament of whether or not to treat a patient lacking the mental capacity to consent.
- The scenario of a 70-year-old man, who is confused and hypotensive from pneumonia, but who refuses hospital admission — as do his two adult children — in the absence of an Advanced Decision to Refuse Treatment (ADRT), shows the importance of GPs acting quickly if a patient is in imminent danger, of GPs feeling confident in assessing capacity, and being willing to act in the patient’s best interests, even if conflict arises with relatives who may, or may not, have a vested interest.

MAKING A SAFEGUARDING ADULTS REFERRAL

Once a concern has been raised, you should act in a way that is legal and protects the individual and others, who may be at risk, while taking into account the views, wishes, feelings, and beliefs of the adult concerned. Always encourage the person to talk freely, while clarifying you may have to break confidentiality if they discuss illegal activity or risks to others.

Mitigate danger

If there is immediate danger, contact the police. If a serious crime has been committed, consider notifying the police, ideally, though not necessarily, with the patient’s consent.⁴ If there is the potential for the involvement of children, or an unborn baby, make a safeguarding children referral.

If others are at risk (for example, other nursing home residents), public interest disclosure permits a safeguarding adults referral without the individual’s consent.

The safeguarding referral

Consider discussing a potential referral with

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Figure 1. Making a safeguarding adults referral in primary care.

REFERENCES

1. Department of Health. *Care and Support Statutory Guidance. Issued Under the Care Act 2014*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf [accessed 5 May 2016].
2. Cooper C, Selwood A, Livingston G. The prevalence of elder abuse and neglect: a systematic review. *Age Ageing* 2008; **37**(2): 151–160.
3. Legislation.gov.uk. *Care Act 2014*. <http://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted> [accessed 5 May 2016].
4. General Medical Council. *Confidentiality*. http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp [accessed 5 May 2016].
5. GOV.UK. *Mental Capacity Act Code of Practice. Code of practice giving guidance for decisions made under the Mental Capacity Act 2005*. <https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice> [accessed 5 May 2016].

a trusted colleague, safeguarding lead or member of the local Clinical Commissioning Group (CCG) safeguarding adults team. Before making a safeguarding referral ensure the patient fits the statutory criteria for an adult at risk (as defined in the introduction) and assess their mental capacity to consent to the referral⁵ (Box 2). If a patient lacks capacity to make a decision about a safeguarding referral, it is acceptable to refer them in their 'best interests'.

Once a decision is made to make a safeguarding adults referral, make as comprehensive a referral as possible, as per local referral procedure (Figure 1). Carefully outline the alleged abuse. Include details about friends, family, or advocacy (who may be able to assist the adult) and any communication difficulties the adult may have. Indicate any concerns about the adult's capacity to understand the safeguarding process.

The safeguarding enquiry

Every local authority now has a statutory obligation to ensure that an enquiry is made if they have reasonable cause to suspect that an adult in their area requiring care and support, is experiencing, or is at risk of, abuse or neglect. Such enquiries could range from a conversation with the adult, or,

if they lack capacity, with their representative or advocate, right through to a more formal multi-agency plan or course of action.

Throughout the process the individual's wishes and wellbeing should be given priority and, if possible (bearing in mind capacity), they should be included in all decisions. It can take time to piece together the whole picture; at every stage inter-agency communication, information-sharing and good documentation are vital. Local authorities should acknowledge all referrals received and give feedback of outcomes to referrers.

CONCLUSION

While the field of safeguarding adults can be complex, by using a structured approach GPs can navigate their way through many of its challenges.

RECOMMENDED READING AND TRAINING

- Pring J. *Silent Victims*. London: Gibson Square Books Ltd, 2003.
- Department of Health. *Female Genital Mutilation Risk and Safeguarding: Guidance for Professionals*. <https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm> (accessed 21 Apr 2016).
- NHS England. *Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework*. <https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf> (accessed 21 Apr 2016).
- Home Office. *Revised Prevent Duty Guidance: for England and Wales*. <https://www.gov.uk/government/publications/prevent-duty-guidance> (accessed 21 Apr 2016).
- Local CCG Safeguarding Adults Teams tend to coordinate an annual training programme: please check with your CCG for more information.

Provenance

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Box 1. Ten categories of abuse as listed in The Care Act (2014)

Physical abuse — including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

Domestic abuse — including psychological, physical, sexual, financial, emotional abuse, so-called 'honour'-based violence.

Sexual abuse — including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault, or sexual acts to which the adult has not consented or was pressured into consenting.

Psychological abuse — including emotional abuse, threats of harm or abandonment, deprivation of contact, *(for example, not being able to see friends and family)*, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

Financial or material abuse — including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Modern slavery — encompasses slavery, human trafficking, and forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

Discriminatory abuse — including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.

Organisational abuse — including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one-off incidents to ongoing ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

Neglect and acts of omission — including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

Self-neglect — this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Box 2. Defining and assessing mental capacity, as described in The Mental Capacity Act 2005⁵

'... a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.'

'A person is unable to make a decision if they cannot:

1. understand information about the decision to be made
2. retain that information in their mind
3. use or weigh that information as part of the decision-making process, or
4. communicate their decision (by talking, using sign language or any other means).'