

Royal College of GPs EVIDENCE

Department of Health: Safeguarding Adults –a consultation on the Review of the ‘No Secrets’ Guidance

1. The College welcomes the opportunity to respond to the Department of Health’s consultation on the Review of the ‘No Secrets’ guidance.
2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. It aims to encourage and maintain the highest standards of general medical practice and to act as the ‘voice’ of GPs on issues concerned with education, training, research, and clinical standards. Founded in 1952, the RCGP has over 36,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline.
3. This is a wide ranging document which considers some fundamentally important questions. We applaud the government for taking up the challenge of trying to make professionals increasingly aware of their responsibility to safeguard, and we agree that forward planning and prevention are far preferable to retrospective action and hindsight.
4. Medical organisations already take safeguarding seriously. The Primary Care Child Safeguarding Forum (PCCSF), an email discussion group associated with the Royal College of General Practitioners, represents doctors working with children and young people in all areas of primary care ranging from general practice, community child health and sexual health. Its aims are to promote an understanding of, and engagement with safeguarding among doctors working in primary care.
5. GPs would welcome a consistent system for practically dealing with reported possible cases of adult abuse. There is a need for national safeguarding adults guidance and, just as in the area of child protection, a necessity for mandatory training on adult abuse within primary care, especially with respect to older people and in particular those with mental health needs. Many GPs are currently completing electronic training on child protection, such as the e-portfolio training the RCGP has developed, and the development of similar training for the safeguarding of adults could be facilitated in coordination with key agencies such as Age Concern, CSIP and Skills for Health.
6. Safeguarding requires effective multi-agency working, which is particularly important in terms of managing risk in the community. Unfortunately poor communication and lack of integration still exists between health and social care in many areas. Poor multi-agency working is a barrier to patient-centred approaches to care.
7. However, there may be a tension between the need to create generic guidance and the different working methods of the multiple agencies and healthcare professions that will be expected to follow it. Because the generality of the guidance might make it difficult to follow in practice, it has been suggested that (for healthcare) specialty-specific guidance should be produced.

Multi professional working

8. The consultation document applauds the concept of multi professional working, which works well in areas where there is a tradition of small communities closely linked, or where some event has brought the agencies in a community closer together. Professionals would like to do the very best for all their patients, and will often go to great lengths to support and care for them in their own homes or communities. Barriers between organisations are built up where organisations have high staff turnover, and individuals are not previously known to one another.
9. UK Primary Care has, since the inception of the NHS, been based on small groups of independent contractor professionals – doctors, dentists, optometrists, pharmacists – working for

the same commissioner but working very much independently. NHS bodies have encouraged the view that "Health" is a single entity, but this is not a true reflection of practice in the front line. The guidance should therefore account for the fact that there are significant differences in the ways that these professions operate.

10. Primary Care Trusts will have to commission services which promote safeguarding. It will not be sufficient to rely solely on national leadership or the altruism of healthcare professionals.

Clinician Engagement

11. It is notable that the Advisory Group is largely drawn from Statutory Government Agencies and the Voluntary Sector, and this is reflected in the high aspirations of the consultation document. It might have been presented differently were the group informed by clinicians in active practice, who will have the challenge of implementing the final guidance. If behaviour change is sought, there will be enormous challenges in terms of distribution of information and delivery of training.
12. The consultation document uses the phrase "get on board with safeguarding" on page 32, but it is crucial to recognise that General Practitioners, and all other independent NHS contractors (Pharmacists, Optometrists, Dentists) have different working arrangements which should, of course, be reflected in the guidance.

Operational Guidance

13. The specifics of implementation of guidance will vary not only between Health and other agencies, but between different parts of health. We would urge the Department of Health to consider the introduction of specialty-specific electronic guidance which could then be integrated with Connecting for Health (CfH) Systems of Choice for Primary Care, Acute NHS Trusts, Mental Health Trusts and Ambulance Services, to give clinicians information about services in their areas. Joint agreed guidance from the General Medical Council (GMC), Medical Defence Union (MDU), Medical and Dental Defence Union of Scotland (MDDUS) and Medical Protection Society (MPS) would be helpful.

Drivers for Standards

14. Within the scientific community, and the NHS as exemplar of that, it is crucial to recognise the value of evidence. Standards are driven upwards by quality evidence showing beneficial outcomes. Policy documents are strengthened if, unless they are endorsed by organisations familiar with comparing strength of evidence. Organisations which lead in this capacity include Medical Royal Colleges, Universities and other academic organisations (including Scottish Intercollegiate Guidelines Network), NICE, non-medical Royal Colleges, Defence Bodies, British Medical Association Board of Science, special interest medical bodies including, for example, the British Heart Foundation and the British Thoracic Society.
15. Practitioners are more swayed by clinical guidance from national organisations with a track record of evidence-based advice, such as NICE. To change the behaviour of Health Professionals may need a more evidence-based approach, and the active support of Primary Care Trusts in rolling out education programmes to all professionals, close to their location.

Independent care homes

16. One member offered two suggestions of how safeguarding for vulnerable adults could be strengthened in independently run care homes. Firstly, they suggested that there should be a regular forum for carers to comment on care provision. The alternative being that complaints are reviewed on an individual basis *after* an event has taken place. Secondly, they suggested that standards for person-centred planning should be improved and, using the experience of a family member to illustrate, reported that the care home had not consulted his family about the family member's care, even though the family were providing 50 per cent of the person's care.

Answers to specific questions in the consultation document:

Prevention

Q2a. Should we be doing more work on prevention? If so, where should we concentrate our efforts? If you are doing preventative work, please tell us what it involves?

17. Prevention of abuse in care homes has been shown in studies to relate to good management with training, support and adequate job satisfaction for the care providers. In domestic situations, the evidence is that abuse occurs in the context of drug and alcohol misuse, mental health issues and poor quality relationships. These will usually be known to the community health care team in one way or another and are usually reported to the primary health care team. The problem is that drug and alcohol services are often overstretched and under-resourced, and mental health services especially for the elderly are very variable. Strengthening these services would help prevent domestic adult abuse.

Outcomes

Q3a. Would an outcomes framework for safeguarding adults be useful? If so, which indicators should we use within the wider responsibilities of local government, the NHS and the police force?

18. This could only be based on comprehensive assessment and follow up of reported concerns within an acceptable time scale. Basing it on successful prosecutions would be doomed to failure as most adults abused by someone they trust either will not press charges, cannot afford the legal fees, or are too mentally impaired or frail to last the course.

Managing Risks

Q4. Managing Risks

19. This is covered by the Mental Capacity Act. The vulnerable person has to be assessed for their capacity to make the decision that will allow them to take the risk they are in/considering. If this is a minor risk (I will not use a commode and want to walk out to the bathroom and accept I may fall) then this can be easily established. If the risk is substantial ('I know my niece has been rough with me but I still want her to live with me') then the assessor may need to feel more certain of the decision, but the principles are the same and most social workers and GPs should be trained and familiar with making these sort of assessments as they do it every day, to varying degrees.

Managing Choice

Q5. Managing Choice

20. If the service user has control of their own budget, then we would assume that they would have the capacity to make their own decision to take a risk and be able to identify any way that they could be helped to minimise its impact. ('I will use my allowance to pay for an alarm I can press if my niece is rough with me.') There needs to be flexibility of response.

Health Services and Safeguarding

*Q6h. Is the **role of GPs** a crucial role for safeguarding in the NHS? Where is the existing good practice and what can be learnt from it?*

AND

*Q6j. What **central leadership** role should there be (if any), and what function should it have (Healthcare Commission, Monitor, Department of Health, General Medical Council, Nursing and Midwifery Council, strategic health authorities)?*

21. Both MENCAP's Death by Indifference and Sir Jonathan Michael's Access to Healthcare for People with Learning Disabilities reports demonstrate that there is a need for a strategic approach

to developing safe practice in primary care, with implications for standards, leadership, investment in training and reflective practice.

Q6i. Are there particular issues in relation to safeguarding and mental health? If so, how should these be addressed?

22. It has been suggested that there is reluctance for GPs to assess mental capacity, and this can be a significant problem in areas where mental health provision for the elderly is poor. This does not just affect safeguarding but all aspects of care for elderly, frail and mentally impaired patients.

23. As a training issue, confidentiality is particularly relevant for those providing care for those with mental disorders. A poor understanding and application of 'confidentiality' can place carers in impossible situations where professionals expect families / informal carers to provide care whilst not providing essential health information. One member suggested that it should be considered 'normal' to share information and that 'confidentiality' should be by exception, with an understanding that the whole issue requires sensitive handling.

Access to the criminal justice system

Q8f. Should information about the safety of a person be passed between health and social care organisations, the ambulance service, GPs, the CSCI and the police? If so, can it happen now or does it need legislation? Should such information include incidents not amounting to abuse, but which may provide early indicators of the likelihood of abuse?

24. Bearing in mind the implications for confidentiality, there would be benefits in sharing information related to the safety of a person between organisations. The downside of compartmentalised information is that it requires a larger critical mass of information to accrue before links are made between service providers.

Q8j. Financial abuse appears to have increased steadily and to have diversified. Is there a need to explore the most common types and most effective responses? Should this include preventive strategies in consultation with the Financial Services Authority and the British Bankers' Association? Should banks, building societies and the Financial Services Authority be encouraged to share information that suggests financial abuse of vulnerable adults?

25. We wonder if there is any check made to assess the level of debt of a person taking on banking on behalf of an elderly person. Situations might arise where relatives with severe financial problems might seek to take out lasting power of attorney.

26. I gratefully acknowledge the contributions of Dr Louise Robinson, Mrs Ailsa Donnelly, Dr David Shiers on behalf of the RCGP Mental Health Task Group, Dr Andrew Mowat on behalf of the Primary Care Child Safeguarding Forum (PCCSF) and the RCGP Child Health Group and Dr Ann Homer towards the above comments. While contributing to this response, it cannot be assumed that those named all necessarily agree with all of the above comments.