

Brigstock Skin and Laser Centre



20. Child Protection and Safeguarding Vulnerable Adults Policy

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Table of Contents:

20.1 SAFEGUARDING CHILDREN POLICY.....	4
20.1.1 Policy statement	4
20.1.2 Basic principles	4
20.1.3 Responsibilities	5
20.1.4. What to do if you are worried about a child	5
20.1.5 Immediate actions	8
20.1.6 Common presentations and situations in which child abuse may be suspected include:	9
20.1.7 What to do when a child alleges abuse:	11
20.1.8 Requests for information:	12
20.1.9 Physical examination of a child or young person:	12
20.1.10 Training – in house	12
20.1.11 Record keeping	13
20.1.12 Designated member of staff for record keeping	13
20.2 SAFEGUARDING ADULTS	15
20.2.1. Introduction	15
20.2.2 Key highlights in decision making	15
20.2.3 Key Principles	17
20.2.4 What is Safeguarding?	18
20.2.5 Which adults may be vulnerable?.....	20
20.2.6 What constitutes abuse?	21
20.6.7 What is capacity?	21
20.6.8 Adults lacking capacity	22
20.6.9 Deprivation of Liberties.....	24
20.6.10 Confidentiality.....	25
20.6.11 Safeguarding and Communication.....	27
20.6.12 When should a clinician refer through multiagency safeguarding adults service?	29
20.6.13 When should concerns about patient safety be reported?.....	30
20.6.14 Sharing information for direct care of vulnerable adults	32

20.1 SAFEGUARDING CHILDREN POLICY

20.1.1 Policy statement

Under the 1989 and the 2004 Children Acts a child or young person is anyone under the age of 18 years. Safeguarding children is the action we take to promote the welfare of all children and protect them from harm.

Child Protection refers to the activity that is undertaken to protect specific children who are suffering or at risk of suffering significant harm. The Clinic recognises that all children have a right to protection from abuse and neglect and the Clinic accepts its responsibility to safeguard the welfare of all children with whom staff may come into contact.

We intend to:

- Respond quickly and appropriately where information requests relating to child protection are made, abuse is suspected or allegations are made.
- Provide children and parents with the chance to raise concerns over their own care or the care of others.
- Have a system for dealing with, escalating and reviewing concerns. Remain aware of child protection procedures and maintain links with other bodies, especially the commissioning body's appointed contacts.
- The Clinic will ensure that all staff are trained to a level appropriate to their role, and that this is repeated on an annual refresher basis. New members of staff will receive induction training within 3 months.

20.1.2 Basic principles

The welfare of the child is paramount. It is the responsibility of all adults to safeguard and promote the welfare of children and young people. This responsibility extends to a duty of care for those adults employed, commissioned or contracted to work with children and young people. The Clinic must have safe recruitment practice including appropriate use of The disclosure and barring service <https://www.gov.uk/government/organisations/disclosure-and-barringservice/about> and safe whistle blowing processes.

Staff who work with children are responsible for their own actions and behaviour and should avoid any conduct which would lead any reasonable person to question their motivation and intentions.

Staff should work and be seen to work, in an open and transparent way.

The same professional standards should always be applied regardless of culture, disability, gender, age, language, racial origin, religious belief and/or sexual identity.

Staff should continually monitor and review their practice and ensure they follow the guidance contained in this document and elsewhere.

The Clinic will ensure regular meetings are held to discuss vulnerable children and families and that such meetings include other Agencies such as Midwives and Public Health Nurses to ensure early recognition of circumstances leading to abuse and neglect and early intervention to help prevent abuse and neglect.

The Clinic will ensure children and their families are able to share concerns and complaints and that there are mechanisms in place to ensure these are heard and acted upon.

20.1.3 Responsibilities

Please see the Kitchen Board for up to date information on the current:

Clinical Safeguarding Lead within the clinic.

Clinical Safeguarding Deputy Lead within the clinic.

Administrative Safeguarding Lead.

The Clinical Safeguarding Lead and Clinical Safeguarding Deputy Lead are responsible for all aspects of the implementation and review of the children's safeguarding procedure in this clinic.

20.1.4. What to do if you are worried about a child

The following website contains the most up-to-date information on who to contact if you are worried about a child:

<http://croydonlcsb.org.uk/what-to-do-if-youre-worried-about-a-child/>

The most recent London Child Protection Procedures can be found at:

<http://www.londoncp.co.uk>

Part A of the London Child Protection Procedures is available at:

http://www.londoncp.co.uk/chapters/A_contents.html

[Thresholds: A Continuum of Help and Support](#) can be accessed here. This is a tool intended to assist practitioners to make decisions about the best course of action, when they have concerns about a child.

SAFEGUARDING CHILDREN

Up to date details of how to make a safeguarding referral in Croydon are detailed in the following link:

<https://www.croydon.gov.uk/healthsocial/families/childproctsafe/childprotect>

To make a child protection referral to Social Care when a child is at risk of harm and in immediate need, please use the following contact; *Child Protection Line – 0208 255 2888*

(This is also the Out of Hours number for children at risk requiring an immediate response)

To make an online MASH referral, the referral form may be found at:

<https://www.croydon.gov.uk/healthsocial/families/childproctsafe/childprotect>

If you need advice in relation to whether a safeguarding referral is appropriate, please contact the Safeguarding Consultation Line at: 0208 726 646

SAFEGUARDING PROFESSIONALS FOR LOOKED AFTER CHILDREN (LAC)

DESIGNATION	LOCATION	PHONE	EMAIL
Fiona Simmons Designated Nurse for Looked After Children <i>Croydon CCG</i> <i>(Monday – Wednesday)</i>	Davis House Suite 2, 2 nd Floor 69-77 High Street CR0 1QQ	Landline: 020 3668 1250 Mobile: 07899973366	Secure address: Fiona.Simmons@swlondon.nhs.uk Fsimmons@nhs.net
Dr Ian Johnston Designated Doctor for Looked After Children <i>Croydon Health Services</i>	Croydon Health Services 12-18 Lennard Road Croydon	Landline: 0208 274 6382	Secure address ian.johnston8@nhs.net
Lyn Glover Named Nurse for Looked After Children & Young People <i>Croydon Health Services</i>	Croydon Health Services 12-18 Lennard Road Croydon	Landline: 02082746433	Secure address lynglover@nhs.net Admin contact for LOC mhn-tr.LookedAfterChildrensTeam@nhs.net

SAFEGUARDING ADULTS

DESIGNATION	LOCATION	PHONE	EMAIL
Estelene Klaasen Designated Nurse Safeguarding Adults Croydon CCG	Davis House Suite 2, 2 nd Floor 69-77 High Street CR0 1QQ	Landline: 020 3668 3240 Mobile: 07825226938	Secure address: e.klaasen@nhs.net estelene.klaasen@swlondon.nhs.uk
<i>To make a safeguarding adults referral to Social Care</i>		Tel: 020 8760 5697 Out of Hours: 020 8726 6500	Referral.team2@croydon.gov.uk
			For further information regarding safeguarding adults go to www.croydon.gov.uk and follow link to 'safeguarding adults'

20.1.5 Immediate actions

Concerns should immediately be reported to the Lead clinician within the Clinic or his / her deputy (above).

Concerns should be discussed internally and an action plan decided.

In the absence of one of the nominated persons, the matter should be brought to the attention of the local Safeguarding Team, or, if it is an emergency, and the Designated persons cannot be contacted, then the most senior clinician will make a decision whether to report the matter directly to Social Services or the Police.

If the suspicions relate to a member of staff there should be internal discussion with the Clinic Safeguarding Lead or deputy, and a plan of action decided, the local Safeguarding Children team and / or social services should be contacted directly. Consideration should be made to involving the LADO.

The LADO (Local Authority Designated Officer) must be contacted within one working day in respect of all cases in which it is alleged that a person who works with children has: behaved in a way that has harmed, or may have harmed a child; possibly committed a criminal offence against or related to a child.

Suspicions should not be raised or discussed with third parties other than those named above.

Any individual staff member must know how to make direct referrals to the child protection agencies and should be encouraged to do so if they have directly witnessed an abuse action;

However, staff are encouraged to use the route described here where possible.

In the event that the reporting staff member feels that the action taken is inadequate, untimely or inappropriate they should report the matter directly. Staff members taking this action in good faith will not be penalised.

Where emergency medical attention is necessary it should be given. If necessary as ascertained by clinical judgement the child should be admitted to the care of the emergency Paediatric service and a social services referral made. Any suspicious circumstances or evidence of abuse should be reported to the designated clinical Lead.

If a Social Services referral is being made without the parent's knowledge and urgent medical treatment is required, social services should be informed of this need. Otherwise, if it is decided that the child is not at risk, suggest to the parent or carer that medical attention be sought immediately for the child.

If appropriate the parent/carer should be encouraged to seek help from the Social Services Department prior to a referral being made. If parents do not consent to medical care or to a social care referral and they fail to do so in situations of real concern the safeguarding Lead will contact social services directly for advice.

Where sexual abuse is suspected the Clinic Lead or Deputy will contact the Social Services or Police Child Protection Team directly. The Lead will not speak to the parents if to do so might place the child at increased risk.

Neither the Clinic Safeguarding Lead nor any other Clinic team member should carry out any investigation into the allegations or suspicions of sexual abuse in any circumstances. The Clinic Safeguarding Lead will collect exact details of the allegations or suspicion and provide this information to statutory child protection agencies: Social Care, the police or NSPCC, who have powers to investigate the matter under the Children Act 1989.

20.1.6 Common presentations and situations in which child abuse may be suspected include:

- Disclosure by a child or young person.
- Physical signs and symptoms giving rise to suspicion of any category of abuse and/or inconsistent with the history provided.
- A history which is inconsistent or changes over time.
- A delay in seeking medical help.
- Extreme or worrying behaviour of a child, taking account of the developmental age of the child.
- Self-harm.
- Accumulation of minor incidents giving rise to a level of concern, including frequent A&E attendances.

Some other situations which need careful consideration are:

- Repeated attendance of young baby less than 12 months of age.
- Any bruising or injury in child under 24 months of age.
- Very young girls or girls with learning difficulties or disability requesting contraception, especially
- Emergency contraception.
- Girls under 16 presenting with pregnancy or sexually transmitted disease, especially those with learning difficulties, chronic long term illness, complex needs or disability.
- Situations where parental factors such as mental health problems, alcohol, drug or substance misuse, learning difficulties, domestic abuse may impact on children and family life.
- Unexplained or suspicious injuries such as bruising, bites or burns, particularly if situated unusually on the body.
- The child says that she or he is being abused, or another person reports this.
- The child has an injury for which the explanation seems inconsistent
- Delayed presentation, which has not been adequately treated or followed up.
- The child's behaviour changes, either over time or quite suddenly, and he or she becomes quiet and withdrawn, or aggressive.
- Refusal to remove clothing for normal activities or keeping covered up in warm weather.
- The child appears not to trust particular adults, perhaps a parent or relative or other adult in regular contact.
- An inability to make close friends.
- Inappropriate sexual awareness or behaviour for the child's age.
- Fear of going home or parents being contacted.
- Disclosure by an adult of abusive activities, including activities related to internet and social media use.
- Reluctance to accept medical help.
- Fear of changing for PE or school activities.

Attitude of parents or carers:

Parental attitude may indicate cause for concern:

- Unexpected delay in seeking treatment.
- Reluctance to have child immunised.
- Failure to take child for dental care.
- Failure to attend scheduled appointment with clinicians/technicians.
- Denial of injury, pain or ill-health.
- Incompatible explanations, different explanations or the child is said to have acted in a way that is inappropriate to his/her age and development.
- Reluctance to give information or failure to mention other known relevant injuries.

- Unrealistic expectations or constant complaints about the child.
- Alcohol misuse or drug/substance misuse.
- Domestic Abuse or Violence between adults in the household.
- Appearance or symptoms displayed by siblings or other household members.

20.1.7 What to do when a child alleges abuse:

- Keep calm
- Reassure the child that they were right to tell you, and that they are not to blame and take what the child says seriously.
- Be careful not to lead the child or put words into the child's mouth – ask questions sensitively
- Do not promise confidentiality.
- Fully document the conversation on a word by word basis immediately following the conversation while the memory is fresh.
- Fully record dates and times of the events and when the record was made, and ensure that all notes are kept securely.
- Inform the child/ young person what you will do next.
- Refer to the Clinic Safeguarding Lead clinician or Deputy.
- Decide if it is safe for a child to return home to a potentially abusive situation. It might be necessary to immediately refer the matter to social services and/or the police to ensure the child's safety.

20.1.8 Confidentiality

Staff are required to have access to confidential information about children and young people in order to do their jobs, and this may be highly sensitive information. These details must be kept confidential at all times and only shared when it is in the interests of the child to do so, and this may also apply to restriction of the information within the clinical team.

Care must be taken to ensure that the child is not humiliated or embarrassed in any way.

If an adult who works with children is in any doubt about whether to share information or keep it confidential he or she should seek guidance from the clinic clinical Safeguarding Children Lead.

Any actions should be in line with locally agreed information sharing protocols, and whilst the Data Protection Act applies it does not prevent sharing of safeguarding information.

Whilst adults need to be aware of the need to listen and support children and young people, they must also understand the importance of not promising to keep secrets. Neither should they request this of a child or young person under any circumstances.

Additionally, concerns and allegations about adults should be treated as confidential and passed to the clinic safeguarding lead or appointed person or agency without delay.

20.1.8 Requests for information:

All requests for information relating to a child protection investigation or report for Case Conference will be passed to the Child Safeguarding Lead or Deputy on the day received.

A response will be made in a timely manner, preferably within 48 hours, and if this is not possible the Agency requesting information will be informed and a reason given.

20.1.9 Physical examination of a child or young person:

- A parent or carer should be present at all times, or a chaperone offered.
- Children should only be touched under supervision and in ways which are appropriate to, and essential for clinical care.
- Permission should always be sought from a child or young person before physical contact is made and an explanation of the reason should be given, clearly explaining the procedure in advance.
- Where the child is very young, there should be a discussion with the parent or carer about what physical contact is required.
- Routine physical examination of an individual child or young person is normally part of an agreed treatment procedure and/or plan and should be understood and agreed by all concerned, justified in terms of the child's needs, consistently applied and open to scrutiny.
- Physical contact should never be secretive or hidden. Where an action could be misinterpreted chaperone should be used or a parent fully briefed beforehand, and present at the time.
- Where a child seeks or initiates inappropriate physical contact with an adult, the situation should be handled sensitively and a colleague alerted.

20.1.10 Training – in house

Safeguarding Children Updates are given regularly by Lead Safeguarding clinician at Team meetings. The Clinic Safeguarding Children Lead is responsible for ensuring training records are kept and maintained and will liaise with the Clinic Appraisal Lead to ensure training is aligned

with identified staff development needs. An annual Update and Refresher is given by a member of the Local Safeguarding Children Team, such as the Named clinician.

20.1.11 Record keeping

All information received regarding children from the Safeguarding Children Team and any other associated Services should be regarded as strictly confidential.

This information should be handled by the designated member of staff who will deal with such paperwork in the following way.

20.1.12 Designated member of staff for record keeping

Child Protection Reports are as important as records of serious physical illness and should be recorded in the same way and with the same degree of permanence.

Case Conference Reports should be ideally be scanned into that individual child's electronic

General Clinic records. If necessary third party references must be blanked out or anonymised before scanning or sharing with appropriate agencies.

Appropriate coding and templates should be used in Active and Past Problem Lists and priority lists

Child's records should be linked in some way to parents even if not living at the same address, siblings and others in household by use of appropriate templates and codes.

Read codes expressing that a child is on a Child Protection Plan should be entered into notes of all individuals living at same address.

It is vital that when a child who is or has been on a Child Protection Plan moves to another area that the full clinical record including Case Conference Reports be shared with the relevant healthcare providers. Therefore they must **NOT be kept separate or isolated from the child's written or computer records.**

Tragedies have resulted from Case Conference Records not being passed on to the child's current. (Pass on welfare concerns even if the child is not subject to a protection plan.)

Important

Case conference records must never be destroyed e.g. by deleting electronic records or shredding hard copies.

Therefore:

- All reports will be scanned onto the relevant child's records.
- These reports will be vetted to remove any 3rd party information especially if external agencies request these medical records.
- All reports/correspondence will be seen and summarised by the clinical lead.
- All contacts with any parties regarding any safeguarding children issues should be recorded on the patient's medical records and any necessary action taken immediately.

20.2 SAFEGUARDING ADULTS

20.2.1. Introduction

This policy sets out Brigstock Skin and Laser's responsibilities in ensuring that all services commissioned by them comply with local and national safeguarding procedures, guidance and legislation.

The policy will support Brigstock Skin and Laser employees by providing clear guidance on how to respond to, and report any concerns in relation to vulnerable adults.

The focus of this policy is people of eighteen years or over who are experiencing abuse, or about whom there is a concern.

The policy sets out the responsibilities of all Brigstock Skin and Laser employees in the recognition, prevention and reporting of suspected abuse against vulnerable adults.

This policy is relevant, and should be followed, by all staff employed by Brigstock Skin and Laser.

Safeguarding vulnerable adults is a complex area of practice. The potential client group is extremely wide, ranging from adults who are incapable of looking after any aspect of their lives, to individuals experiencing a short period of illness or disability. A wide range of services and service providers can also be involved, making it difficult to identify those with responsibility to act.

Another key distinction is between adults who have decision-making capacity and those on whose behalf decisions have to be made.

There is also the question of whether the adult can best be safeguarded through ordinary care routes, or whether the risks require the involvement of dedicated multi-agency safeguarding procedures.

20.2.2 Key highlights in decision making

Step one: Prevention

Identifying adults who may be vulnerable clinicians should be able to identify those adults in their care who may be vulnerable. Identifying and recording factors that may contribute to a patient's vulnerability can be a vital first step in ensuring that he or she receives necessary support.

Step two: Assessing the individual's needs

Once an individual has been identified as vulnerable, the next step is to assess his or her needs. Where harm or abuse has occurred, or where an individual is at immediate risk, it is important to consider whether the local multi-agency adult safeguarding procedures should be engaged.

Step three: Responding to harm or abuse – assessing competence. Where there are any doubts about an adult's decision-making capacity this should be assessed.

Adults with capacity have the right to make decisions about their own care and treatment. Treatment decisions made on behalf of adults lacking capacity should be made on the basis of an assessment of their best interests.

Step four: Responding to harm or abuse: identifying relevant services

Following discussion with the patient, taking into consideration the need to look laterally beyond direct health needs to wider personal and social factors, relevant supporting services should be identified and offered.

This could involve referral to social care, or to other sources of support such as citizens' advisors or to charitable organisations offering support and advice for individuals suffering from specific disorders or with particular social needs.

Step five: Responding to harm or abuse – taking a consensual approach

The majority of adults with capacity take up the offer of support services. Where adults with capacity decline services, the reasons should be explored and alternatives offered where appropriate. Ultimately the decision about accepting care and treatment rests with the competent. Where adults lack capacity, they should be involved in decision-making as far as possible. Those close to the adult, including specifically anyone with the power of a health and personal welfare or property and affairs attorney should be involved as appropriate.

Information may need to be shared without consent where others are at risk of significant harm.

Step six: Safeguarding

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

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

20.2.3 Key Principles

Principle 1 – Empowerment

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

Principle 2 – Protection

Patients should be offered the support necessary for them to protect themselves. Where adults are less able to protect or promote their own interests, health professionals should take reasonable and appropriate measures to ensure their protection. This also involves assessing whether more proactive measures may be required to protect a person, such as where, for example, an adult may lack the capacity to make a specified decision. This may require the involvement of dedicated multi-agency procedures.

Principle 3 – Prevention

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

Principle 4 – Proportionality

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

Principle 5 – Partnership

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

Principle 6 – Transparency and accountability As with all other areas of health care delivery, responsibilities for safeguarding should form part of ongoing assessment and clinical audit in order to identify areas of concern and to improve delivery. Good safeguarding requires collaboration and transparency with partner agencies.

In addition to these principles, care providers must avoid discriminating unfairly between groups of patients. Care and treatment decisions must be made on the basis of a fair and objective assessment of individual needs and not on assumptions about age or disability.

20.2.4 What is Safeguarding?

Safeguarding is about keeping vulnerable adults safe from harm. It involves identifying adults who may be vulnerable, assessing their needs and working with them and with other agencies in order to protect them from avoidable harms.

It is a challenging area of practice. The group of adults involved is extremely diverse, making a one-size-fits all approach inappropriate.

Adults who may be the focus of safeguarding range from those whose decision-making capacity is severely impaired, to adults with no underlying cognitive impairment but whose physical situation, or a brief period of illness, has temporarily affected their ability to protect their own interests.

The nature of the harms involved can also range from violent physical and psychological abuse through varieties of personal, financial or institutional abuse or neglect to a failure to provide timely access to key services such as dentistry or prostheses.

Abuse or neglect of vulnerable adults can also take place in a wide variety of contexts, including private homes, nursing or residential care units, hospitals and custodial settings.

Perpetrators of abuse can be family members, professionals, paid care workers, volunteers or other service users.

Just as the nature and context of harms can vary, so can the nature of the response. An important distinction to be made in relation to safeguarding is between meeting the needs of vulnerable adults as part of ordinary care, and the recognition of vulnerable adults who are at risk of significant harm and require intervention from adult protection services provided by local authorities.

A person-centred approach

Competent adults have a right to make decisions that affect their lives, even where this may result in exposure to risk. Labelling adults 'vulnerable' can be stigmatising and lead to unfounded assumptions that individuals lack the ability to direct their own lives. Recognising the wide range of circumstances in which safeguarding issues can arise, a key is the need for an approach that addresses the specific needs of individuals. Such a person-centred approach, rooted in good communication skills and respectful of each individual's dignity and independence is likely to lead to optimal outcomes.

Clinicians and safeguarding – promoting professional standards

The majority of clinicians will have experience, for example, of victims of domestic abuse, of patients whose mental and physical health problems lead to difficulties protecting and promoting their interests and of adults experiencing difficulties in their relationships with partners, family members or carers. Doctors are advocates for their patients, and the support that clinicians in particular offer their patients often extends beyond narrowly defined health needs to wider welfare considerations. Safeguarding has been defined as that range of activities aimed at respecting an adult's fundamental right to be safe. Many of the activities associated with safeguarding will therefore already be familiar to doctors as part of good practice. The maintenance of professional standards for example has a direct impact on the welfare of patients, and, in particular patients who may have difficulty promoting their own interests. Clinical governance procedures, including adverse incident reporting, peer review and revalidation that are aimed at ensuring that poor practice is identified and that the highest standards of clinical practice are maintained are central to safeguarding.

Identifying vulnerable adults

In addition to promoting professional standards, the ability to identify those adults who are at risk of either abuse or neglect, is critical. Protecting and supporting these adults will ordinarily entail both the identification of risk factors, assessing the nature and extent of those risks and the provision, or at least the offer, of targeted and proportionate services.

Meeting the challenges to safeguarding – multi-agency working

Where an adult lacks capacity in relation to a specific decision, for example, this will involve making an appropriate decision on his or her behalf. It will also frequently involve the identification of care partners in order to provide, where appropriate, a comprehensive, multi-agency approach. In addition to the variety of circumstances in which adults can be vulnerable and the complexity of individual needs, which can bring together physical, psychological, social and interpersonal factors, safeguarding presents challenges in relation to the wide range of agencies with safeguarding responsibilities.

It is important therefore that where multi-agency support is required, health practitioners identify and agree the appropriate agencies to act or be the lead agency. It is also important to understand the scope of each agency's responsibility and the limits of its authority to intervene. Authority boundaries are not always coterminous, and appropriate support for a vulnerable adult can require cooperation between agencies that have not always worked together successfully.

It is vital that agencies work cooperatively to ensure that vulnerable adults do not fall between services, particularly where there is confusion about responsibility and 'ownership' of the safeguarding process.

20.2.5 Which adults may be vulnerable?

Definition of 'vulnerable adult'

The term 'vulnerable adult' is contentious. By labelling adults 'vulnerable' there is a danger that they will be treated differently. The label can be stigmatising and result in assumptions that an individual is less able than others to make decisions and to determine the course of his or her life.

In this way the term can lead to subtle forms of inappropriate discrimination.

Adults who have capacity retain the right to make their own decisions and to direct their own lives. Adults lacking capacity to make decisions, though they retain the right to be involved in decision-making as far as possible, nevertheless require decisions to be made on their own behalf, and the overall approach shifts to promoting their best interests.

The judgement that an adult is vulnerable should not be confused with decision about his or her capacity. They are distinct questions, although a lack of capacity will ordinarily contribute to an adult's vulnerability.

The overwhelming majority of adults in receipt of health care are able to look after their own interests, and to label them vulnerable can the definition of a vulnerable adult could also lead to a failure to recognise that systems can also play a part in neglect and abuse.

A vulnerable adult is a person aged 18 or over: Who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or maybe unable to take care of him or herself, or unable to protect him or herself against significant harm or

Factors contributing to vulnerability

There are a number of factors that can contribute to vulnerability, although their presence is by no means determinative and individuals will vary according to their circumstances and needs. It is nevertheless broadly accepted that the following groups are at enhanced risk of being vulnerable to neglect or abuse:

- An older person who is particularly frail
- An individual with a mental disorder, including dementia or a personality disorder
- A person with a significant and impairing physical or sensory disability

- Someone with a learning disability
- A person with a severe physical illness
- An unpaid carer who may be overburdened, under severe stress or isolated
- A homeless person
- Any person living with someone who abuses drugs or alcohol
- Women who may be particularly vulnerable as a result of isolating cultural factors.

The presence of one or more of these factors does not necessarily mean that the adult is vulnerable –age, disability or physical illness for example should not lead to the automatic assumption that the individual is vulnerable. A key factor in each case is whether the individual is able to take steps to protect and promote his or her interests.

20.2.6 What constitutes abuse?

Although abuse can take many forms, there is broad agreement that the following are among the most significant:

- physical abuse including hitting, the misuse of medication, inappropriate or unlawful restraint or other sanctions
- sexual abuse including any sexual act to which the person did not or could not consent
- psychological abuse including coercion, emotional abuse, humiliation, harassment, bullying, verbal abuse, enforced isolation or withdrawal from services
- financial abuse including theft, fraud, the misuse of property, finances and benefits, including coercion in relation to wills and other forms of inheritance
- neglect and acts of omission including deliberate or neglectful failure to meet health or physical care needs or to provide the necessities of life including food and appropriate shelter. It can also include thoughtless forms of neglect such as leaving food or drink out of reach, the removing of spectacles, hearing aids or false teeth and the placing of them out of reach
- discriminatory abuse including racial, religious, gender-based abuse, or abuse based upon an enduring condition or disability, or a person's age

20.6.7 What is capacity?

Capacity is a vital concept in relation to the care and treatment of adults who may be vulnerable.

For many adults vulnerability can develop over time. Deteriorating health, declining alertness or a change in residence or care regime can exacerbate vulnerability and present challenges to the ability of adults to manage risk. Vulnerability is not therefore static, and may vary according to the individual's circumstances and must be made on a case-by-case basis and be subject to regular review

Checklist of key points

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

20.6.8 Adults lacking capacity

Decision-making in relation to adults who lack capacity is regulated in England and Wales by the Mental Capacity Act 2005 (MCA).

This section contains a very brief outline of the legislation emphasising those aspects most relevant to a safeguarding approach. Professionals are strongly advised to refer to detailed guidance.

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

Mental Capacity Act 2005

The MCA sets out a number of basic principles that must govern all decisions taken in relation to adults lacking capacity. A brief list is given below.

- A presumption of capacity. Adults are assumed to have the capacity to make decisions on their own behalf unless it is proven otherwise.
- Maximising decision-making capacity. Everything practicable must be done to support individuals to make their own decisions, before it is decided that they lack capacity.
- The freedom to make unwise decisions. The fact that an adult makes a rash, unwise or impulsive decision is not in itself evidence of lack of capacity.

Best interests. Where it is determined that an adult lacks capacity, any decision or action taken on his or her behalf must be in his or her best interests.

- Less restrictive alternative. Whenever a person is making a decision on behalf of an adult who lacks capacity, he or she must consider if it is possible to make the decision in a way that is less restrictive of that person's fundamental rights or freedoms.

An assessment of mental capacity is decision specific. The question is whether the individual has the capacity to make a specific decision at a specific time. Although some patients, such as those who may be unconscious, will not be able to make any decisions, most individuals will be able to participate in at least some decisions, even very straightforward ones such as what to wear.

Best interests

Under the MCA, all decisions taken on behalf of someone who lacks capacity must be taken in his or her best interests. A best interest's judgement is not an attempt to determine what the person would have wanted, although this must be taken into account. It is as objective a test as possible of what would be in the person's actual best interests taking into account all relevant factors including:

- the likelihood that the person will regain capacity, and whether the decision can be delayed until that time
- the person's past and present wishes and feelings, including any relevant written statement
- his or her beliefs or values where these would have an impact on the decision
- other factors the person would have considered if able to do so, such as the effect of the decision on other people.

A crucial part of any best interests decision will involve a discussion with those close to the individual, including, where appropriate, family, friends or carers, bearing in mind both the duty of confidentiality and the caution that would be 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.

Please see:

www.bma.org.uk/ethics/consent_and_capacity/mencaptoolkit.jsp

for further information on the MCA.

20.6.9 Deprivation of Liberties

Where adults lack the capacity to consent to treatment, the Mental Capacity Act, makes it clear that they should be cared for using the less restrictive of the available options.

There will be occasions however where adults lacking capacity will need to be cared for in a manner that amounts to a 'deprivation of liberty'.

In April 2009 the deprivation of liberty safeguards (DOLS) were introduced to provide protection for this particularly vulnerable group of adults.

In July 2018, parliament held its first debate on the Mental Capacity (Amendment) Bill, in the House of Lords. During the session, peers discussed the government's proposed Liberty Protection Safeguards (LPS) model, which will replace the current Deprivation of Liberty Safeguards system (DoLS) after the bill becomes law. It is unclear when this Bill will be passed. Changes would include more authority to be given to care homes to make decisions in the best interest of their clients.

A brief outline of what factors might currently amount to a deprivation of liberty, and the safeguards are given below.

What is deprivation of liberty?

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

- restraint is used, including sedation, to admit a person who is resisting
- professionals exercise complete and effective control over assessments, treatment, contacts and residence
 - the person would be prevented from leaving if they made a meaningful attempt to do so
 - a request by carers for the person to be discharged to their care is likely to be refused
 - the person is unable to maintain social contacts because of the restrictions placed on access to other people
 - the person loses autonomy because they are under continuous supervision and control.

How can deprivation of liberty be authorised?

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

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

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

Deprivation of Liberty Safeguards (DOLS)

Where health professionals identify that an individual lacking capacity is at risk of being deprived of his or her liberty in a hospital or care home setting, the 'managing authority' of the hospital or care home has to make an application to a 'supervisory body' to request an authorisation of the deprivation.

In the case of a private clinics, the managing authority will be the person registered, or required to be Safeguarding vulnerable adults.

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

20.6.10 Confidentiality

When can information be shared about vulnerable adults?

Health professionals owe the same duty of confidentiality to all their patients regardless of age, vulnerability or the presence of disability. The existence of a mental disorder, a serious physical illness or a learning disability should not lead to an assumption that the individual lacks capacity to make decisions relating to the disclosure of confidential information. Competent adults have considerable rights about the extent to which their information is used and shared and these are protected both by law, and by professional and ethical standards. Although there is a presumption that information will be shared between health professionals involved in providing care to a patient, where a competent adult explicitly states that this information should not be shared, this should ordinarily be respected.

Sharing information

The multi-agency approach to safeguarding vulnerable adults nevertheless means that, where it is lawful and ethical to do so, appropriate information should be exchanged between relevant agencies in order to ensure that support that is right for the individual can be provided. Health professionals can sometimes feel challenged when a competent adult refuses to agree to the sharing of information that would seem to be in their best interests, or that could help mitigate a potential

Where a health professional is in this position and believes that information should be exchanged, the reasons for this should be carefully explained, the benefits that are likely to accrue, and the duty of confidentiality that the various agencies are subject to.

The reasons for the refusal should also be sensitively explored, and, where appropriate, options that might prove more amenable to the patient offered. At the end of the day, however, where a competent patient refuses to permit disclosure, this should be respected.

Next of Kin

Next of Kin details are requested during the registration process for new patients.

Improving carer identification is achieved by:

Having a lead person nominated for carers

Having patients with long term conditions are asked to identify their carers

Displaying posters in the clinic building to encourage carers to self-identify

Improving health care is achieved by

Offering carers flu vaccination

Screening carers regularly for depression and other health problems

Offering flexible appointments for carers

Improving support is achieved by:

Providing access to carer support groups or advice surgeries

Using surveys to gather carers' feedback about services and their satisfaction with them

Referrals to carers services for more specialised information, advice and support

Through registration checks are made and if the SCR form is missing then the patient is asked to complete this missing section before submitting their form.

During the registration process once a carer is identified, the patient is coded appropriately on the clinic's software system i.e is carer, has a carer

Once the individual is informed about how their information will be used and that it will be shared across the individual's integrated care team when relevant and they then object; they complete a SCR opt out form which is then recorded on patient notes and patient status is marked as dissent to sharing information.

Exceptions

The only exceptions to this are where confidentiality can be overridden either by a court order or other legal authority, or in the public interest. Public interest justifications usually relate to disclosures to prevent significant harm to third parties or to prevent or to prosecute a serious crime.

Where an adult lacks capacity

Information can be disclosed in accordance with the Mental Capacity Act, where, in the opinion of the relevant health professional, it would be in the incapacitated person's best interests.

Where an adult lacks capacity to consent to disclosure it is usually reasonable to assume that they would want people close to them, or directly involved in their care to be given appropriate information about their illness, prognosis and treatment, unless there is evidence to the contrary.

20.6.11 Safeguarding and Communication

Good communication is a basic medical skill, but can, however, take time, particularly where there may be language difficulties, or some degree of cognitive impairment. There can often be time constraints in hospitals, surgeries and care homes, which can present challenges to the delivery of personalised health care.

In these circumstances, it is important that professionals are sensitive to the potentially coercive effects of pressurised decision-making. The basic principle is that all individuals should be offered information about their condition and about options for treatment or support in a manner appropriate to their needs. This should extend to the offer of information about their wider care. Vulnerable adults should be supported to explore choices about their safety and wellbeing. This includes adults who may lack capacity but who have some ability to participate in decision-making.

Listed below are key aspects of good communication:

- Good communication involves an honest and sensitive exploration of health conditions, treatment options, prognosis, risks and side-effects.
- Euphemism should be avoided, and thought should be given to timing of discussions and to the use of communication aids where appropriate.
- Information should be tailored to the individual's needs. This may, for example, involve the use of pictures, or, where English is not a first language, translators.
- Consideration should be given to the use of fact sheets and other written communication supports.
- All patients should be encouraged to participate as far as possible in decision-making.
- Most patients will want those close to them to be involved in communication and decision making, but all patients have a right to confidentiality and where an individual has indicated that information should not be shared this should be respected.
- Health professionals must avoid the use of communication styles that inadvertently imply that patients lack autonomy, dignity or competence.
- Good communication is about more than conveying information; it is also about establishing positive professional relationships.

- Time should be taken to identify the patient's underlying values and beliefs that may have a bearing on decisions that need to be made.
- Where the criteria in the Mental Capacity Act are met, consideration should be given to involving an advocate, such as an Independent Mental Capacity Advocate (IMCA). Although the IMCA's role is to promote the best interests of the incapacitated adult, they can also help facilitate good communication.

Discussion with vulnerable adults, including discussion of concerns about harm or abuse, can involve broaching sensitive subjects and this requires good communication skills. Where health professionals are likely to be working with adults who may be vulnerable appropriate training should be provided.

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

Working with carers

Another source of possible harms to vulnerable adults can result from carers who may be under severe and long-term stress. Good practice can also, therefore, involve discussion with those who are in a long-term non-professional care role with a vulnerable adult, including partners and family members.

Respite care and the provision of some professional care support can be important contributors to supporting both the carer and the vulnerable adult.

Prevention as a part of ordinary care

Tragically, every winter older people die from hypothermia. Such deaths are avoidable. The majority of these older people will have been in receipt of health and social care services some will have been living in social housing or will otherwise have been known to supporting services. Such appalling deaths are often the result of failures within – and between – systems, often where adults who are unable actively to promote their own interests, and have no family or friends who can offer support and assistance, become lost to the services that are geared to support them.

Prevention is clearly critical to safeguarding and many clinics have developed innovative methods for ensuring continuity of contact with vulnerable adults, including appropriate use of flags in electronic notes, regular clinic meetings to discuss vulnerable adults, or, where required, the use of successive appointments, home visits or other reminders. In this way, targeted support can be offered to patients with the highest levels of need.

Some clinics allocate lists of vulnerable patients to specific doctors. In this way, doctors, who are extremely busy, can be supported by a system that helps them look out for vulnerable adults. Such approaches are obviously not limited to those who may be at risk of hypothermia or malnutrition, but can be used wherever doctors have concerns that adults may be at risk.

Some clinics have also introduced early warning systems in relation to developing trends or where, for example, concerns are emerging about the standards of care in particular care homes.

20.6.12 When should a clinician refer through multiagency safeguarding adults service?

Overall responsibility for coordinating multi-agency responses to the harm or abuse of vulnerable adults rests with the local authority, and it is important that clinicians are familiar with the relevant local contacts. Where adult patients are at risk of harm due to a lack of appropriate health resources, or poor clinical performance, doctors have clear responsibilities, outlined by the General Medical Council (GMC), to take appropriate action via established channels to protect patients.

This will include engaging multi-agency safeguarding services. Through multi-agency procedures, agreement can best be reached about how to support vulnerable adults and how to investigate the concerns of abuse or neglect

Although, for example, health services might lead any investigation into allegations of misconduct about a health professional, a multiagency approach can ensure openness and accountability, as well as a multi-agency approach to supporting the vulnerable adult.

Significant harm

A key question for health professionals is the point at which they should consider involving local authority adult protection procedures. A useful starting point here is the concept of 'significant' harm. This is likely to include not only violent and unlawful acts including hitting, sexual abuse and harmful psychological coercion, but also any acts, or omissions, likely to lead to a serious impairment of physical or mental health. Factors that should be taken into account when considering the involvement of adult protection services will include:

- the vulnerability of the individual
- the nature and extent of the abuse
- the length of time it has been occurring
- the effect of the abuse on the individual
- the risk of repeated or increasingly serious abuse
- the likelihood that other vulnerable individuals may also be put at risk
- the risk of serious harm
- whether criminal offences are involved.

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

Serious crime

Where doctors or other health professionals suspect that a serious crime may have been, or maybe about to be, committed, action should be taken as a matter of urgency. Although health professionals owe a duty of confidentiality to all their patients, this duty is not absolute (see Card 9). Where an adult has the relevant decision-making capacity, they retain the freedom to decide how best to manage the risks to which they may be exposed, including whether a referral through multi-agency procedures would help them.

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

Checklist of key points

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

20.6.13 When should concerns about patient safety be reported?

A key component of safeguarding is ensuring that vulnerable adults are kept as safe as possible. While this may mean identifying abusers and working to ensure that adults are protected from them, it can also mean identifying both systemic failures and poor professional performance that can lead to harm.

Health systems and poor resources

Where systemic problems or poor performance are identified, early intervention is important, leading to better outcomes for vulnerable adults, and for health professionals. There are

currently a range of safeguards in place, such as regular inspection of nursing and care homes, and strict licensing specifying what kinds of patients certain homes can admit. Properly implemented, these safeguards can be very effective at minimising harms.

In terms of medical regulation, in its guidance, the GMC states that, in relation to concerns about patient safety: If you have good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems, you should put the matter right if that is possible.

In all other cases you should draw the matter to the attention of your employing or contracting body. If 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.

Where doctors or other health professionals have concerns about colleagues, or about the impact of services on vulnerable adults, they may first need to gather information to establish the facts, taking into consideration patient confidentiality as appropriate. Where patients are at risk, health professionals have a responsibility to act. Although local policies and procedures will differ, every clinic should have procedures in place to deal with concerns about health services, and individual performance. In relation to the performance of doctors, final responsibility lies with the GMC. In the first instance, concerns can be discussed with the GMC without necessarily revealing the identity of the doctor concerned, and advice on how to proceed can be sought. Where patients are at risk, however, it may be necessary formally to refer the matter to the GMC for further action.

Whistle-blowing

Where these remedies are exhausted, and patients are still at risk, it may be necessary to consider raising the issue more widely – by 'whistle-blowing', for example, which may involve providing information to media or MPs. The Public Interest Disclosure Act protects whistle-blowers who disclose information 'in good faith' to a manager or employer

Wider dissemination of information is protected, as long as it is reasonable, not made for gain and meets the following conditions:

- whistle-blowers reasonably believe they would be victimised if they raised the matter internally or with a prescribed regulator
- they believe a cover-up is likely and there is no prescribed regulator
- they have already raised the matter internally or with a prescribed regulator. Further advice on whistle-blowing can be obtained from the BMA or from support organisations such as Public Concern at Work.

Clinician's responsibilities as employers

Where Clinicians are employers, they have specific legal responsibilities in relation to ensuring that their employees do not present a threat to vulnerable adults.

Under the Safeguarding Vulnerable Groups Act 2006 employers such as GPs have an obligation to refer an employee to the Independent Safeguarding Authority (ISA) when 'they remove a person from a regulated or controlled activity, or that person resigns, retires, is made redundant or is transferred to a position which is not regulated or controlled activity' because the employing clinician thinks that the person:

- has engaged in conduct that endangers or is likely to endanger a vulnerable adult, including emotional, sexual, psychological or financial abuse or has failed to meet a vulnerable adults basic physical or psychological needs
- may harm, may cause to be harmed, put at risk of harm or may attempt to harm or may incite another person to harm a vulnerable adult
- has been cautioned or convicted of a relevant specified offence involving harm to a vulnerable adult In a clinician context, a 'regulated activity' means work that involves or can involve contact with vulnerable adults either 'frequently' (once a week or more), 'intensively' (four or more days in an period of 30 days) or 'overnight' (between 2am and 6am). The relevant specified offence refers to any of a very large number of offences laid out in the Act's Regulations.

The Safeguarding Vulnerable Groups Act and the obligations to refer employees to the ISA are explained in detail on the ISA's website (www.isa.homeoffice.gov.uk).

Where a clinician identifies that an employee, whether a health professional or ancillary or support staff such as administrators or cleaners has access to vulnerable adults and has either harmed a vulnerable adult, or presents a risk of harm to a vulnerable adult, then the clinician needs to consider his or her legal duty to refer.

Where there is any doubt, clinician's should take advice from the ISA.

20.6.14 Sharing information for direct care of vulnerable adults

Appropriate information sharing documentation and the logging of consent is an essential part of the provision of safe and effective care. Patients may be put at risk if those who provide their care do not have access to relevant, accurate and up-to-date information about them. Multidisciplinary and multi-agency teamwork is also placing increasing emphasis on integrated care and partnership working, and information sharing is central to this, but information must be shared within the framework provided by law and ethics.

Implied consent and sharing information for direct care

Most patients understand and expect that relevant information must be shared within the direct care team to provide their care. You should share relevant information with those who provide or support direct care to a patient, unless the patient has objected.

The usual basis for sharing information for a patient's own care is the patient's consent, whether that is explicit or implied. You may rely on implied consent to access relevant information about

the patient or to share it with those who provide (or support the provision of) direct care to the patient if all of the following are met.

You are accessing the information to provide or support the individual patient's direct care, or are satisfied that the person you are sharing the information with is accessing or receiving it for this purpose.

Information is readily available to patients, explaining how their information will be used and that they have the right to object. This can be provided in leaflets and posters, on websites, and face to face. It should be tailored to patients' identified communication requirements as far as practicable.

You have no reason to believe the patient has objected.

You are satisfied that anyone you disclose personal information to understands that you are giving it to them in confidence, which they must respect.

If you suspect a patient would be surprised to learn about how you are accessing or disclosing their personal information, you should ask for explicit consent unless it is not practicable to do so (see paragraph 14). For example, a patient may not expect you to have access to information from another healthcare provider or agency on a shared record.

Patient objections to sharing information for their own care

If a patient objects to particular personal information being shared for their own care, you should not disclose the information unless it would be justified in the public interest,¹² or is of overall benefit to a patient who lacks the capacity to make the decision.

You should explain to the patient the potential consequences of a decision not to allow personal information to be shared with others who are providing their care. You should also consider with the patient whether any compromise can be reached. If, after discussion, a patient who has capacity to make the decision still objects to the disclosure of personal information that you are convinced is essential to provide safe care, you should explain that you cannot refer them or otherwise arrange for their treatment without also disclosing that information.

If a patient cannot be informed

Circumstances may arise in which a patient cannot be informed about the disclosure of personal information, for example in a medical emergency. In such cases, you should pass relevant information promptly to those providing the patient's care.

If the patient regains the capacity to understand, you should inform them how their personal information was disclosed if it was in a way they would not reasonably expect.

Sharing information with those close to the patient

You must be considerate to those close to the patient like carers or next of kin and be sensitive and responsive in giving them information and support, while respecting the patient's right to confidentiality.

Establishing what the patient wants

The people close to a patient can play a significant role in supporting, or caring for, the patient and they may want or need information about the patient's diagnosis, treatment or care. Early discussions about the patient's wishes can help to avoid disclosures they might object to.

Such discussions can also help avoid misunderstandings with, or causing offence or distress to, anyone the patient would want information to be shared with.

You should establish with the patient what information they want you to share, with whom, and in what circumstances. This will be particularly important if the patient has fluctuating or diminished capacity or is likely to lose capacity, even temporarily. You should document the patient's wishes in their records.

Abiding by the patient's wishes

If a patient who has capacity to make the decision refuses permission for information to be shared with a particular person or group of people, it may be appropriate to encourage the patient to reconsider that decision if sharing the information may be beneficial to the patient's care and support. You must, however, abide by the patient's wishes, unless disclosure would be justified in the public interest.

If a patient lacks capacity to make the decision, it is reasonable to assume the patient would want those closest to them to be kept informed of their general condition and prognosis, unless they indicate (or have previously indicated) otherwise. You can find detailed advice on considering disclosures about patients who lack capacity to consent in paragraphs 41 - 49.

Listening to those close to the patient

In most cases, discussions with those close to the patient will take place with the patient's knowledge and consent. But if someone close to the patient wants to discuss their concerns about the patient's health without involving the patient, you should not refuse to listen to their views or concerns on the grounds of confidentiality. The information they give you might be helpful in your care of the patient.

You should, however, consider whether your patient would consider you listening to the views or concerns of others to be a breach of trust, particularly if they have asked you not to listen to specific people. You should also make clear that, while it is not a breach of confidentiality to listen to their concerns, you might need to tell the patient about information you have received from others – for example, if it has influenced your assessment and treatment of the patient. You should also take care not to disclose personal information unintentionally – for example, by confirming or denying the person's perceptions about the patient's health.

Disclosures about patients who lack capacity to consent

You must work on the presumption that every adult patient has the capacity to make decisions about the disclosure of their personal information. You must not assume a patient lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical

condition (including mental illness), beliefs, apparent inability to communicate, or because they make a decision you disagree with.

You must assess a patient's capacity to make a particular decision at the time it needs to be made, recognising that fluctuations in a patient's condition may affect their ability to understand, retain or weigh up information, or communicate their wishes.

We give detailed advice on assessing a patient's mental capacity in our guidance Consent: patients and doctors making decisions together. Practical guidance is also given in the Adults with Incapacity (Scotland) Act 2000 and Mental Capacity Act 2005 codes of practice.¹⁴

Considering the disclosure

You may disclose personal information if it is of overall benefit to patient who lacks the capacity to consent. When making the decision about whether to disclose information about a patient who lacks capacity to consent, you must:

- make the care of the patient your first concern
- respect the patient's dignity and privacy
- support and encourage the patient to be involved, as far as they want and are able, in decisions about disclosure of their personal information.

You must also consider:

- whether the patient's lack of capacity is permanent or temporary and, if temporary, whether the decision to disclose could reasonably wait until they regain capacity
- any evidence of the patient's previously expressed preferences
- the views of anyone the patient asks you to consult, or who has legal authority to make a decision on their behalf, or has been appointed to represent them
- the views of people close to the patient on the patient's preferences, feelings, beliefs and values, and whether they consider the proposed disclosure to be of overall benefit to the patient
- what you and the rest of the healthcare team know about the patient's wishes, feelings, beliefs and values.

You might need to share personal information with a patient's relatives, friends or carers to enable you to assess the overall benefit to the patient. But that does not mean they have a general right of access to the patient's records or to be given irrelevant information about, for example, the patient's past healthcare.

You must share relevant information with anyone who is authorised to make health and welfare decisions on behalf of, or who is appointed to support and represent, a patient who lacks capacity to give consent. This might be a welfare attorney, a court-appointed deputy or guardian, or an independent mental capacity advocate. You should also share information with independent mental health advocates in some circumstances.

If a patient who lacks capacity asks you not to disclose

If a patient asks you not to disclose personal information about their condition or treatment, and you believe they lack capacity to make that decision, you should try to persuade them to allow an appropriate person to be given relevant information about their care. In some cases, disclosing information will be required or necessary, for example under the provisions of mental health and mental capacity laws.

If the patient still does not want you to disclose information, but you consider that it would be of overall benefit to the patient and you believe they lack capacity to make that decision, you may disclose relevant information to an appropriate person or authority. In such cases, you should tell the patient before disclosing the information and, if appropriate, seek and carefully consider the views of an advocate or carer. You must document in the patient's records your discussions and the reasons for deciding to disclose the information.