GUIDANCE ON THE INVOLVEMENT OF GPs IN MULTI-AGENCY PROTECTION ARRANGEMENTS

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CONTENTS

Introduction

1. This guidance has been produced by the Scottish Government to help support the involvement of GPs in adult protection. It is designed to ensure that GPs are part of local multi-agency arrangements for adult protection and are thereby enabled to:

- fulfil their statutory responsibilities under the Adult Support and Protection (Scotland) Act 2007 [1]('the 2007 Act')
- make a broader contribution to adult protection beyond that required by statute

2. Section 1 provides an overview of the framework for the multi-agency arrangements enshrined in the 2007 Act and offers advice on how GPs might be included within the management structures of these networks. A collaborative approach is vital and GP involvement invaluable when developing and/or refining local adult protection policy, procedure and strategy to ensure statutory obligations can be met and adult protection delivered effectively. However, this guidance is not intended to be a substitute or replacement for locally agreed arrangements already in place. Its aim is to guide thinking and encourage consistency in the overall approach to GP involvement in multi-agency arrangements for adult protection across Scotland.

3. Section 2 sets out the main ways GPs may come into contact with the 2007 Act and considers the issues this raises, such as the benefit of having local adult protection policies which cover the range of interested professionals and the duty GPs have in regard to patient confidentiality.

4. The guidance is for GPs primarily and for those involved in the management of adult protection. It is also for their colleagues in primary care teams and others involved in GP activity, such as practice managers, Local Medical Committees and the BMA. For these people, it will aid understanding of the wider context for adult protection, including the network of interests involved, and provide guidance on the key issues adult protection raises for them.

5. An overview of the 2007 Act is provided at **Annex A**. A flowchart highlighting the key actions that GPs must take when responding to possible adult protection cases, and exploring the decisions that may need to be taken along the way, is provided at **Annex D**.

6. NHS Circular PCA (M) (2009)12[2], issued by the Scottish Government in September 2009, continues to be relevant and is provided at **Annex B**. This sets out that Health Boards, and those working with them providing an NHS service, have a range of duties under the 2007 Act. These include:

- co-operating in investigating suspected or actual harm

[1] http://www.scotland.gov.uk/Publications/2012/07/7344/10
[2] www.scotland.gov.uk/Resource/0039/00396393.pdf

- reporting the facts and circumstances of a case to the council where they know, or believe, that a person is an adult at risk, and that protective action is needed
- co-operating with a council making inquiries and with other public bodies where that would assist the council

Section 1: Multi-agency adult protection arrangements

Integrating GPs into local multi-agency networks

7. GPs have a key role to play in adult protection. They may be the first professional to see signs of potential harm, and are crucial not only in helping to protect adults, but also in helping to develop effective multi-agency responses.

Duty to co-operate

8. Multi-agency partnership is at the heart of the 2007 Act. This approach is underpinned by a statutory duty placed on a range of public bodies and office holders to co-operate with councils and with each other where harm is known or suspected. The duty to co-operate applies to:

- all councils
- Health Boards
- the Mental Welfare Commission for Scotland
- Contractors (including GP independent contractors
- University staff with honorary contracts
- the Care Inspectorate
- Healthcare Improvement Scotland
- the Public Guardian
- chief constables of police forces
- any other public body or office holder that Scottish Ministers specify

Adult Protection Committees

9. Adult Protection Committees (APCs) help set the multi-agency strategic direction for adult protection at the local level. By providing a forum for multi-agency consideration of the ongoing implementation and delivery of adult protection, they ensure that adult protection activity is carried out effectively across all interests. A core function of the APC is to evaluate the ongoing effectiveness of multi-agency adult protection arrangements. In support of this the expectation is that APCs extend their core membership beyond those required by statute to include other interests key to Adult Protection processes including GPs), as well as establishing sub-groups to tackle specific challenges.

10. Given the centrality of GPs in adult protection, APCs should have a GP representative as part of their core membership. Local Medical Committees and GP sub-committees represent the interests of local GPs and members of these groups may be able to fulfil this role. Where direct GP representation is not possible, APCs should ensure that, at the very least, clear lines of communication are established with local GPs. One option is for a member of the APC to function as a liaison; this is a role the Health Board or council representative would be well placed to fulfil.

However, it is important to note that while a Health Board or council representative may be able to offer a link to GPs, they will not be able to represent the GP point of view.

11. Involving GPs in multi-agency arrangements for adult protection will help develop a strong understanding of the considerations and pressures that apply in adult protection cases. It will help to raise awareness of adult protection generally among GPs, so that they know how to respond when they encounter a possible adult protection case. Their involvement will allow their views to be taken into account in the development, revision and implementation of adult protection policies and procedures, as well as when agreeing strategic directions. It will also help foster a greater collaborative approach.

12. This type of collaborative approach will help to develop a shared understanding of the issues GPs must consider when interacting with the 2007 Act and carrying out adult protection activity, including respecting patient confidentiality. It should also help GPs to better understand the various processes and considerations that all professionals involved in adult protection are required to make. Involving GPs in this way will help to build mutual confidence in the processes to be followed and provide clarity on where roles and responsibilities lie.

13. This will help to address any practical difficulties in sharing information appropriately and developing strong, positive relationships between GPs and social workers. For example, local arrangements might be developed so that on referring a concern to the council, GPs are sent details of the allocated social worker and an outline of the action that will be taken within a certain timeframe.

14. APCs may decide to work with GPs and others with adult protection responsibilities to develop a quick reference guide aimed at GPs. For example, this could include local information on the referral process, similar to that summarised in the flowchart at **Annex C** to aid GPs when responding to a suspected case of harm. This might sit alongside contact details for local partners in the adult protection network. A quick reference guide of this sort would supplement, rather than replace, more comprehensive local policies on GP involvement in adult protection at the local level.

15. GPs should be included in multi-agency adult protection training organised by APCs. Consideration should be given to providing bespoke adult protection training to GPs. This might be delivered at GP surgeries, which would allow other members of the practice to develop an awareness of adult protection. It may also be useful to explore the possibility of developing local enhanced services and to use Health Boards' Protected Learning Time initiatives to provide adult protection training. Councils can provide advice on how Health Boards might extend multi-agency adult protection training to GPs. It is essential that training includes guidance on safe and appropriate data sharing, including the establishment of data sharing protocols. The Information Commissioner's Office would be please to provide separate advice to Health Boards in relation to data protection aspects to such training.

16. The likelihood of disputes arising should be reduced by ensuring that GPs are a key part of the adult protection network with a shared understanding of processes

and practices of all involved. Where disputes do arise (for example, over the sharing of patient information or carrying out a medical examination under the 2007 Act) this should be dealt with through local multi-agency dispute resolution protocols rather than creating any additional responsibilities. In certain areas for example a referral to the Chief Officers' Group or an equivalent could be the most practical approach. This will provide all parties with a means of raising and resolving any difficulties which arise and which cannot be addressed through other means.

Section 2: GP roles and responsibilities in adult protection

Overview of GP responsibilities

17. GPs can become involved in the adult protection process in a number of ways. This section sets out the various responsibilities GPs have under the 2007 Act and the type of activities they may be asked to undertake as part of multi-agency adult protection arrangements. It also offers advice to APCs and others involved in the management of adult protection on the issues that local policy, procedure and strategy might cover to ensure appropriate and effective GP involvement in the delivery of adult protection.

18. There are four main ways in which GPs are most likely to be involved in adult protection:

- taking appropriate steps when they identify possible adult protection cases
- carrying out medical examinations when requested to do so by a council undertaking action under the 2007 Act
- providing relevant information from healthcare records to a council officer who is carrying out certain functions under the 2007 Act
- participating in other activity subsequent to action being taken under the 2007 Act, such as attending case conferences, providing reports and, on some occasions, providing evidence during court proceedings

19. In order to be able to respond promptly where there is cause for concern that an adult is at risk of harm, GPs should be familiar with:

- the guiding principles of the 2007 Act and the duties they may be required to perform (see **Annex A**)
- local multi-agency adult protection arrangements, including key contacts in the network, particularly in the council Social Work Department
- how to make an adult protection referral and how the council is obliged to respond
- the Code of Practice [3] to the 2007 Act (which offers useful practical advice on carrying out functions)
- the Multi-agency adult protection arrangements set out in Section 1 of this guidance note
- the Data Protection Act[4] and the ICO Data Sharing Code of Practice[5]

Identifying and responding to harm

20. Where a GP knows or believes that a patient is or may be an adult at risk of harm they must make a referral to the council in line with local Adult Protection

[3] http://www.scotland.gov.uk/Publications/2009/01/30112831/0
[4] http://www.ico.gov.uk/for_organisations/data_protection.aspx
[5] http://www.ico.gov.uk/for_organisations/data_protection/topic_guides/data_sharing.aspx

Procedures. The circumstances may be so serious that it may be necessary to alert the police straight away. However in the majority of cases contact with the duty social work service would clarify when and who would involve the police. For example, a suspected case of neglect might be referred to the council only, but where it is suspected that a crime is being committed, such as physical or financial harm, the GP should alert the police as well. When a council is made aware of a possible case of adult harm it has a duty under section 4 of the 2007 Act to make the necessary inquiries to decide if action is required to stop or prevent harm from occurring. This will include considering whether the adult meets the 'adult at risk' definition as per the three-point criteria at **section 3**. Where the criteria are not satisfied the 2007 Act will not apply; however, this decision will not prevent the council from working to identify alternative and appropriate means of support and/or protection for the individual using means other than the 2007 Act. Local protocols can be important to ensure that all appropriate actions are taken.

21. The dynamics of harm can be complex and a number of factors may need to be considered. Some types of harm are subtle and have no obvious physical trace, such as psychological harm or financial harm. It should also be borne in mind that harm may occur through acts of omission. Some harm may be the result of lifestyle choices made by the adult. As such, care should be taken to avoid implying that deliberate or malicious abuse has occurred.

22. Councils have a legal obligation to instigate an adult protection inquiry if they know or believe that an individual is or may be an adult at risk of harm. A council will be able to provide general advice on adult protection, including the kind of steps that will be taken when a referral is received and the sorts of services an adult may be offered. It should be noted that if guidance is sought on an actual case this may trigger the duty to inquire by the Council. GPs should familiarise themselves and regularly update their knowledge of local adult protection procedures and guidelines so that they understand what processes will be set in motion by a referral. This will be made easier by involving GPs in multi-agency adult protection procedures.

23. Before referring a case, GPs may wish to seek advice from an experienced colleague, including, for example, a Caldicott Guardian[6]. See also paragraph 63 about provision of relevant information.

24. Where a GP has made a referral the council should keep the GP informed about what action is being taken as result. Social workers carrying out adult protection activity should be mindful that GPs are likely to have ongoing relationships with any patient who they have referred to the council. Being kept up to date with progress will be important in informing any future interactions between the GP and their patient. More generally, this will help to build strong links between adult protection leads in councils and GPs. Local multi-agency adult protection arrangements should therefore ensure that where a GP has made a referral that he or she is subsequently provided with information on:

- any intervention made to support and protect the adult
- whether the adult is safer as a result of any intervention

[6] http://www.nhsnss.org/pages/corporate/caldicott_guardians.php

- whether the adult has an improved quality of life as a result of any intervention

Information about outcomes could also be gained through GP engagement in Adult Protection processes such as Initial Referral Discussions (IRDs) and case conferences,

25. GPs should ensure that all actions carried out by them, including records of any conversations and meetings with public bodies, and decisions made by them are documented fully in the patient's healthcare records.

Patient consent in the referral process

26. When responding to a suspected case of harm, the duty of confidentiality will be a key consideration for GPs, as it is for all public bodies involved in adult protection. GPs must consider the need to balance his or her duty of care to the patient and towards public protection with the need to protect patient confidentiality and autonomy. Where the adult has the capacity to consent (to a particular decision), GPs will always seek to gain his or her consent before taking action on their behalf and this includes when making a referral under the 2007 Act. There are a number of sources of advice on patient confidentiality including:

- the NHS Code of Practice on Protecting Confidentiality[7]
- the General Medical Council's guidance document *Confidentiality*[8]
- the BMA's Confidentiality and Disclosure of Information Toolkit [9]
- the BMA's Handbook of Ethics and Law [10]

27. It should be assumed that an adult has capacity to consent to a particular action until proven otherwise. It is not the case that an adult who has a mental disorder automatically lacks capacity. Similarly, no assumptions should be made about an adult's capacity on the basis of age, appearance, condition or any aspect of their behaviour.

28. Capacity is decision-specific and not necessarily static: for example, it may fluctuate from one day to the next, and may apply differently to specific decisions. An adult's capacity should therefore be judged based on specific circumstances at a given time, including consideration of the nature of the decision which requires to be made. Consent might also be granted after initially being refused.

29. Where an adult's capacity to consent to an adult protection referral being made is in question, an assessment of his or her capacity should be undertaken. There is no single test of capacity, and any test should not be so high that it undermines an adult's right to autonomy. Efforts should be made to assist the adult in understanding why an assessment of his or her capacity is needed, to assist their consideration of the result of that assessment and to enable them to communicate this to other significant individuals, such as their carer or nearest relative. The adult

[7] www.ehealth.scot.**nhs**.uk/.../**nhs-code-of-practice-on-protecting-patient-confidentiality**.pdf
[8] http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp
[9] http://bma.org.uk/practical-support-at-work/ethics/confidentiality-tool-kit
[10] http://bma.org.uk/practical-support-at-work/ethics/medical-ethics-today

should also be advised or their right to access independent advocacy and to make a referral for this if they wish.

30. Where the patient has a Responsible Medical Officer (RMO), it is expected that the RMO would provide advice on the patient's ability to consent, as well as assisting with an assessment of capacity as necessary. Where there is no RMO, in many cases the GP will be able to carry out the assessment of capacity but where an assessment is complicated (e.g by mild Learning Disability or mental illness) then appropriate steps should be taken to seek advice and input from an appropriately skilled medical practitioner.

31. Although the decision as to whether or not an adult has capacity will be made by a single medical practitioner, assessments of capacity should be undertaken on a multi-agency basis. Professionals from different backgrounds who have a long-standing or ongoing relationship with an adult may be able to offer a view on whether:

- the adult's behaviour or ability at the time of the assessment is typical;
- whether they have demonstrated capacity in particular regards in the past; or
- whether there are certain methods of helping the adult make a decision which have previously proved successful.

32. The GP should consider seeking the views and contribution of relevant professionals with whom the adult is familiar to provide the adult with the support and confidence necessary to make the decision to consent to the proposed action being taken.

Adults with incapacity

33. Adults assessed as being unable to consent to an adult protection referral being made may be particularly at risk. GPs must immediately take action on their behalf and make a referral to the council, and, if they judge it to be appropriate, also alert the police. The formal assessment of capacity is more likely to come later, on request from a council officer exercising functions under the Act. Any subsequent intervention made under the 2007 Act will be guided by the 'least restrictive' principle (see **Annex A**).

34. GPs may wish to seek reassurance from senior colleagues or professional representative bodies such as the BMA, medical defence unions, Caldicott Guardians, and the GMC, but should not delay taking action. The sources of information on patient confidentiality listed at paragraph 26 may also be of use and councils will also be a good source of advice on how best to respond in these type of circumstances, bearing in mind that councils have a duty to make inquiries when they know or believe that a person is an adult at risk of harm and that they might need to intervene.

35. When an adult has been assessed as having incapacity, GPs should ordinarily seek to speak to anyone who has guardianship powers or welfare power of attorney in regard of the adult. This engagement may also help the GP and/or council decide on the most relevant course of action. However, in some cases it may be someone with guardianship or welfare responsibilities who is the source of the

harm so GPs must make a careful consideration about discussing the case with such individuals. If there is any doubt the GP should liaise with the council as necessary.

Adults with capacity who withhold consent

36. The decision on how to respond to a suspected case of harm is made additionally complex where the adult has the capacity to consent to the GP making a referral under the 2007 Act, but chooses not to do so.

37. 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 the 2007 Act requires relevant information to be shared with the council, or any other public body, for the purposes of protecting an adult at risk of harm, where a competent adult explicitly states that an adult protection referral should not be made, this should ordinarily be respected. Well established local arrangements will help reassure patients that any information sharing will be handled sensitively.

38. Where a competent adult refuses to agree to an adult protection referral that would seem in their best interests and could help to mitigate a potential harm, the GP might consider it appropriate to employ the following strategies when discussing the matter with their patient:

- advise them of the risks of failing to alert relevant authorities and the benefits of doing so
- sensitively explore the reasons for their refusal to grant consent
- encourage them to speak to the council directly, emphasising that it is in their best interest to allow the council to carry out an inquiry under the 2007 Act
- explain the 'least restrictive' principle that guides any intervention made. (see Annex A).
- assist or empower them to take steps to safeguard themselves, including providing advice on independent advocacy services and other services which could offer support and protection. This may include the GP, with the adult's consent, contacting independent advocacy services in the local multi-agency adult protection network on their behalf
- seek further advice, perhaps consulting the Mental Welfare Commission

39. It is reasonable to ensure that the adult is informed about and understands the consequences of his or her decision, but an adult with capacity has the right to make his or her own decisions without interference or coercion.

40. Pressure should not be exerted on an adult to consent, nor should another professional exert pressure on a GP to take action, including sharing information, where an adult with capacity has refused to consent to action being taken. In order to best comply with the Data Protection Act, approaches outlined above should be adopted prior to seeking consent, to ensure that the patient is properly informed at the outset, removing any suggestion of coercion if consent was not initially forthcoming.

41. While adults with capacity have the right to consent or otherwise to the GP making a referral, this right is not absolute and may be overridden. The multi-agency approach to adult support and protection means that, where it is lawful and ethical to do so, appropriate information should be shared between relevant agencies to ensure that support that is right for the individual can be provided. GPs should take a proportionate approach to make balanced decisions about whether to share information without consent.

42. Where it appears to the GP that a crime is being, or has been, committed, the GP must report it to the police. In such circumstances, a GP should keep the patient informed as much as possible, even though the report may have been made against the patient's wishes. In addition to informing the police, the GP may also choose to notify the council if it appears necessary or appropriate to safeguard the adult or his or her interests. Failure to report a crime may lead to a GP being held accountable for a serious failing of his or her duty to protect the adult or other people.

43. GPs should also be alert to the possibility that consent may be withheld because the adult in question is being unduly pressurised to refuse. Undue pressure could include, for example, threats, blackmail, manipulation, dependency on the harmer, or a sense of responsibility or loyalty to the harmer. If a GP suspects that consent is being withheld because of undue pressure from another party, it is reasonable to take action in the patient's best interests and make a referral to the council. Similarly, if the GP considers it appropriate in the circumstances, for example if the adult is at risk of ongoing harm if no intervention is made, they must refer the case to the council, even though consent has not been given. In such circumstances, the GP must consider the need to balance his or her duty of care to the patient and towards public protection with the need to protect the patient's confidentiality and autonomy.

44. GPs may seek advice in such situations from senior colleagues and/or professional representative bodies such as the BMA, medical defence unions, Caldicott Guardians, and the GMC.

Protection Orders and consent

45. A protection order [11] cannot be made in respect of an adult who has refused to consent to the making of the order, except where it is believed that:

- undue pressure has been put on the adult to refuse consent
- there are no steps which could reasonably be taken with the adult's consent which would protect them from harm

46. However, a protection order can be made in respect of an adult who has incapacity and is therefore unable to consent.

47. When a council is applying for a protection order and consent has been refused, evidence of lack of capacity to consent to the making of the order will be

[11] http://www.legislation.gov.uk/asp/2007/10/part/1/crossheading/protection-orders-and-visits-supplementary

required by the Sheriff, as set out by the Code of Practice[12] for the 2007 Act. A GP may be asked to carry out an assessment of the adult's capacity for such a purpose. As in other circumstances, the GP may not be the best person to carry out such an assessment, but should be involved in the multi-agency assessment where he or she has a professional relationship with the adult. In these circumstances completion of an assessment is likely to be time-critical in order to secure the protection of an adult from a harmful situation.

48. The possibility of involvement with court processes will mean that GPs will want to seek advice from the BMA and their medical defence organisation.

Requests to undertake medical examinations

49. The 2007 Act creates powers for councils to ask a nominated health professional to undertake a medical examination for the purposes of establishing whether an adult is at risk and to inform the council's decision on whether any further action is required.

50. In the context of the 2007 Act, 'health professional' means a doctor, nurse, midwife or any other type of individual described (by reference to skills, qualifications, experience or otherwise) by order made by the Scottish Ministers (to date, no such order has been made).

51. In most cases covered by sections 9 and 11, the adult's GP may be the most appropriate health professional to carry out a medical examination. GPs are an important part of multi-agency adult protection arrangements and must consider favourably requests to carry out examinations and other activity under the 2007 Act.

52. Two sections of the 2007 Act relate specifically to medical examinations. Section 9[13] allows a medical examination in private to be carried out where a council officer is carrying out a visit under Section 7[14] of the 2007 Act and finds a person who is, or may be, an adult at risk of harm. The council officer must be accompanied by a health professional for this purpose and before any examination is carried out the adult must be informed of his or her right to refuse.

53. Section 11[15] allows a council to apply for an assessment order for the purpose of taking a specified person from a place being visited under section 7 to allow a council officer, or a person nominated by the council, to interview the person in private, and to allow a health professional nominated by the council to conduct a medical examination of the specified person in private.

54. In practice, councils should ask GPs or other health professionals who know the adult. This will mean they are more likely to be familiar with the circumstances of the case. GPs may be asked to carry out such an examination at any time. It is therefore necessary for them to be familiar with the 2007 Act and local multi-agency adult protection arrangements so that they understand why they are being asked to

[12] http://www.scotland.gov.uk/Publications/2009/01/30112831/0
[13] http://www.legislation.gov.uk/asp/2007/10/section/9
[14] http://www.legislation.gov.uk/asp/2007/10/section/7
[15] http://www.legislation.gov.uk/asp/2007/10/section/11

carry out an examination. A GP will not be compelled to perform an examination if there is a valid reason for not doing so (if, for example, the adult is unwilling to agree to a medical examination, or if doing so would damage the doctor-patient relationship).

55. Where a GP carries out an initial medical examination and indicates that a further examination is required to identify the specific cause of harm, it will be necessary to involve a specialist medical professional. If the police are involved in a case, it is likely that a Forensic Physician (also known as a Forensic Medical Examiner or police surgeon) will carry out a medical examination of the adult. In such cases, the GP may still have a role to play, particularly where the adult is well-known to them; however, a GP is unlikely to have the specialist skills required to carry out the actual examination.

56. Depending on the circumstances of the case, it may be appropriate for a specialist medical professional to undertake the initial assessment. In such cases, it may be useful for relevant information about the patient to be shared between the GP and the special medical professional, in line with professional standards.

57. The council should seek to involve GPs from the outset of a case where possible. In particular, sufficient notice should be given to a GP that he or she may be asked to carry out a medical examination. This will allow the GP to prepare, including arranging locum cover where necessary. However, in some instances it will not be possible to give advance notice, but where GPs are a key part of the local multi-agency adult protection arrangements, they will have a general awareness of adult protection issues and the need for their involvement at short timescales on occasion.

58. Local policies, procedures and strategies relating to medical examinations carried out under the 2007 Act will be developed jointly under multi-agency arrangements for adult protection. This will provide consistency and clarity for all involved, including on the issue of fees. Policies should be developed in conjunction with all relevant stakeholders, including GPs through the, CHCP/CHPs, Health Boards, the local Adult Protection Committee and any other relevant organisation or body.

59. Policies should set out the full range of issues relevant to this process, including:

- when medical examinations may need to be carried out
- the process by which this will be arranged
- the level of fee for a health professional and the process for claiming this
- when GPs might be involved beyond the initial medical examination
- what specialists may be involved in assessing adults under the 2007 Act

60. In particular, policies should help GPs understand the purpose of examinations and why tight time timescales will often apply. However, policies will also need to take account of work pressures faced by GPs, and should emphasise why integrating GPs into the multi-agency adult protection network will, at the very

least, ensure they are aware of typical adult protection procedures and have access to key contacts where they can get advice.

61. It is important that councils know that they will be able to call on GPs to carry out medical examinations when required and have an agreed process in place for doing so. Local policies should address this, and it may be useful to develop a memorandum of understanding between the council and the Local Medical Committee, Health Boards and CHCPs/CHPs as appropriate which takes account of their work and of GPs and the need to act swiftly to protect adults who are at risk.

Providing relevant information from healthcare records

62. In carrying out inquiries and investigations under the 2007 Act, a council officer may request health records (as well as financial and other records) relating to an individual who the officer knows, or believes, to be an adult at risk of harm. This is an important part of a council carrying out its functions under the 2007 Act, as it will help to ascertain whether the individual is an adult at risk, as well as potentially indicating the nature and extent of any harm which has been experienced. This will not only allow appropriate support and protection to be offered to the adult, but it may lead to action being taken against the person who caused the harm. Records should be handled securely in accordance with DPA principle 7 with local protocols developed in line with the Information Commissioners office Code of Practice.

63. Section 10 requires any person holding health records to disclose them to a council officer carrying out an adult protection inquiry or investigation for the purpose of enabling the council to decide whether it needs to do anything further to protect an adult at risk. Under section 49(2), it is an offence for a person to refuse or otherwise fail to comply with a request made under section 10, without reasonable excuse.

64. Only a health professional may physically inspect health records. The Adult Support and Protection (Scotland) Act 2007 (Restriction on the Authorisation of Council Officers) Order 2008[16] allows a council to authorise a person to carry out the council officer functions under the 2007 Act if they are a nurse and have at least 12 months' post qualifying experience of identifying, assessing and managing adults at risk. If the council officer requesting health records under section 10 does not meet this definition, he or she must pass the records to a health professional for examination and the GP should be informed of this.

65. In carrying out this function, the council officer must speak to the GP to provide context as to why the records are being requested, in particular emphasising that only information relevant to the assessment of risk and to allow the council officer to assess whether any further action is required to safeguard the adult is needed. There is not necessarily a need for entire healthcare records to be provided; only such information as is relevant to the case, and this may not need to be in writing if that is sufficient for the council officer to carry out his or her duties under the 2007 Act. However if a council officer receives information verbally a note of any relevant information might be prepared and agreed with the healthcare professional for accuracy and to provide an audit trail of actions. The council officer must discuss

[16] http://www.legislation.gov.uk/ssi/2008/306/introduction/made

the nature of the case with the GP to decide jointly what medical information is required for this purpose.

66. Those involved in the management of adult protection, such as APCs, should work with their local partners to develop policies and procedures that facilitate these types of requests. For example, GPs may prefer that a standardised format for requests is agreed and that this includes the provision of identification as a matter of course.

67. GPs considering a request for information under section 10 (or any other part of the 2007 Act) must take account of the confidentiality of the patient and should discuss the request with the adult to ensure they understand the reasons for it and the likely benefits. Often, where the adult is competent, they will have already agreed to action being taken on their behalf.. However, even where consent has not been granted to share information with relevant agencies, GPs are under a legal obligation to provide relevant records under section 10 of the 2007 Act. Again, close joint working between the GP and council may help overcome any obstacles, including working together to ensure the adult agrees to the relevant information being shared.

Participating in other activity

68. Local policies should also set out what other involvement GPs may have beyond initial medical examinations and provision of relevant information from healthcare records. GPs have a role in case conferences whether by attendance or through the provision of reports. GP reports stand out in practice as a key factor in comprehensive decision making particularly in complex cases involving both health and welfare protection concerns. There is also the possibility of GPs attending court as professional witnesses if criminal proceedings are brought.

Further information

69. The Scottish Government Adult Support and Protection Policy Team can be contacted on 0131 244 4472 or aspunit@scotland.gsi.gov.uk.

Annex A

Adult Support and Protection (Scotland) Act 2007: Overview

GPs are well placed to identify adults at risk and are a vital component in the multi-agency arrangements that exist to provide support and protection where it is necessary. GPs must make themselves aware of the 2007 Act and its implications for them. The Act places a duty on councils to make inquiries where they know or believe that an individual may be an adult at risk. Other public bodies and office holders have a duty to inform councils of situations where an individual may be an adult at risk.

The 2007 Act has a rights-based approach and has an overarching principle which demands that any intervention provides a benefit to the adult that would not be possible otherwise and is the option least restrictive to the adult's freedom. Any action to support and protect is always balanced with the rights of individuals to live their lives as they wish.

Definition of Adult at Risk

The 2007 Act defines adults at risk as individuals, aged 16 years or over, who:

- are unable to safeguard their own well-being, property, rights or other interests;
- are' at risk of harm'; and
- because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected

All three elements of this definition must be met for an adult to be regarded as an adult at risk of harm. This is commonly referred to as the 'three point test'. So, for example, an adult is not necessarily an adult at risk of harm simply because they have a disability.

It is the responsibility of the council to decide whether or not an adult meets the definition of an adult at risk. Where someone is suspected of being an adult at risk, a referral should be made to the council.

Definition of harm

The 2007 Act defines harm broadly as 'all harmful conduct'. The Act specifically highlights the following types of harm:

- physical
- psychological/emotional
- sexual
- neglect
- financial or material

However, all kinds of harm fall within the scope of the 2007 Act.

Council responsibilities

The 2007 Act places a duty on councils to make the necessary inquiries and investigations where they know, or believe, that an adult is, or may be, at risk of harm and may need to intervene to safeguard the adult's well-being, property or financial affairs. It is the council who is responsible for deciding whether an individual is an adult at risk of harm and what further action, if any, is necessary. However, this decision should be arrived at on a multi-agency basis wherever possible. In order to make inquiries, council officers have powers to:

- carry out visits
- conduct interviews
- require health, financial or other records to be produced in respect of an adult at risk (see paragraph 64 of the guidance).
- nominate a health professional (e.g. a doctor or nurse) to carry out a medical examination (see paragraph 51)

In addition, the 2007 Act creates a suite of protection orders which can be used to:

- remove adults from certain places for defined periods of time, both to assess whether they are adults at risk, as defined by the 2007 Act, and to remove them from exposure to harm
- ban those who cause harm from being in certain places

Protection orders are the most formal and far-reaching options possible through the 2007 Act. In line with the least restrictive principle which underpins the Act, they should be considered only where they are absolutely necessary. Depending on the circumstances, less restrictive, support-based interventions may provide an effective and proportionate response, for example the use of care packages.

Annex B

NHS Circular PCA (M)(2009) 12: GPs undertaking duties under the Act

NHS Circular:
PCA(M)(2009)12

Primary and Community Care Directorate
Primary Care Division

The Scottish Government

23 September 2009

Addresses

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Dear Colleague

The Adult Support and Protection (Scotland) Act 2007: GPs undertaking duties under the Act

Summary

1. This circular provides a summary of the information regarding the Act and also confirms current arrangements for those seeking payment for undertaking duties associated with the Act.

Information

2. Information about the Act was published in February 2009 and is summarised in **Annex A.**

Funding

3. The Scottish General Practioner Committee has agreed that funding should continue under current Collaborative fee arrangements. However, as these fees are no longer negotiated at a national level, Medical Practioners are advised to approach their Health Board or Local Authority to establish and agree their own fees in advance of undertaking the work. Details on Collaborate arrangements can also be viewed at: www.bma.org.uk/sc/

Action

4. NHS Boards are requested to bring this Circular to the attention of all relevant staff.

Yours sincerely

Frank Strang
Deputy Director, Primary Care Division

Protection orders

GPs may be requested to write reports, attend adult protection case conferences or required to attend court. Protection orders do not authorise the adult to be detained.

- An **Assessment order** allows a council officer to conduct an interview in private and/or a health professional to conduct a medical examination in private. This may be required to establish whether the person is an adult at risk and if further action is required to protect him/her.

- A **Removal order** allows the local authority to remove the adult at risk to a specified place for up to 7 days where the adult is likely to be seriously harmed if not moved to another place.

- **Banning orders and Temporary Banning orders** ban the subject of the order from a specified place for up to 6 months. Conditions may be attached, for example contact under specified circumstances.

- **Warrants for entry** authorise a council officer to visit any place specified in the warrant accompanied by a constable.

Where an adult at risk has capacity to consent to an order and refuses consent, then the local authority must satisfy the sheriff that they have been unduly pressurised to refuse consent. Examples of this would where the adult is afraid of or being threatened by an individual, a person is applying undue pressure as they do not wish the order granted, perhaps to protect another individual, or where the adult has confidence and trust in that person and would otherwise consent.

Code of Practice

Anyone authorised or required to perform any functions under the Act, including health professionals, must have regard to the code of practice issued by the Scottish Government. http://www.scotland.gov.uk/Resource/Doc/232219/0063534.pdf

Further information can be obtained from:

http://www.scotland.gov.uk/Topics/Health/care/VAUnit/ProtectingVA.

February 2009

ANNEX C

Useful reference materials

Adult Support and Protection

a) The Adults with Incapacity (Scotland) Act 2000, the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adult Support and Protection (Scotland) Act 2007 have introduced significant changes in the ways that adults considered to be at risk of harm are supported in health and social care services. *Respecting and Protecting Adults at Risk in Scotland - legislation and practice: An Educational Resource*[17] is designed to support front line staff in the appropriate application of the Acts.

Consent: patients and doctors making decisions together[18] - Ethical guidance for **doctors** which expands on the guidance in Good Medical Practice concerning the issue of a **patient's consent** to care.

c) Guidance from the Mental Welfare Commission - Consent to treatment: A guide for mental health practitioners[19]

d) GMC case study on Should a doctor disclose evidence of abuse without the patient's consent? Confidentiality Case Study[20]

e) BMA (2008) *Confidentiality and Disclosure of Health Information Tool Kit* [21]:

- Card 6 *Assessment of capacity and determining 'best interests'*
- Card 7*Adults who lack capacity*.

[17] www.nes.scot.nhs.uk/.../**respecting_and_protecting_adults_at_risk_in_scotland**_2011.pdf

[18] http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_part3_capacity_issues.asp

[19] www.mwcscot.org.uk/media/51774/**Consent**%20to%20**Treatment**.pdf

[20] http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality_elder_abuse.asp

[21] http://bma.org.uk/practical-support-at-work/ethics/confidentiality-tool-kit

Annex D: Adult Support & Protection Act 2007: Patient Referral Process for GPs