



BMA

**Adult
safeguarding –
a toolkit**



Introduction

This toolkit is about doctors' role in safeguarding adults who may be at risk of abuse or neglect. Designed principally for doctors, it is also useful for any professional working in health who encounters adults whose ability to protect their own interests may be challenged – either directly by an abuser, because of their care or support needs, or through institutional neglect or disempowerment. Due to devolved legislation, this toolkit applies to England, although best practice is universal.

The Care Act 2014

The Care Act 2014 (the Care Act) was a watershed in adult safeguarding, and the biggest single change in social care law for more than 60 years. It applies to England and sets out how an individual's care and support needs should be met. It also defines the responsibilities of local authorities and partner organisations, including the NHS, toward adults who have care and support needs and who may be at risk of abuse or neglect.

The Care Act followed a review that found existing legislation narrow and paternalistic, with insufficient focus on the needs of individual service users.

At the heart of the Act is a 'wellbeing' principle. The focus of interventions must be on the wellbeing of individuals. It aims to bring about a shift among service providers from response to prevention – the goal is to prevent abuse and neglect from occurring. Responses should be structured to give people more control over their lives so they remain independent.

From a safeguarding perspective, it sets out statutory responsibility for the integration of care and support between health and local authorities. Although local authorities have statutory authority, NHS England and CCGs (clinical commissioning groups) must work in partnership with local social care services to ensure the safety and wellbeing of all patients receiving health services.

This toolkit explains the key concepts and responsibilities for health professionals in relation to adults who may be at risk of abuse in England.

What is adult safeguarding?

Safeguarding adults is complex. The potential group is wide – it ranges from adults who are incapable of looking after any aspect of their lives to those going through a short period of illness or disability. More than one service can be involved, making it difficult to identify those with responsibility to act. It can involve adults who have decision-making capacity and those on whose behalf decisions must be made.

A key question for doctors is whether the adult can best be safeguarded through ordinary health and social care routes, or whether the risks require dedicated multi-agency safeguarding processes.

Under the Care Act, the purpose of adult safeguarding is to protect and promote a person's right to live in safety and to ensure they are free from abuse and neglect. Safeguarding interventions should focus on:

- preventing harm and reducing the risk of abuse and neglect for adults with care and support needs
- responding to individuals in ways that support them in making their own choices
- promoting an outcomes approach – focussing on what is best for adults with care and support needs and structuring the safeguarding response appropriately.

The Care Act takes a wellbeing approach: the priority in safeguarding is actively to promote the independence and wellbeing of individuals and therefore reduce the likelihood of abuse and neglect occurring.

Person-centred

Safeguarding should address the specific needs of individuals. Everyone is different and every adult receiving services will have different needs, interests and perspectives. Competent adults have a right to make decisions that affect their lives, even where this may result in risk. They may, however, benefit from additional consensual support. A person-centred approach, rooted in good communication and respectful of each person's dignity and independence, is likely to have optimal outcomes.

Professional standards

Doctors and other health professionals have considerable experience promoting the interests of their adult patients. Many have patients who have lived through domestic abuse, or whose mental and physical health problems undermine their ability to protect their wellbeing. Doctors are advocates for their patients, and their support can extend beyond narrowly defined health needs to wider welfare considerations.

Safeguarding is that range of activities designed to respect adults' rights to be free from harm. Many safeguarding activities will be familiar to doctors as part of good practice. Maintaining good professional standards straightforwardly promotes patient welfare, particularly for those patients who may have trouble looking after their own interests.

Clinical governance procedures, including adverse incident reporting, peer review and the appraisal and revalidation process, can help identify poor practice and maintain the highest clinical standards. They are central to 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 carers 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 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 care home manager'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. 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 wanted to leave the building he would tell the staff and wait until somebody could go with him. A written record of the discussions, and the assessment of Mr Hart's capacity to manage the risks, was made.

Key points

- Health professionals should be able to identify adults whose physical, psychological or social conditions are likely to put them at risk of neglect or abuse.
- Health professionals should be able to recognise signs of abuse and neglect, including institutional neglect.
- Health professionals need to be familiar with local procedures and protocols for preventing neglect and abuse.

Which adults might require safeguarding?

Under the Care Act, safeguarding duties apply to any person aged 18 or over who:

- has care and support needs, and
- is experiencing or is at risk of abuse or neglect, and
- is unable to protect themselves because of their care and support needs.

Adults with care and support needs who may be at risk of abuse and neglect can include:

- an older person who is particularly frail
- someone with mental health needs 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
- someone who misuses substances or alcohol to the extent that it affects their ability to look after themselves
- someone living with a person who abuses substances or alcohol
- women who may be particularly in need because of isolating cultural factors.

This list is not exhaustive. The Care Act includes victims of modern slavery, domestic abuse and sexual exploitation. These are largely criminal matters and would require police involvement; they are discussed in more detail later in this toolkit.

People with care and support needs are not always at risk of abuse or neglect. Most adults receiving healthcare can look after their own interests and labelling them 'vulnerable' can be patronising and pejorative. Too much attention on the individual can lead to a failure to recognise that, as highlighted by the Francis report into the Mid-Staffordshire NHS Foundation Trust, systems can contribute to neglect and abuse.

All bodies involved in commissioning health services must make sure the services they commission are provided safely and to a high standard.

Throughout this toolkit, we emphasise the distinction between adults who have capacity to make decisions and those on whose behalf some decisions need to be made. Although adults lacking capacity to make decisions must be involved in decision-making as far as possible, the approach shifts to promoting their best interests in those decisions.

Sadly, more and more health professionals are becoming aware that their patients may be victims of financial abuse. This can be particularly important in assessments of capacity in relation to the transfer of decision-making authority to proxies such as attorneys. Where doctors have concerns about those acting under the authority of a lasting power of attorney, they can contact the Office of the Public Guardian.

Good practice example – identifying someone who may be at risk

Mrs Granger was a wealthy elderly lady living on her own in a large townhouse. 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. After careful investigation, including discussion with colleagues, the GP diagnosed her as being in the initial stages of Alzheimer's and at her next visit to the GP she became distressed. She had always been 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, 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 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.

Key points

- Personalised care is more important than labels – the focus must be on the needs of the individual and how to promote their independence and control.
- Adults who have the relevant decision-making capacity have the right to make decisions about their lives, even if it involves risk.
- Attention must be paid to systemic sources of risk.

Your safeguarding responsibilities – a stepped approach

Safeguarding adults is straightforwardly part of good medical care, linked to both patient safety and overall wellbeing. Doctors work with adults with a range of needs, many of whom will not require support beyond the direct provision of medical care. As mentioned, the purpose of safeguarding is to give people as much control as possible and to help them make informed choices.

Step 1: Identifying adults who may have safeguarding needs

As a first step it is important that doctors can identify factors that may put adults at risk, as set out in more detail in cards 2 and 4. Identifying and recording factors that contribute to risk can be a vital first step in ensuring patients receive necessary support.

Step 2: responding to immediate risks

Where you identify that an adult may have safeguarding needs, you must establish whether they are at immediate risk of harm, if a crime has been committed and whether emergency services, including the police, need to be involved – the priority is to ensure their safety and wellbeing. You should also consider whether a referral to the appropriate local authority safeguarding adult services is required as a matter of urgency.

Step 3: assessing the individual's needs

Having addressed immediate safety issues, it is important to make a thorough and holistic assessment of your patient. This will ordinarily extend beyond the presenting clinical issue to look at their broader emotional, psychological and safeguarding needs. In addition to presenting physical and clinical factors, it is important to consider:

- are there any existing safeguarding alerts or any current agency involvement?
- might there be others at risk, such as children or other adults?
- what are the patient’s home circumstances? Do they contribute to risk?
- what kinds of support does the patient have?

Step 4: assessing capacity

Does the patient have the capacity to make relevant decisions, or do best-interests decisions need to be made on their behalf? Remember that adults with capacity have the right to make decisions on their own behalf, even where it may expose them to risk. In these circumstances it is important to ensure that the patient understands the nature of the risks and is offered support as appropriate. More information on mental capacity is included in cards 6,7 and 8.

Step 5: responding to harm or abuse – identifying relevant services

The aim of safeguarding is to help people develop resilience and maintain independence, and attention must be given to all aspects of the individual’s wellbeing, not just their safety. It is important to explore with your patient what their goals are and how they want to live. Following discussion, relevant supporting services should be identified and offered.

Local authorities have overall responsibility for adult safeguarding and it may be appropriate to refer the individual to social care, particularly where they cannot keep themselves safe.

Where adults are at risk because of poor care, it may be appropriate to contact the CQC (Care Quality

Commission) and/or the body responsible for commissioning the care.

Alternative support services should also be considered. These may include citizens' advisors or charitable organisations offering support and advice for individuals with specific conditions or with social needs.

It is vital that all health professionals familiarise themselves with their local adult safeguarding procedures.

Step 6: a consensual approach

Most adults with capacity accept the offer of support services. Where adults with capacity decline services, the reasons should be sensitively explored and alternatives offered where appropriate. As far as possible you should ensure they are aware of risks and the possible impact on their wellbeing, and encourage them to develop strategies to protect themselves. Ultimately, the decision to accept care and treatment rests with the competent adult.

In some cases information may need to be shared without consent, where others are at risk of significant harm.

Step 7: review

Where significant incidents have taken place, doctors – particularly GPs – will often have an important role. Local authority safeguarding adult boards have a statutory obligation to undertake safeguarding adult reviews in especially serious cases where an adult has been seriously injured or has died and abuse or neglect are suspected.

The six safeguarding principles

There are six safeguarding principles enshrined in the Care Act, and reflected throughout this toolkit.

Principle 1 – Empowerment

As far as possible, adults should be in control of their care and the decisions that affect their lives. Safeguarding must involve promoting their independence and quality of life, and must maximise their ability to control their lives. There should be a presumption that adults will make their own decisions and will be engaged in discussions about what they want from safeguarding.

Principle 2 – Prevention

It is clearly better to act before harm occurs. Prevention of abuse or neglect is the primary goal of safeguarding. It involves working with individuals to reduce risks of harm or abuse and delivering high-quality, person-centred services in safe environments. All adults have a right to care and support focused on their individual needs and requirements.

Principle 3 – Proportionality

Safeguarding responses should be proportionate. They should be no more intrusive than is necessary to respond to the risks involved.

Principle 4 – Protection

Patients should receive the support they need to protect themselves from abuse and neglect. The greater the risk to the individual, the greater the support offered. Where adults are less able to protect themselves, health professionals should take reasonable and proportionate steps to ensure their protection. This will usually involve assessing whether

more proactive measures are required to protect someone. It may involve a multi-agency response.

Principle 5 – Partnership

Safeguarding adults is effective where individuals, professionals and communities work together to prevent, detect and respond to neglect and abuse. Communities have a part to play in safeguarding adults.

Principle 6 – Transparency and accountability

Professional engagement with safeguarding should form part of ongoing assessment and clinical audit to identify areas for improvement in service delivery. Good safeguarding requires collaboration and transparency within and between partner agencies.

Care providers must also avoid discriminating unfairly between groups of patients. Care and treatment decisions must be based on a fair and objective assessment of individual needs, in partnership with service users, and not on assumptions about age or disability.

Abuse and neglect – the categories

Abuse and neglect can take many forms and the distinction between them is not always clear. Neglect can lead to harms as significant as direct abuse. Within healthcare, neglect is the most serious form of abuse and in practical terms this toolkit treats neglect as a category of – frequently institutional – abuse.

Abuse involves the misuse of the power. When identifying if abuse has taken place, it is important to remember that intent is not the issue. The definition of abuse is not based on whether the perpetrator intended to harm the individual, but whether harm was caused, and its impact on the individual. The Care Act guidance identifies these types of abuse:

- Physical abuse – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions
- Domestic violence – including psychological, physical, sexual, financial, emotional abuse, and 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, 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, 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, forced labour and domestic servitude
- 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 care setting such as a hospital or care home, or in one’s own home
- Neglect and acts of omission – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate healthcare 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 that involves neglecting to care for one’s personal hygiene, health or surroundings.

Abuse and neglect can amount to serious violations of an individual’s rights. Many acts of abuse are criminal offences and all 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 the police.

**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 at risk. Retaining control means that competent adults have the right to assess and manage 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 intention is to protect the individual, can itself be a form of abuse.

A key feature of adult safeguarding is considering how best to balance respect for agency – or the ability of adults to make informed choices about their lives – with the provision of support to help them 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

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’. It extends to decisions that entail personal risks and 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 to the person challenging it.

The fact that an adult is regarded as 'at risk' is not by itself evidence that capacity is lacking, and 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 capacity is at risk of harm, but they refuse assistance, health professionals should ordinarily respect this decision but keep an accurate and contemporaneous record of the support offered and the reasons for refusal. Such decisions should also be kept under review and ongoing support should be offered.

For example, where an adult is offered a protective measure but refuses, the situation is likely to be challenging to health professionals. Where possible, the options available to the individual and the nature of the professional's concerns should be discussed in detail, including presenting a range of options to manage risk. Where a competent adult explicitly refuses any supporting intervention, however, this should normally be respected. Exceptions are 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, an abusive adult is in a position of authority in relation to other adults, it may be appropriate to breach confidentiality and disclose information to a relevant authority. Where a criminal offence is suspected, it may also be necessary to involve the police or take legal advice. Ongoing support should also be offered.

An adult should not be lost to or abandoned by relevant services because they initially refused the offer of assistance. The situation should be monitored and the individual informed that they can take up the offer of assistance at any time.

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 led to her being exploited by a door-to-door salesman who had talked her into agreeing to £10,000 worth of unnecessary building work. Her GP was asked to carry out an assessment of mental capacity with a view to admission to 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 her 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 capacity in relation to the decision to move to a care home. The provision of additional social support enabled her to regain a high level of independence.

Where there are doubts about a person's capacity

As discussed above, although an adult with relevant capacity has the right to make decisions, including those that involve risk, difficulties arise where some capacity exists but its extent is uncertain. In these circumstances, 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 their decision may expose them to – the more formal the assessment of capacity is likely to be.

Depending on the circumstances it may be appropriate to refer the patient to a psychiatrist or psychologist with experience in assessing capacity. Where there are doubts about a person's capacity that cannot be resolved using more informal methods, the court of protection can be asked for a judgement.

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

Occasionally an individual whose capacity is in doubt may refuse to be assessed. In most cases, a sensitive exploration of the consequences of such a refusal, such as the possibility that decisions may be challenged later, 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

Mrs Carmichael was experiencing an episode of mental illness. Although she had briefly been an in-patient she was now being treated at home. Largely because 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 continue living with and supporting his wife, despite recognising that there were abusive aspects to her 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 consider the possibility of providing him with some support, such as respite care. In this way, Mr Carmichael's decision-making freedom was respected, but help was offered to mitigate some of the potential harms.

Key points

- All adults are presumed to have the capacity to make decisions on their own behalf.
- Exceptions to the obligation to respect adults' informed decisions 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 that time.
- Where there is doubt about an adult's capacity, a more formal assessment should be made.

Adults lacking capacity

Decision-making in relation to adults who lack capacity is governed in England and Wales by the Mental Capacity Act 2005 (MCA). This section contains a brief outline of the legislation, emphasising the aspects most relevant to safeguarding. Professionals are strongly advised to refer to the detailed guidance signposted at the end of the card.

Adults lacking capacity to make decisions that would protect and promote their interests are potentially at risk of abuse or neglect. Although, in accordance with the principles of the Act, adults lacking capacity should be supported to enable them to participate as far as possible in decision-making, and to express their views, emphasis should shift to ensuring that decisions made on patients' behalf promote their overall best interests.

Assessing capacity

An assessment of capacity involves three stages:

Stage 1: Does the person have an impairment of the mind or brain?

Stage 2: Is the person able to:

- understand the decision they need to make?
- understand, retain, use and weigh the information relevant to the decision?
- understand the consequences of making, or not making the decision?
- communicate the decision – by any means?

If the answer to any of these questions is no, the adult lacks capacity.

Stage 3: Is the lack of capacity a result of the person's impairment of the mind or brain (the causal nexus)?

Mental Capacity Act 2005

The MCA sets out several basic principles that must govern all decisions taken in relation to adults lacking capacity. This is a brief list:

- A presumption of capacity – adults are assumed to have the capacity to make decisions on their own behalf unless it is proven otherwise.
- Maximising decision-making capacity – everything practicable must be done to support individuals to make their own decisions, before it is decided that they lack capacity.
- The freedom to make unwise decisions – the fact that an adult makes a rash, unwise or impulsive decision is not in itself evidence of lack of capacity.
- Best interests – where it is determined that an adult lacks capacity, any decision or action taken on their behalf must be in their best interests.
- Less restrictive alternative – whenever a person is deciding 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, including with the provision of appropriate support. Although some patients, such as those who are 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.

Best interests

Under the MCA, all decisions taken on behalf of someone who lacks capacity must be taken in his or her best interests. Although a best-interests judgement is not an attempt to determine what the person would have wanted, the courts have made it clear this must be considered and may be determinative. Any decision taken that contradicts an adult's previously expressed wishes would need clear justification.

A best-interests decision will involve taking into account all relevant features, 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 a best-interests decision is 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 required if the adult was believed to be in an abusive relationship.

Lasting Powers of Attorney (LPA)

The MCA allows individuals aged 18 or over and who have capacity to appoint an attorney under an LPA, to make financial and 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 (IMCAs)

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 a 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.

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 can be at risk.
- 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.

**Care and treatment
amounting to
a deprivation
of liberty – the
deprivation of
liberty safeguards**

Where adults lack the capacity to consent to treatment, the MCA is clear they should be cared for using the less restrictive of the available options. There will be occasions, however, where adults lacking capacity 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 group of adults.

What is deprivation of liberty?

In 2014 a supreme court ruling lowered the threshold in relation to identifying a deprivation of liberty. The court introduced an 'acid test': that the person is under continuous supervision and control and is not free to leave. Each element of the test must be satisfied. These factors are likely to be relevant:

- 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
- the person is unable to maintain social contacts because of the restrictions placed on access to other people.

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.

DoLS only applies to people who are in a care home or hospital. The care home or hospital is called the managing authority in the DoLS. Where a managing authority thinks it needs to deprive someone of their liberty, they must seek authorisation by a supervisory body. They can do this up to 28 days in advance. For care homes and hospitals, the supervisory body is the local authority where the person is ordinarily resident. This is usually the local authority where the care home is located, unless the person is funded by a different local authority.

A person may need to be deprived of their liberty before the supervisory body can provide a standard authorisation. In these situations, the managing authority can use an urgent authorisation. Urgent authorisations are granted by the managing authority itself.

The managing authority can deprive a person of their liberty for up to seven days using an urgent authorisation. It can only be extended (for up to a further seven days) if the supervisory body agrees to a request made by the managing authority to do this.

Recent case law suggests that where care and treatment is being provided in ordinary circumstances in acute settings, it is unlikely to amount to a deprivation of liberty.

Outside care homes and hospitals, the DoLS scheme does not operate and any deprivation of liberty must be authorised by the court of protection.

When can information be shared about adults at risk?

Duty of confidentiality

Health professionals owe the same duty of confidentiality to all their patients regardless of age, vulnerability or the presence of disability. A mental disorder, serious physical illness or 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 adults nevertheless means that, where it is lawful and ethical to do so, appropriate information should be exchanged between relevant agencies to ensure the right support 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 threat. Where a health professional believes that information should be exchanged, they should carefully explain the reasons for this, the likely benefits, 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.

Ultimately, however, where a competent patient refuses to permit disclosure, this should be respected. The only exceptions 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 prosecute a serious crime.

Adults lacking capacity

Where an adult lacks capacity, information can be disclosed in accordance with the MCA 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.

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: 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 their 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 that Mr Atjit was unable to consent to disclosure because of his 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 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.

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

Good communication is a basic medical skill, and many of these points are common to all discussions between doctors and patients. Good communication can take time, particularly if there are language difficulties or some degree of cognitive impairment. There can be time constraints in hospitals, surgeries and care homes, which can challenge the delivery of personalised 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 the options for treatment or support in a manner appropriate to their needs. This should extend to the offer of information about their wider care. Adults at risk 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.

Key aspects of good communication

- Good communication involves an honest and sensitive exploration of health conditions, treatment options, prognosis, risks and side effects, as well as broader interests and issues including the involvement of social services, changes of residence and disclosure of information to the police or those close to the patient.
- 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. For example, it may involve the use of

- pictures, or translators where English is not a first language.
- 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 – where an individual has indicated that information should not be shared, this should be respected.
 - Health professionals must avoid the use of communication styles that inadvertently imply that patients lack autonomy, dignity or competence.
 - Good communication is about more than conveying information; it is also about establishing positive professional relationships.
 - Time should be taken to identify the patient's underlying values and beliefs that may have a bearing on decisions that need to be made.
 - Where the criteria in the MCA are met, consideration should be given to involving an advocate, such as an independent mental capacity advocate (IMCA). Although the IMCA's role is to promote the best interests of the incapacitated adult, they can also help facilitate good communication.
 - Discussion with adults can involve broaching sensitive subjects, including concerns about harm or abuse, and this requires good communication skills. Where health professionals are likely to be working with adults who may be at risk, appropriate training should be provided.

Safeguarding and the Government's anti-radicalisation Prevent strategy

Section 26 of the Counter-Terrorism and Security Act 2015 places a duty on health authorities to have 'due regard to the need to prevent people from being drawn into terrorism'. The Act does not confer new functions on any authority, but imposes a duty to consider how to prevent people from being drawn into terrorism in the exercise of their ordinary duties. In turn, health staff are placed under a general duty, as part of their ordinary work, to be alert to those who may be at risk of being drawn into terrorism and to refer as appropriate.

As the legislation makes clear, the Prevent duty exists in a 'pre-criminal space'. Its purpose is to identify those at risk of being drawn into terrorism, not to identify those who already present a terrorist threat. It creates no new duties for doctors.

Disclosure of information

As part of the Prevent duty, where health professionals identify individuals who may be at risk of being drawn into terrorism, they will ordinarily refer them to the relevant Prevent lead. As mentioned, the Counter-Terrorism and Security Act creates no new obligations regarding disclosure of information or exceptions to the usual rules on confidentiality. Therefore, information must be disclosed in accordance with the law and professional duties.

Confidential patient information can ordinarily be disclosed:

- where it is shared within the healthcare team for the purpose of providing care and treatment to the patient – in these circumstances, consent is understood to be implied

- where the patient explicitly consents to the disclosure
- in the best interests of an adult who lacks capacity to consent to the disclosure
- where the law requires disclosure (for example, under section 38b of the Terrorism Act 2000 all citizens are required to tell the police if they become aware of information relevant to the prevention of a terrorist act, or securing the arrest or prosecution of someone involved in terrorism where there is an overriding public interest in disclosure).

Children and young people are owed the same duty of confidentiality as adults. Consent should be sought from children who have the relevant decision-making ability. If a child lacks the ability to make the decision, consent should ordinarily be sought from someone with parental responsibility.

Disclosure in the public interest

Information can be disclosed without consent if necessary, where there is an overriding public interest at stake.

Ordinarily disclosure will be justified in the public interest where it is necessary to prevent a serious and imminent threat to public health, national security, the life of the individual or a third party, or to prevent or detect a serious crime. This would also include those planning or carrying out terrorist activities or those who have carried out such activities in the past. These duties remain unchanged following Prevent.

Domestic violence and abuse

It has been estimated that one woman in three, and one man in five, will experience domestic abuse. Two women a week are killed by a current or former male partner. Domestic violence and abuse are a central part of adult safeguarding, and a wide range of detailed guidance is available. Doctors who are likely to work with adults at risk of abuse should familiarise themselves with both local procedures and more detailed guidance. Links are given at the end of this toolkit.

What are domestic violence and abuse?

The UK Government's definition of domestic violence is 'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass but is not limited to psychological, physical, sexual, financial and emotional abuse.'

It can also include:

- coercive control
- digital/online abuse
- so-called 'honour-based' violence
- female genital mutilation.

Doctors need to ensure they have appropriate training to identify patients whose physical or psychological symptoms indicate that they may be subject to domestic violence or abuse. Emotional factors can include:

- agitation and anxiety
- depression

- a constant state of alertness that makes sleep or relaxation difficult
- a sense of hopelessness because they believe they will never escape the control of their abuser.

Physical symptoms can include:

- physical signs such as bruising or cuts
- headaches
- gastrointestinal problems
- chronic pain
- restless sleep or insomnia
- genital soreness
- pelvic pain
- back pain.

Responding to concerns

Where doctors are concerned that an individual may be at risk, the first response should be sensitive, safe and empathetic. When asking questions about domestic abuse it is important to ensure, as far as possible, that the environment is both safe and conducive to raising such a sensitive issue – questions about domestic abuse should not be asked in the presence of others, including any children over two years old. If there are language issues, professional interpreters should be used, not family members.

Where doctors have concerns about domestic violence, it is important to ask the question directly. Euphemism and indirection should be avoided. Guidance from NHS England recommends questions along the lines of: 'Are you in a relationship with someone who hurts, threatens or abuses you?' or, 'Did someone cause these injuries to you?'

It is important that doctors are familiar with local procedures for responding to disclosure, and know what to do when there is immediate risk of harm to patients and their children.

Doctors must make clear, contemporaneous records of any concerns and discussions regarding domestic abuse, including evidence of any injuries. These records should be kept securely – they may be required later for evidential purposes.

Sharing information

Sharing information with appropriate agencies can be an important part of keeping people safe. Many people who are subject to abuse are understandably anxious about information being disclosed, in case it gets back to the abuser and puts them at further risk. It is therefore vital to be clear that, in almost all circumstances, the patient's information will only be disclosed with their consent. It may be appropriate for doctors to encourage disclosure where it is necessary for their protection, and this can include warning about the risks of not disclosing, but doctors should ordinarily respect the wishes of adults with capacity, even if their decision leaves them at risk of harm.

In exceptional circumstances – for example, where a third party such as a child or other adult is at risk of harm – it may be necessary to share information without consent. Information should not be disclosed without consent unless there is clear evidence of immediate risk.

Some cases considered at multi-agency risk assessment conference (MARAC) meetings may constitute exceptional circumstances because MARACs discuss the most serious cases of alleged or suspected domestic abuse.

Information about responding to concerns about female genital mutilation is available from the BMA.

Modern slavery and trafficked people

The terms 'modern slavery' and 'trafficking of people' are often used interchangeably. They refer to the movement of people from one place to another for the purpose of exploitation, usually involving deception, coercion, abuse of power or of the person's vulnerability. The movement of people can be from country to country, or from one place to another within a country. It is a global crime, estimated to affect nearly 50 million people worldwide. In the UK in 2016, 3,800 potential victims of trafficking were identified, although the actual number is likely to be far higher.

Modern slavery covers a wide range of coercive and exploitative activities, including:

- Sexual exploitation – this can include forced prostitution, sexual abuse and the abuse of children to produce abusive imagery. Approximately a third of reported trafficking in the UK is linked to sexual exploitation.
- Domestic servitude – this involves people being forced to work, largely doing domestic chores and childcare duties in private households. They may be deprived of their liberty and be forced to work long hours for little or no pay.
- Forced labour – victims can be forced to work for little or no pay in terrible conditions, frequently subject to threats of violence. It takes place in a range of industries, including hospitality, agriculture and construction. Nearly half of all victims of modern slavery are forced into labour.
- Criminal exploitation – this is where an individual is coerced into criminal activity for the financial benefit of the trafficker. It can include pick-

pocketing, drug-trafficking, cannabis cultivation and credit card or benefit fraud.

- Organ harvesting.

Who are the victims of modern slavery?

There is no typical victim of trafficking and modern slavery, although many originate from areas of political instability and economic deprivation. Two thirds of victims are women, and one in four is a child. Although potential victims have been reported from at least 100 countries of origin, the most common are the UK, Vietnam, Romania, Nigeria and China.

What signs might suggest someone is being trafficked?

Identifying victims of trafficking in a health context is not straightforward. They are unlikely to self-identify as victims. They may be frightened, ashamed, and may have poor English. Factors to look out for include:

- The individual is accompanied by someone controlling or who insists on giving information
- The individual is withdrawn or submissive and defers to the accompanying person
- They give a vague, inconsistent or implausible account of themselves and the origins of their presenting complaint
- They are unregistered with a GP or other relevant local service
- They have moved frequently, whether nationally or internationally
- They have old or serious injuries that have not been treated properly
- They may be suffering from psychiatric or psychological distress such as PTSD.

How should you respond if you have concerns that someone may be trafficked?

Where you have concerns that someone may be trafficked, it is important to try to find out as much as you can about their situation. This must be done in private, without any accompanying person. You should reassure the individual that the consultation is safe and that information will not be released without consent to anyone accompanying them, or to anyone other than relevant statutory services. Although it may be difficult, you should offer ongoing support and explore ways in which the individual can access appropriate services.

Where you identify that an adult may have been trafficked you should discuss it urgently with your safeguarding lead. If you have a reasonable belief that the individual is at immediate risk of serious harm, consider taking appropriate immediate action.

Further information is available from the Department of Health at:

www.e-lfh.org.uk/programmes/modern-slavery

How can safeguarding adults be made part of ordinary care?

High-profile cases where adults have been subject to serious abuse 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 from the work of committed health professionals in the provision of healthcare and support to adults. While abuse of any sort cannot be tolerated, the overwhelming concern of doctors and other health professionals is to meet the health and care needs of their patients. It is in this day-to-day work that most support is provided to adults with care or support needs.

Exploring the needs of 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 mean decision-making is difficult.

In addition to taking a normal medical history, it may be helpful for doctors to think more laterally, to look beyond medical concerns and explore wider aspects of the patient's experience, such as social, financial and emotional factors that may contribute to a loss of wellbeing. This can help to establish a richer understanding of the needs of adults. Time spent in this way can be vital in identifying those adults for whom multiple factors – mobility issues, financial or other difficulties in providing for the necessities of life, health deficits, domestic or other abuse – can combine to put adults at risk of serious harm.

Working with carers

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

Prevention as part of ordinary care

Tragically, every winter older people die from hypothermia. Such deaths are avoidable. Many of these older people will have been in receipt of health and social care services; some will have been living in social housing or 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 to offer assistance, become lost to the services that should support them.

Prevention is clearly critical to safeguarding. Many GP practices have developed innovative methods for ensuring continuity of contact with adults who may be at risk, including appropriate use of flags in electronic notes, regular practice meetings to discuss at-risk adults or, where required, the use of successive appointments, home visits or other reminders. This means targeted support can be offered to patients with the highest levels of need. Some practices allocate lists of at-risk patients to specific doctors. In this way doctors, who are extremely busy, can be supported by a system that helps them look out for adults at risk.

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 standards of care in some homes.

Good practice example – effective communication as part of ordinary care

Mrs Edgman had been active well into her 80s, but because of a faulty heart valve, her health deteriorated and she began to neglect herself. She lived on her own and had gradually become 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 antidepressants, 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 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 review 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 such patients.

When should GPs refer through safeguarding services?

Overall responsibility for coordinating multi-agency responses to the harm or abuse of 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 GMC, to take action via established channels to protect patients. This will include engaging multi-agency safeguarding services. Multi-agency procedures can be the best way to reach agreement about how to support adults and how to investigate the concerns of abuse or neglect. Although health services might lead an investigation into allegations of misconduct about a health professional, for example, a multi-agency approach can ensure openness and accountability, as well as multi-agency support for the 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 is the concept of 'significant' harm. This is likely to include not only violent and unlawful acts such as hitting, sexual abuse and harmful psychological coercion, but also any acts, or omissions, likely to lead to a serious impairment of physical or mental health. Factors to take into account when considering the involvement of adult protection services include:

- the risks to 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 individuals may also be put at risk
- the risk of serious harm
- whether criminal offences are involved.

Although these factors are important, the nature of the response, and the agencies that may be contacted, will vary according to circumstances and to local procedures and protocols. Doctors and other health professionals should ensure they are familiar with local procedures, local authority adult protection leads and multi-agency adult protection panels.

Serious crime

Where health professionals suspect that a serious crime may have been, or is 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.

Adults with decision-making capacity have the freedom to decide how best to manage the risks to which they are exposed, including whether to be referred through multi-agency procedures. Where other individuals may be at 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 to contact the police directly.

Key points

- Where harm or abuse has occurred or there is significant risk, multi-agency procedures are 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 help 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, to protect patients.
- Where doctors or other health professionals suspect that a serious crime may have been, or may be, committed, action should be taken as a matter of urgency.

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

A key component of safeguarding is ensuring people 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, which 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 patients and for health professionals. A range of safeguards are 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 harm.

In terms of medical regulation, in its *Good medical practice* guidance, the GMC states in relation to concerns about patient safety:

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

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

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

Information gathering

Where doctors or other health professionals have concerns about colleagues, or about the impact of services on patient safety, they may first need to gather information to establish the facts, taking patient confidentiality into consideration as appropriate. If patients are at risk, health professionals have a responsibility to act. Although local policies and procedures differ, every practice and commissioning body should have procedures to deal with concerns about health services, and individual performance.

In relation to doctors' performance, 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 to refer the matter formally to the GMC for further action.

Whistleblowing

If these remedies are exhausted and patients are still at risk, it may be necessary to raise the issue more widely – by 'whistleblowing', for example, which may involve providing information to media or MPs. The Public Interest Disclosure Act protects whistleblowers

who disclose information 'in good faith' to a manager or employer. In the NHS, disclosure in good faith to the Department of Health is protected in the same way. Wider dissemination of information is protected, as long as it is reasonable, not made for gain and meets these conditions:

- whistleblowers 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 whistleblowing can be obtained from the BMA or from support organisations such as Public Concern at Work.

Useful sources of guidance

British Medical Association and the Law Society (2015) *Assessment of Mental Capacity*. 4th edition.

British Medical Association (2016) *Confidentiality and health records toolkit* www.bma.org.uk/advice/employment/ethics/confidentiality-and-health-records/confidentiality-and-health-records-tool-kit/introduction

British Medical Association (2016) *Consent toolkit* www.bma.org.uk/advice/employment/ethics/consent/consent-tool-kit

General Medical Council (2017) *Confidentiality: good practice in handling patient information* www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp

General Medical Council *Domestic abuse: case study* www.gmc-uk.org/guidance/ethical_guidance/30854.asp

NHS England (2017) *Safeguarding adults* www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf

Office of the Public Guardian www.gov.uk/government/organisations/office-of-the-public-guardian

Social Care Institute for Excellence *Adult safeguarding* www.scie.org.uk/adults/safeguarding

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