**Safeguarding: Adult Safeguarding**

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**Dr Rowena Christmas GP. Safeguarding Lead there for over 20 years and established their Cluster Safeguarding Peer Support group in 2018. A Bevan Exemplar for Safeguarding and RCGP Safeguarding Lead for Wales since 2019.**

0:01 **Chair**: Good afternoon, everybody. Thank you for joining us again for the next in our series of webinars on Safeguarding. I'd like to welcome back our speaker, Rowena Christmas, who is a GP and a real expert on all aspects of safeguarding. So, I'd like to hand over to Rowena to discuss adult safeguarding issues. Thank you.

0:33 **Speaker**: Thank you to all of you for coming to this talk. I think adult safeguarding is sometimes seen a little bit as the Cinderella speciality compared to child safeguarding. But actually, it makes up a huge amount of our safeguarding work in primary care. We have a peer support group in North and South Monmouthshire clusters where we discuss complex cases. And over the last three years, I think probably about 70% of the cases we've wanted to talk about have been adults at risk, rather than children. So, it's a really important area for us.

1:11 **Speaker**: It's a big area. So, trying to cover the whole thing in 60 minutes is quite a challenge. But I'll do my best. We're going to talk about what the unique challenges are with looking after adults at risk. Talk about the Care Act 2014, which sort of underpins all the safeguarding principles that we're thinking about and the Mental Capacity Act. Lots of us, particularly those who look after people in care homes, are aware of DOLS - the Deprivation of Liberty Safeguards Framework, but that's being replaced with Liberty Protection Safeguards. So, we briefly talk about what's coming in. We will talk about enduring power of attorney because we're often asked to be certificate providers for our patients. And then briefly at the end, I'll talk about a couple of the different types of abuse that adults at risk are susceptible to. And then we finish off with some signposting resources.

2:08 **Speaker**: I think I've been asked to talk about this, I mean, largely because I've just always been really passionate about the importance of safeguarding in primary care. I think we're in a really unique position to look out for problems. And if we practise curiously, you know, think what's going on with every consultation, we're going to pick up more problems.

And if we pick up these safeguarding concerns, we can signpost people to help and support,

ideally, before there's a crisis, before they've come to harm. And we can change lives doing that and also have a huge economic benefit to society. So, it's really important.

As I say, I set up the peer support group in Monmouthshire and these have been expanded out across South Wales now. And if anyone's interested in in leading one of those groups in your own area, please don't hesitate to get in touch. I'll be able to support you to do that.

3:07 **Speaker**: So, what is adult safeguarding? In a nutshell, it's about protecting adults with care and support needs to live in safety, free from abuse and neglect. And we try and do this with a rights-based approach. So, we're trying to move away from protection and focus much more on freedom and letting people live their best lives, free from degrading and inhumane treatment and trying to trying to give them the rights to a family life, the rights to liberty and to privacy, which I'm sure is what we all want. And this should be embedded in every part of our sort of routine holistic care that we offer to our patients. Clinical leads for adults safeguarding in our practices really should be working hard to ensure that everybody is sort of focussing on achieving this.

I was asked to point out that we should be using the term ‘adults at risk’ rather than vulnerable adults, because the latter term can suggest that some of the fault for the abuse lies with the victim. And of course, that's not the case.

4:15 **Speaker**: Safeguarding issues in adults are absolutely out there. You know, one Google and you'll probably have pages and pages of headlines of shocking things that have happened. Anyone who thinks, well, we haven't really got too much of a problem in our practice, they are probably not really looking hard enough. They are out there. And if you look for them, you'll spot them. I had just, for instance, a patient who was really quite abrupt with me when she was asking when she was going to have her second Covid vaccination. I talked about it. And then at the end she apologised, and she got a bit upset. And she said that she had had a text for her first Covid vaccination and it had scared her because she'd been a victim of a financial scam and she'd lost about £20,000 pounds. And it came through by a text. And she was very nervous about any text that came from unfamiliar sources. And, you know, the shame and the, you know, the loss of money and the long-term impact of that was huge. So, this stuff is going on all the time. It really is. And we need to be looking out for it.

5:27 **Speaker**: So, this is my mantra - ‘Safeguarding is everybody's business’, and we've all got a duty not just as primary care clinicians, but also just as people in society to sort of be aware and alert to signs of abuse or neglect and then act on those concerns. You know, I don't think someone else is going to do it. So, family and friends have got a responsibility we all have in health and social care. Other people working in public sector e.g. the housing people, Social Security, the police, they've all got a responsibility and private sectors too. So, people working in banks should be aware. So, I've just had to transfer some money for my July tax bill. And I had four or five questions from the women at the bank checking that I knew where the money was going, what I was going to do with it. And, you know, that just feels great that everybody's on this case and is aware and trying to do something to help people.

6:28 **Speaker**: Human rights will underpin everything in adult safeguarding, and we've got this inherent tension all the time trying to balance personal autonomy against keeping them safe. Relationship based working, which is such an important part of our role in primary care, helps us to manage these risks in people's lives, you know. So, it's a buzzword at the moment - co-production - but it's never more important than working with adults at risk of harm. A personalised approach, promoting people's independence will give us the best outcomes time and again. Effective safeguarding needs people and organisations to work together. So just as with child safeguarding, where you pick up the phone and talk to the teacher or the nursery nurse or, you know, the people involved in the children's lives exactly the same way with adult safeguarding. We need to share the risk, communicate concerns early because lots of soft concerns suddenly become a much more significant concern.

Really important to remember the adults with safeguarding needs tell us time and again that what they want is to be listened to. They want to be believed. They want to be trusted, and they want to be an informed and involved in their care. And they never want to be judged, which is the same for all of us.

7:52 **Speaker**: Our whole team in primary care plays a really important part with safeguarding. For example, everybody is entitled to see a GP whether they have an address or not. Now, when someone registers at the practice, they need to bring a whole load of information in order for that to happen now. But actually if someone's homeless and

doesn't have that information our receptionists need to know that they can still come and have an appointment and look after that person. So, you know, it's empowering the receptionist to know that the info is needed, but if this is a crisis, then it's not always needed.

Or, for instance, our Read Coders. Our read coder is superb. And she was recognising that a middle-aged woman in our practice had been seen over the previous six months in several different emergency departments, in different parts of the country. So, she came in and recognised that was a worry and brought it to me as Safeguarding Lead. It turned out that that woman was actually a keen mountain biker, but not very good and kept falling off and hurting yourself. But, you know, it could have been that she was being assaulted by her partner.

Or you've got your summariser. They need to know what to be looking out for. So, you know, an example was someone was summarising a new patient record and they recognised that in that household there was an adult with learning difficulties as well as a victim of domestic violence. So, she brought that to me because that was obviously a concern not just for the victim, but also for the adult with safeguarding needs.

Our practise nurses. We had somebody who was just slowly developing dementia and she didn't come for their routine three monthly B12 injection. And she made several phone calls, managed to get consent to discuss future appointments with a family member to make sure that they were being looked after and came for appointments.

And then finally, if you're lucky like me and you've got a practice manager who underpins everything in your practice and takes overarching responsibility for everything, you know, they make sure that everyone's safely recruited, references are checked, DBS checks are in place, makes sure that all of the safeguarding training has been done along with the Safeguarding Lead. All of this are really important here. And it's really important that we empower our team to know just how important they are and what a difference they can make to people's lives.

10:27 **Speaker**: So, there are six principals of adults safeguarding, and it's worth keeping them in mind when you're practising. So, **empowerment** is key to what we're doing. We really want to ensure that people are making decisions for themselves about themselves, that we've got informed consent for anything we do, that they are informed. Clearly as with everything, **prevention** is better than cure. So, try and take action before harm happens. And that's about, you know, looking out for problems, practising with professional curiosity. Particularly in adults, safeguarding **proportionality** is absolutely key. So, we need to always be taking the least intrusive response appropriate to the risk. You know, don't have a catastrophic reaction to something and then change everything. You know, try and keep it all in perspective. **Protection** is all about supporting those in greatest need, working in **partnership** with our local community. **Accountability** is very important. We need to be carefully documenting everything. Always be transparent, you know, everything that we're doing (unless, I mean, potentially in domestic violence, you have to be careful) you will be telling the adult at risk what you're doing, explaining why, finding out their opinion and making sure everything is very, very up front.

11:59 **Speaker**: The Care Act was introduced in 2014, and the idea of this act is that we are basing all of our decision making and our actions on a person's wellbeing, on their strengths, on their rights and finding out what their resilience are. Now wellbeing is defined as a sense of belonging, of purpose, of being able to actively participate and contribute to your community. And I think we all recognise that we all feel better and live a better life if we if we have that. We must try and shift ourselves away from professional solutions and try and find out what the person sitting in front of us actually wants to happen.

We need to work with the risks that people face and try and offer them a person centred, rights-based approach to it. We've got to avoid our tendency of just risk avoidance at all costs. You know thinking ‘Oh my gosh, what are the litigation risks here? You know, I've got to make sure that I'm safe. They're safe’. Actually, that's not necessarily the absolute priority, and we need to develop a more reflexive engagement with risk. Now, the way we do this is by taking a good history, which is our bread and butter. You know, this is what we're really good at as GPs. So, if we can take the time - obviously that's the thing we haven't got so much of - to be interested, to respect them, to listen to what's going on and empathise with the problems. So often adults at risk actually know what challenges they're facing, and they've often got really good ideas for how they can solve them. And then we can be their advocate and we can empower them to put those solutions into place and live the life that they want to live. We really can make a difference if we try. And although as I say, it does take time, it probably saves a ton of time down the down the track. You know, if you can get this right now, then then the problems that you'll be saving are significant.

14:07 **Speaker**: This is really important and what we sort of say all the time. take the person with you. No decision about me without me. See what they want and try and make that happen. Always make sure that the person in front of you is informed and that they are informing us about what they want.

14:25 **Speaker**: Co-production is key, as I said. Previously, a risk assessed by the professional held greater weight than the person's own experiences. And that just goes against everything we're trying to achieve in adult safeguarding. Co-production is all about realising that people with care needs have expertise and skills in their own situations. They know what's going on better than we do. So, a rights-based approach uses the legal framework to intervene only when there's a serious risk of harm.

Narrative analysis, you know, taking a good history will improve our assessment and help us understand what's working and what's not working and what else we can try. We've just got to take the time to listen. These are a group of people whose views are not easily heard. And if you try and take a history when they're feeling very stressed or if they're not very well, you know, if they've got a urine infection or something, it's not going to work. You need to just pause and then regroup and come back when those things are better. Try and find a nice, calm environment where you're not being interrupted or they're not feeling that they're being overheard. Really, all those things make a real difference. It's important that we move away from a sort of process-led tick box culture, go into a person-centred approach, and that will give us our best outcomes.

16:05 **Speaker**: Structured dependency is something I think that a lot of us who work with care homes will recognise, and it's where care institutions contribute to a deepening dependency of people using the services. I mean, particularly, you know, people who go into hospital for several weeks at a time. They've really changed when they come out. It's not good for people to sort of lie in bed and be brought their meals three times a day. And structured dependency can be reinforced by the very processes that are supposed to protect them, like an unquestioning safeguarding referral.

So, an example of that is, is a patient that I used to look after. I'll call him Frank. Frank was about 93/94, and he'd come to our residential home because his wife had died, and he just wasn't really coping very well at home. Cognitively, he was absolutely sharp as a tack. Physically, he was really well. And he chosen that care home because he used to love fell walking. And it was nestled in the inside of banks of the Wye Valley in the middle of the woods. Beautiful. When he joined us, I went and did his new patient check and asked how he was settling in, and he said he was really very happy. He got a cooked breakfast every morning without having to scrub the bacon pan. He said he was never going to have to wrestle another double duvet into a duvet cover. And he was very settled. And I could relate to that. What he tended to do was have his breakfast and then every day he would either walk out the woods and explore or he'd walk down the hill along the lane and into the village and buy himself a paper and a bag of jelly babies. Then one day he was obviously walking down the lane, going around a bend, tiny little country lane and a car, I suspect going a bit too fast met him on the corner. And I think it scared the car driver to death to the point where they wrote a letter of complaint to the care home. And the letter was using, you know, strong, terrifying words, basically like neglect, which caused the manager of the care home huge concern. He was worried about his reputation and felt really perhaps we were wrong to be allowing Frank to go out for his walks every day. This caused Frank an awful lot of upset. So, we convened a multidisciplinary meeting. We had the manager and the lead nurse, social worker, me as his GP and, of course, Frank. And all the professionals sat around and talked, weighed up the risks and the benefits until suddenly Frank piped up and sort of speaking with magnetic importance he said: ‘Well, look, you say what you like.

If you're going to stop me walking, you may as well put me in my coffin because my life will not be worth living’. And so, yeah, that's fair enough, actually. You know, I love going for a walk every day and I'll be miserable if I didn't. So, Frank agreed to wear a high viz jacket. We documented everything. The care her manager had reports, you know, that we'd thought it through. And I'm happy to say that Frank carried on walking for another 18 months, no problems with cars. And it certainly contributed to his quality of life.

19:28 **Speaker**: Now, complaints about the care of older people to the Ombudsman. I've had a look through. Time and again they highlight concerns about their dignity not being respected or concerns about their nutrition and about their personal care. And some highlight an attitude towards older people that fails to recognise their individuality or to respond with appropriate sensitivity or compassion or professionalism to their needs. And of course, this is a stark contrast to the principles and values of the NHS and absolutely not what we want to be doing as GPs. So, we need to be aware of that. And also, what is absolutely key is that we must not protect people to their detriment. That's not what this is about.

20:12 **Speaker**: So, if we have got a safeguarding concern, first thing we have to do is establish the facts. Talk to the person we're worried about. Talk to the people around them. Find out what the impact is on them. Ascertain important relationships. The impact that this concern has got on those. What their wishes are. Very, very important to assess the risk to others like children or other adults at risk in the household. Look at their ability to protect themselves. Look at what they've got in their network that could increase their support. Very important - think about the potential of action actually increasing the risk to the adult.

You know, domestic abuse is the one that springs to mind, but there are other situations where it could potentially put them at risk of harm. And always it's important that we consider the responsibility of the person or the organisation that's actually caused that abuse or neglect.

21:10 **Speaker**: If we're making a referral, of course, our first priority is to ensure that the patient is safe and deal with any immediate medical needs. Tell the patient what's going on. Find out what their views are. If they lack capacity, talk to their family at an early opportunity. And these cases are often really challenging. You know, it's often not quite black and white. So, talk to your colleagues, talk to your Safeguarding Lead or your area safeguarding nurse, you know, a superb source of support to give yourself a little bit of shared risk, I guess. Make sure your notetaking is comprehensive. Write down exactly what the patient has said. State the source of your evidence. Be clear between fact and what's opinion. Avoid your own opinions. Having a sort of in quotation marks phrase coming from the patient or the patient person that's raised the concern carries much more weight.

Our responsibility does not end when we send the referral. You know, we need to carry on providing the person at risk support. Consider whether anyone else is at risk. And also, very key if our referral isn't accepted, if you still feel there's a risk, don't just shrug your shoulders and feel that that's all that you can do. Actually, the responsibilities then back with you. And I've had situations where I've had to rewrite a referral, add a bit more information, and then it does get accepted. It's a pain and it takes time, but it's really important.

22:56 **Speaker**: Now, this is very key. The Mental Capacity Act makes it very clear that making an unwise decision does not necessarily mean you lack capacity, and a lot of family members find that hard to understand. Now, if a patient has capacity and they decline a safeguarding referral, there's nothing more you can do. You need to you need to accept that that is their right. Important to carry on offering other support. You know, don't say ‘Oh, well, fair enough. There's nothing I can do’. You are still there as their GP. And also, it's worth revisiting it, you know, particularly domestic abuse. It's a bit like brief intervention with smoking. I'll often go back to the problem and say: ‘I'm still here’. We can still do things if you need to.

If others are at risk, so children, for instance, and the adult is declining a referral, you need to explain that you're very sorry, but you still do need to refer that to safeguarding and that's essential really. Important that all of your team are empowered with a responsibility and freedom to act on concerns. I sort of liken this to an urgent suspected cancer referral really. If every single one of your USC referrals resulted in a patient being treated for cancer, you probably wouldn't be referring enough. You'll be missing case of cancer. It's exactly the same with safeguarding some of your concerns raised will be OK. You know, you’ll have got it wrong effectively. But that's fine. That means that that you're not missing.

People are not referring enough.

Really important with this that you're open, transparent. Explain to the patient what you're doing and why. Doing this right can have a profoundly positive impact on people's lives. So, it is challenging, but it's really important.

I've got a story about a patient I'll call Mary, who is a good example of possibly making an unwise decision, but we didn't need to do anything. Mary was living in sort of quite salubrious sheltered accommodation, you know, very nice place. If you’ve read ‘The Thursday Murder Club’, it's a bit like that. And she was very settled and happy there. She had two daughters who were quite different. The one was quite affluent. She had a high-powered professional job, and she couldn't visit her mum as often as she'd like to. She had power of attorney for health and social welfare, but not for finances. And she was the one that took responsibility. Mary's other daughter, Jess, was a bit more vulnerable. She had just gone through a divorce. She had some mental health problems with anxiety and depression. But she saw Mary a lot. And I think both sisters loved their mum very much but were very different.

Now, unfortunately, Jess had further problems with the mental health and lost her job, and that meant that she couldn't afford her car. She had a nice car on a finance deal, and it was going to have to go back. So, Mary decided that she didn't want that to happen and that she was going to pay the finance on Jess's car. Sophie, the other daughter, was very worried about this because she knew after her mum had sold her house, she had enough money for about eight or nine years in this nice accommodation. And she thought if she was paying her sister's finance, she'd only be able to stay there for three or four years. And she thought that was the wrong decision. She thought her mum didn't really understand the implications of paying for the car. And she felt really frustrated with her sister that she was taking her mum's money when she felt her mum needed it. She tried to raise these concerns with her mum and with Jess but didn't feel she was listened to, so she raised a safeguarding concern. The social worker contacted me and we both visited Mary and decided that she did have capacity to make this decision. She fully understood that maybe she wouldn't be able to stay in her home for as long as if she didn't pay for her daughter's car, but she didn't care about that. She said she loved going out with Jess. They'd go to the garden centre or go out for lunch or go to the cinema in the afternoon. She said she'd much rather go in the posh car and in some old rust bucket that might not be so reliable. And I think more importantly, she was really worried that if Jess had lost her job, she'd lost her marriage and she also had to lose her car, she felt that she might really go down a sort of decline into a worse depression and she didn't want that to happen. So, we felt that it was Mary's decision to make and explained that to Sophie, who wasn't very happy, but there was nothing she could do about it. And that was a tricky decision. It's not it's not a black and white, clearly that's the right thing. Other professionals may have felt that was the wrong thing. These situations are shades of grey, and that's why it's good to talk about them and to discuss them with colleagues to ensure you make the best decision you can with the information you've got.

28:23 **Speaker**: The Mental Capacity Act of 2005 is a legal framework which is designed to support and protect people with serious cognitive impairments. Now we always have a legal presumption in favour of mental capacity. We assume that someone has capacity to make their own decisions and do what they want until we're absolutely certain they don't. And we have a duty to ensure we do everything we possibly can to help them have capacity. So, if they've got a urinary tract infection, you give them some antibiotics and come back when that's been treated. If they've just had a big argument with their daughter, like Mary about the car, you know, you don't assess her capacity when she's still shaking and upset and tearful. She may not have capacity at that time, but a couple of days later, when she's had time to calm down, you'll probably find she does. So, although, again, that's a time-consuming thing for us as GPs it's really important.

29:26 **Speaker**: So, capacity is time and decision specific. It can fluctuate and that's OK. If someone has got mental capacity, then we've got no legal powers to protect them against their will, as we said. So, they can stay in an abusive relationship and we can't do anything about that and shouldn't be able to. The key thing is we judge that someone has lost mental capacity when they can no longer understand the information needed to make the decision. They need to be able to weigh the information up, retain it for as long as is necessary to make the decision, and they need to be able to communicate their decision to others. So, for instance, Mary said to me at the end of our discussion, so what you're saying is if I pay for Jesse's car, I'll only be able to live here for two years, whereas if I don't pay for her car, I'll be worried sick about her and I won't be able to go out, but I might be able to stay here for six years. That's easy for me. I'll take the two years. So that made me feel ‘Yes, she completely understands the situation’.

30:30 **Speaker**: The five statutory principles are:

* We assume someone has capacity, unless it's established that they don't.
* We need to take all practical steps to ensure that they can make a decision.
* We don't treat them as unable to make a decision merely because they make an unwise decision, even though family members may be really, really confused and upset with us about that.
* A decision that's made on behalf of a person who lacks capacity must be made in their best interests. Now, that sounds obvious, but actually in reality, it isn't always the case. You know, you think of your example where a child is looking after their aged parent who keeps falling over or leaving the house and wandering is at risk of harm. And they're absolutely exhausted and terribly worried about their parent. And they say, right, it's just too much. This is ridiculous. They have to go in a home. This isn't safe. And what they want now, they've sort of come full circle in their own mind and they want their parent in the home because then they'll be protected. And the sort of burden of anxiety and responsibility is taken away from the child, which makes perfect sense. I've been there with my own dad. But actually, if the parent doesn't want to go in a home, we still have to move heaven and earth to try and see what we can do to keep them in their own home but keep them safe. And that might be frustrating to the daughter or the son, but it's the right thing to do.
* So, before a decision is made, we need to just make sure that it can't effectively be achieved in a less restrictive way. Always keep the person at risk at the forefront of your mind.

32:17 **Speaker**: The Mental Capacity Act is intended to be enabling and supportive, not restrictive and controlling. I love this. We should be for our patients, ambassadors of human rights and creative enablers to try to help people live their best lives. Empowerment first and foremost, protection second and just when needed. We want to protect people's best interests through enabling decisions to focus on them as individuals. You know, not blanket decisions for people. Always try and involve family and friends in that. If there aren't any, then refer to an independent mental capacity advocate, delay a decision if there's a chance that the capacity could come back.

33:10 **Speaker**: And a nice example of a patient where sometimes you've got a capacity and sometimes you haven't. This is a patient I'll call Dai. I looked after him for years. He got really significant learning disabilities. He was deaf, had very, very rigid behaviours, and he'd lived for many years in a sort of sheltered fostering environment. His carers were devoted to him, really cared for him, looked after him very well. But they were very anxious to always be seen to do the right thing for him, particularly in terms of his health. He was religiously brought for his six-monthly medication reviews, for his chronic disease management check-ups, always on top of everything. So, when the Bowel Screening Wales faecal occult blood testing kit dropped through the letterbox, they were really keen that Dai should do this and tried to explain it to him. Dai was not interested in having anything to do with this at all. He had a very, sort of very rigid life. He would get up in the morning, eat breakfast, go upstairs to the bathroom to do his business. Then he'd come down and he'd do artwork for a couple of hours before lunch, then go outside, split some logs, or go for a walk before coming in and eating his tea, watching a bit of telly, having a bath and going to bed. That was his life. So, his carers thought, how can we how can we fix this? We can't persuade him. So, they put a margarine tub in the loo hoping they could catch it. Dai was not up for that at all, and the margarine tub was slung out of the bathroom window. And then his carers took the bolt off the bathroom door, hoping that they could kind of burst in before he flushed and catch some poo. That didn't work. And they came to me and I said, don't do that because you're going to end up with chronic constipation. You're going to stop him going to the loo at this rate. So, I tried to explain to Dai. I think he understood that this was about his health. This was about making sure he didn't become seriously unwell. He got that. He subjected to sort of me listening to his chest every 12 months and things like that. He did not want to know. So, we decided to take a best interests decision and I was able to look back through his medical records. We had about ten years of full blood counts every six months, and his haemoglobin was really stable over that time period. His weight was stable. And as I said, he was trundling up to go to the loo after his breakfast every morning with no change in that, there was no soiling in his pants. As far as we knew, there was no change in his bowel habit. So, we decided he had capacity to refuse this test. As we know, lots of people who don't have learning difficulties don't fancy doing it either. And we felt in this situation he had capacity. We would leave it. Now, obviously, if Dai had an acute abdomen and was refusing to go to hospital, I don't think I would make that decision that he had capacity. I'd feel he didn't. And I would insist that we managed by one way or the other to get him into hospital in that situation.

So, you know, you make a best decision for the person in front of you at the time. And again, lots of documentation, lots of discussion to ensure that if something goes wrong, you're backed up.

36:34 **Speaker**: If someone doesn't have capacity, we need to consider their rights and their wellbeing and their happiness when we safeguard them as well as their risk. Really try to base decisions on what they've said in the past. If the stronger and clearer the wishes are, the greater the weight that should be given to them. And sometimes there'll be something that's just got magnetic importance, a bit like Frank with his walks, which overrides everything else. So, until now, the Mental Capacity Act has been limited by a sort of prevailing culture of paternalism and risk aversion. And lots of serious case reviews have highlighted a lack of a personalised approach. Mumby in the House of Lords said very eloquently, ‘What's the point of making someone safer if it really makes the miserable?’

37:27 **Speaker**: We are just going to move on and talk about Deprivation of Liberty, Safeguards (DoLS) which were part of the Mental Capacity Act of 2005. These come into account when a person is under continuous supervision and control, usually in a care home or hospital where they're not free to leave and they lack capacity to consent to these arrangements.

Restraint is lawful if it's deemed necessary to prevent harm, but it's got to be the last option. Use the least amount of force for the shortest time possible and it's got to be linked to a care plan. Now, this safeguard is supposed to ensure that the arrangements are in the person's best interests. They need to have someone appointed to represent them. That person has a legal right of appeal and the arrangements are reviewed regularly and continued for no longer than necessary.

DoLS have been, as probably many of you are aware, subject to very heavy criticism since their inception. They are frequently not used when they should be so. So, the individuals and also that the care providers are both subject to legal challenge. They're described as it administrative and a bureaucratic nightmare, placing additional pressures on an already overstretched system. And they often fail to achieve any positive outcome for the person concerned or their family. They only cover one setting. So, if somebody is in a care home and they want to go to a day care centre once a week, you need to go to the Court of Protection to transfer the authorisation for that. You know, it's all a bit of a nightmare and they regularly fail to prioritise people's wishes and feelings.

39.13 **Speaker**: To replace them, the Liberty Protection Safeguards are supposed to have been brought in. As you can see from this slide from December 2019, the plan was for this to be up and running by May 2020. But of course, Covid rather took over from that. The Liberty Protection Safeguards are supposed to serve the same essential purposes as DoLS, but they are covering more than one setting. They're set up before the event happened. So, before the person, for instance, is moved to a care home. The options are considered when there are still options when you can still change the plan. The idea is that they're going to impose a discipline on the care and the treatment planning itself and should reduce bureaucracy. Ideally, they're going to improve outcomes through a more rights focussed decision making process. All the stuff I've been talking about through the through the talks so far. And importantly, they also cover 16 and 17-year-olds, which DoLS didn't. That sort of poor group of young adults or older teenagers that so often fall through the net in the NHS.

So, they apply to any arrangements that would give rise to a deprivation of liberty. They talk about people being of unsound mind. This is people with learning disabilities and also people with mental health problems or sometimes personality disorders. The arrangements must be necessary and proportionate, and a required consultation must be carried out before they're brought in. In two situations where the deprivation of liberty is against what the person wishes or if third parties are at risk of harm, then an approved mental capacity professional has to be involved with it.

41:07 **Speaker**: This is a sort of flow chart of what happens when it's brought in.

41:17 **Speaker**: As I say, it was all postponed because of Covid and Covid had such a huge impact on adults safeguarding. Remote contact with adults at risk made it much harder for us to work out exactly what they wanted. Many care homes weren't well equipped to support remote contacts although I did find once our care home got its iPad, it was amazing how much the residents appreciated seeing me on the iPad. They were not familiar with using them but delight when my face popped up on the screen to ask them how they were feeling. So, it can work well once you get the kit.

Just devastating loss of family contact for these people. Terrible loneliness and sadness, emotional impact from that. But also, family members going in and visiting regularly have a key role in raising concerns and recognising problems in care settings. We had a big risk of blanket decisions being made in the first wave, especially with some terrible newspaper headlines about blanket DNACPR decisions and so on. So, there was an awful lot of potential harm to adults at risk at this time.

It's important that the mental capacity principles remain a priority in situations like that rather than just trying to seek easements because of the pressures.

And there was a confusing interface between Mental Capacity Act and DoLS and then the Coronavirus Act 2020, which gave public health emergency powers. There was a huge variation in what care homes are doing. Some of them wouldn't even let professionals in with a statutory role.

And another key problem, as well as family members not being allowed to visit residents, many of the staff who knew them well, who cared about them, were off sick or were isolating them. You know, bank staff were brought in not only with the infection risk of that, but also, they didn't know the patients and the patients didn't trust them in the same way. A really, really tough time.

43:25 **Speaker**: So, I'm going to move on now to the lasting power of attorney. This is a way of giving someone you trust, your attorney, the legal authority to make decisions on your behalf if you lose mental capacity to do so in the future or if you no longer want to make decisions for yourself.

It can only be set up by a person who has mental capacity. Doing so before you lose capacity means that important decisions can still be made once capacity is lost. Health and welfare lasting power of attorney comes into effect once the person has lost capacity, whereas a property and financial affairs LPA comes into effect as soon as it's registered unless other instructions are stated.

Now, you know, many of us think that if you're in a civil partnership or if you're married, our partners will be able to deal with our finances and make decisions about us if we lose the ability to do so. But if I was hit by a bus today and I didn't have an LPA, my husband would not be able to do anything without applying to the Court of Protection, which is time consuming, complicated, expensive and absolutely the last thing he would want to be doing when he was looking after our kids and trying to look after me and run the house. So, I think we should all try and do that. Lots of us have got wills. Not all of us have got LPAs. In order to set up a lasting power of attorney you can contact the Office of the Public Guardian and download the forms. Or you can go to a solicitor. Or the Citizens Advice Bureau has loads of information. You then get it signed by a certificate provider. It needs to be then registered with the Office of the Public Guardian before it can be used. And that generally takes about nine weeks. It must be registered while the donor has mental capacity. Costs one hundred £82 so £164 for both. But you can get a reduction in that fee for low-income groups.

45:28 **Speaker**: Now, we are probably aware of this because often we're asked to be a ‘Certificate Provider’. The certificate provider is confirming that the patient is making the lasting power of attorney decision by choice, that they understand its purpose and the scope of authority it gives to the attorney. Important to document that discussion. How you've confirmed that the patient hasn't been put under undue pressure, that there's no financial conflicts of interest, that they do understand what they're doing. Now that's probably easier if your patient has been known to you for a while and they've got capacity. It's much more difficult, for instance, if someone's just moved to a care home, you've not met them before and you're not 100% sure if they've got capacity. If you don't feel confident to sign as a certificate provider, do not do it. Don't feel under pressure. There sometimes is pressure for that. But the certificate provider is acting as a really important safeguard.

46:30 **Speaker**: There's two types. There's category A, which is anybody who's known the donor for at least two years. It can be a friend or a neighbour or a colleague from work. And then, ours is the professional skills-based certificate provider. And like I say, if you don't feel comfortable, social workers are brilliant at this. They do it a lot. And, you know, I've several times referred to a social worker because I'm not quite sure whether they have capacity. There's no shame in that.

47:01 **Speaker**: Now going to talk about different types of abuse that adults at risk can be subject to. We all know about physical abuse, financial abuse, verbal abuse, psychological abuse. This can be the result of an act or the failure to act. Some abuse is illegal and that needs to be referred to the police. But it's all about misusing power and control. Much more likely when someone is dependent on another. It tends not to occur in isolation and an older person may be at risk of more than one kind of abuse or neglect.

47:44 **Speaker**: These are all the different forms, and it seems to be more and more as time goes on. You know I'm coming across modern slavery now and sexual abuse is more common. There’s lots of it about.

48:02 **Speaker**: I'm going to talk about financial abuse because this is probably the most prevalent form for adults at risk. The Office of the Public Guardian receives and records more instances of financial abuse than any other. This includes having money or property stolen, being scammed, put under pressure in relation to money or property, or having your money and property misused. And with our growing elderly population, they have deteriorating cognitive skills and that reduces their financial literacy. This is a huge issue, and we need to be providing people with information and support to prevent harm occurring. The awful thing is it's frequently not reported because there's so much shame and guilt and humiliation attached to it. You know, victims often don't speak out.

48:59 **Speaker**: In the average scam - I couldn't believe this when I read it - £91,000 is achieved with each scam that goes on.

Signs of financial abuse for us as GPs and also as members of society to look out for are selling possessions, people being unable to pay their bills, losing financial documents being cut off from their family or friends, their carers suddenly having lots more money to spend.

Changes in how a cashpoint card is being used or bank accounts being used or sudden and unexpected change someone's will. I mean, it all sounds obvious, but you've got to be looking for it, really.

49:45 **Speaker**: The risk factors for financial abuse by far and away the greatest one is age, but also social isolation is really important. And even before Covid, over a million older people say they often or always feel lonely, makes them much more vulnerable. Cognitive impairment is really important for this. A previous history of having been abused makes someone much more likely to be abused again. Tensions within the family and you know,

looking at this picture is upsetting but the brutal reality is that the family are often the people who are the perpetrators here.

50:23 **Speaker**: Self-neglect is a really difficult one for us to manage, mainly because of our fundamental human rights to a private life. And if someone chooses to live in a particular way, however worrying that is, there are limited circumstances when the law can intervene. Important for cases like this that we take a multiagency approach because we're trying to protect whilst maintaining autonomy and justifications for both of those things can be drawn from the human rights laws. Self-neglect covers a range of behaviours from neglecting to care for your personal hygiene, to not looking after your health, to not looking after your surroundings. We need to make sure we don't hide behind a principle of choice where we're saying, you know, oh, well, you know, it's up to them how they live.

They can still be helped and supported. But at the same time, we shouldn't disregard their own insights into their situation, and we shouldn't assume there can be no rational reason why anyone would live in such a way. So, don't shy away from respectful curiosity. Discuss with them what's going on where appropriate, challenge them. Be kind, be supportive for gosh, it must be quite difficult to live in this room. That that kind of thing is helpful.

51:44 **Speaker**: But I think many of us working in general practice doing home visits, will be familiar with sort of examples like this where you're sort of picking your way over sticky carpet, avoiding the rotting cat food and trying to find the patient in amongst it.

52:05 **Speaker**: So self-neglect needs to be assessed on a case-by-case basis. Whether we need a safeguard response really depends on the adult’s ability to protect themselves by controlling their own behaviour. I've found it's always really useful, even if you don't think that it needs a referral to safeguarding to involve social care because they often have brilliant, constructive suggestions to make things a bit better. There's a host of reasons why people self-neglect and the condition more than any other calls for a sort of person-centred approach, flexible approach. And we need to be ready to challenge their lifestyle choice rather than abandoning them to it. A road we should softly and skilfully negotiate an ongoing relationship, an intervention. And, you know, this is about building relationships, brief intervention, keeping going, trying to help them.

52:57 **Speaker**: And that's the end of the talk. Largely, I finish with words of one of my heroes, Khalil Gibran, who said ‘safeguarding the rights of others is the most noble and beautiful end of a human being’. And I passionately believe this is one of the most important things we do in primary care. We can make such a difference.

I'm aware we don't have much time for questions. So, there's some good resources at the end of this talk. But I'm going to stop now so that we've got time for just a few questions if that's OK.

53:33 **Chair**: What about covert administration of medication from Rosie Preece?

53:36 **Speaker**: That is frequently asked and sometimes you have to do it. I think the key thing is always do a really careful medication review when you're asked for this. Some people absolutely won't take their medication. But when you look, you're being asked to give tablets that probably they don't really need to have anyway when you get to that stage. So, again, if it's absolutely essential, if their blood pressure's, you know, 180 over 100 and they won't take their amlodipine, it probably is worth covertly giving them some amlodipine. But weigh it up on a case-by-case basis and don't just, you know, get your guidelines and see what you can dissolve and just give it to them. Think it through carefully.

54:20 **Chair**: And that's the only question at the moment. Can I suggest you go through some of the resources?

53:36 **Speaker**: This is a really nice, easy to read book with a good index at the back that that you can look things up that covers all the legal aspects and gives a nice synopsis.

This is all of the different books that I use to inform this talk. And there's some fantastic stuff in there. I mean, with the end in mind, I can't recommend highly enough for advance care planning. All the stuff on ethics just gets you thinking a little bit more about how you're practising. Some great resources there. And then if you're like me and you enjoy learning through narrative medicine or, you know, stories effectively, there's some great books here. Maggie O'Farrell wrote about the long-term consequences of institutionalisation and the impact of adverse childhood experiences. Beautiful book, that one. And I've just read ‘Purge’ which is the most vivid, horrific description of modern slavery and the long-term impact, again, of childhood trauma. And then I read an autobiography by Stephen Westaby, who's a cardiologist, and that made me really reconsider my advanced care planning because he carried out some massive operations on patients that I would have thought a more conservative approach would have been more appropriate and actually gained really good extra years of quality of life for them. So, it's really good to challenge our thought processes with books like that. So, yes, some good resources there.

And then I think there's some just more good organisations that you can turn to if you need to, some signposting resources for patients and stuff for us to look up. Public Health Wales is always very good. I think that's it.

56:16 **Chair**: Thank you, Rowena. There doesn’t appear to be any more questions.

56:29 **Speaker**: I've put my email address in the slides, which you'll be sent, and I'm more than happy to always answer questions if I can or, you know, have a chat about a complicated patient any time anyone would like to. So please feel free.

56:44 **Chair**: There's just a lot of thank you messages coming through for an excellent talk, which I will echo hugely. And thank you once again, Rowena, for a fabulous tool, giving us so much insight into the whole range of safeguarding issues. And I believe the next one is about advance care planning, and that's towards the end of July when emails will be coming out for people to look on to that as well. Thank you very much once again. An excellent talk.