Adult Support and Protection (Scotland) Act 2007

Guidance for General Practice

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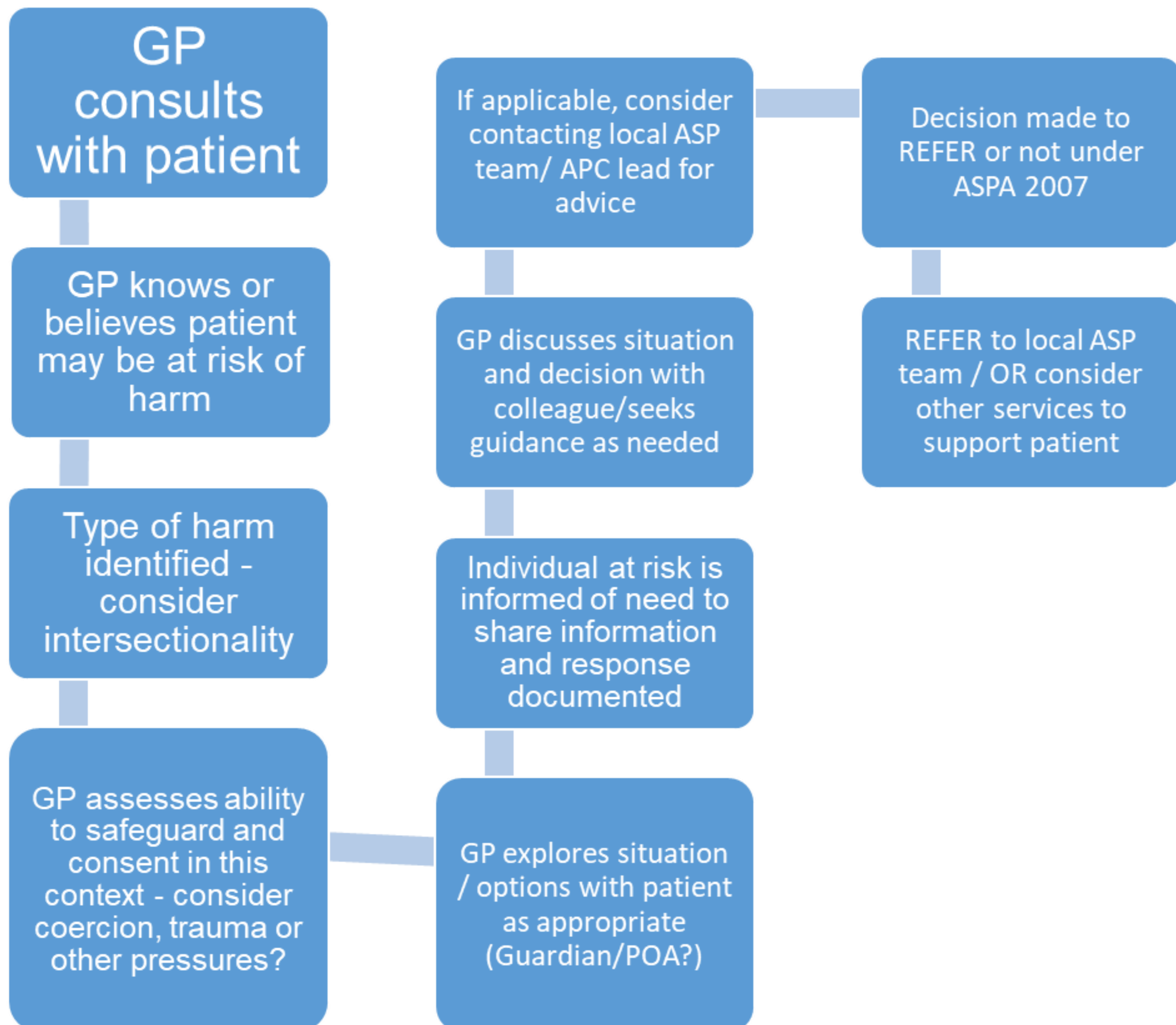

* To note: GP = General Practice staff member or individual GP

What is Adult Support and Protection (“ASP”)?

In 2008 new legislation was introduced to support and protect adults who are at risk of harm – the **Adult Support and Protection (Scotland) Act 2007** (“the Act”). The Act requires public bodies to work together to support and protect adults who are unable to safeguard themselves, their property and their rights. Public bodies are required to work together to take steps to decide whether someone is an adult at risk of harm and balance the need to intervene with an adult’s right to live as independently as possible.

GPs and General Practice staff are well placed to identify adults at risk of harm and are a vital component in the multiagency arrangements to support and protect where necessary. This guidance is to support GPs and General Practice staff when they may have need to refer to the Act, and should be used in conjunction with the main Adult Support and Protection Code of Practice.

The focus of the Act is to support and protect adults (individuals, aged 16 years or over) who are – or may be - at risk of harm. For children up to 18 years, or up to 21 years if “looked after” see Child Protection Guidance 2021, although to note there is some overlap in legislation and the most appropriate legislative route for the individual must be determined.
There is a “three-point criteria” in Section 3 of the Act to define an adult at risk:

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

Remember:

- an adult is not necessarily an adult at risk of harm simply because they have a disability or diagnosis;
- ASP applies to those with and without mental capacity;
- ASP is **not contingent on capacity assessments** as per the Adults with Incapacity (Scotland) Act 2000. Instead, it relies upon an assessment of a person’s ability to safeguard themselves within a specific context.
- ASP can be used alongside the Adults with Incapacity (Scotland) Act 2000 and/or the Mental Health (Care and Treatment) (Scotland) Act 2003, when circumstances warrant.

You do not have to evidence that the three criteria are met in order to make a referral. Your information may form part of a larger picture. The criteria is that you

'know or believe' an adult is at risk of harm. In this regard, following receipt of an ASP referral, it is ultimately the responsibility of the council to decide whether an adult meets the definition of an adult at risk of harm.
When deciding to make a referral and what information to share, consider what you believe to be relevant and proportionate to the specific concerns you have.

Types of Harm

Section 53 states that "harm" includes all harmful conduct and gives the following examples:

- conduct which causes physical harm;
- conduct which causes psychological harm (for example by causing fear, alarm or distress);
- unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion);
- conduct which causes self-harm.

The list is not exhaustive and no category of harm is excluded simply because it is not explicitly listed. In general terms, behaviours that constitute harm to a person can be physical, sexual, psychological, financial, or a combination of these. The harm can be accidental or intentional, as a result of self-neglect, neglect by a carer or caused by self-harm and/or attempted suicide. Other forms of harm can include domestic abuse, gender-based violence, forced marriage, female genital mutilation (FGM), human trafficking, stalking, scam trading and hate crime. Some such cases will result in adults being identified as at risk of harm under the terms of the Act, but this will not always be the case.
The Social Care Institute for Excellence ("SCIE") has a comprehensive downloadable resource illustrating types of harm in detail: Types of abuse: Safeguarding adults.
Evidence of any one indicator should not be taken on its own as proof that abuse is occurring, and, conversely, practitioners must remember that individuals may well be subject to more than one type of abuse at a time, and intersectionality should be considered as a compounding factor. With this in mind, you should consider making further assessments, consider other associated factors, and consider making relevant and appropriate referrals which would be of benefit in supporting and safeguarding the individual concerned.

The SCIE identify some commonly recognised types of 'harm' though note this list is not exhaustive:

Physical harm

Sexual harm
Psychological or emotional harm
Financial or material harm
Modern slavery
Discriminatory harm
Organisational or institutional harm
Neglect or acts of omission
Self-neglect
Also see:
NHS inform:
Self-harm

For further detailed explanation of types of harm to consider, you should refer to the main Adult Support and Protection Code of Practice.

Trauma

The majority of adults who are, or are believed to be, at risk of harm will be people for whom the application of the three-point criteria will be relatively straightforward. This will lead to consideration of options for intervention whether under the provisions of the Act and/or other relevant legislation.

As mentioned in the "unable or unwilling" section in the Code of Practice, there are, however, a number of people for whom straightforward application of the three-point criteria is not possible, and some may remain in situations which continue to compromise their health, wellbeing and safety. All adults who have capacity have the right to make their own choices about their lives, and these choices should be respected if they are made freely. Many people affected by trauma and adverse childhood experiences remain able to safeguard their own wellbeing. However, for some, the complexity, severity and persistence of post traumatic reactions may impact to the extent that these individuals repeatedly take decisions that place them at risk of harm.

Equally, issues with their sense of self and interpersonal relationships, seriously affecting all or many of their relationships across many areas of life, can severely compromise their ability to safeguard. These safeguarding challenges can be associated with patterns of chronic difficulties in experience of emotions, emotional expression and/or regulation, and associated coping strategies such as self-harm, care-seeking and use/misuse of alcohol and drugs.

As part of an assessment – which may require significant time to undertake - it is crucial to understand the person's decision-making processes. Consideration should

be given to any factors that may have impacted upon the adult with the effect of impinging on, or detracting from, their ability to make free and informed decisions to safeguard themselves. This could therefore mean that, in some circumstances, they should be regarded as unable to safeguard themselves.

Trauma informed practice is an approach to care provision that considers the impact of trauma exposure on an individual's biological, psychological and social development. Delivering services in a trauma informed way means understanding that individuals may have a history of traumatic experiences which may impact on their ability to feel safe and develop trusting relationships with services and professionals.

Trauma informed practice is not intended to treat trauma-related issues. It seeks to **reduce the barriers** to service access for individuals affected by trauma, and to promote **understanding** of the **impact of trauma** on individuals.

Key principles of a trauma informed approach are:

- safety
- trustworthiness
- choice
- collaboration
- empowerment

Taking a trauma informed approach to adult support and protection practice enables all those who perform any of the functions under the Act to better understand the range of adaptations and survival strategies that people may make to cope with the impacts of trauma. Practitioners should be alert to the need to view behaviours that compromise health, wellbeing and safety as adaptations that may have played a useful role in the individual's life in helping them to survive, and cope with, their experiences of trauma. Examples of such adaptations can include: maintaining contact with an alleged harmer; use of drugs or alcohol; self-harm; hoarding, and avoidance of places and people, including professional relationships and services, which may trigger reminders of prior traumatic experiences. As above, in these circumstances, some people's ability to take and action decisions about safeguarding themselves may effectively be compromised.

The 2017 Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce details the specific range of knowledge and skills required across the workforce, depending on their and their organisation's role and remit in relation to people who have experienced trauma. Those with direct and frequent contact with people who may be affected by trauma should be equipped to 'trauma skilled' level of practice. Those professionals with regular and intense contact with people affected by trauma and who have a specific remit to respond by providing support, advocacy or specific psychological interventions, should have adequate

training and experience to practice at 'trauma enhanced' level. Practitioners with responsibilities under the Act should be trained to the appropriate levels, as noted in The Scottish psychological trauma training plan (page 22). This is to ensure their adult support and protection practice reflects the in-depth knowledge and understanding required to intervene in the lives of those affected by trauma.

Taking a trauma informed approach can result in better outcomes for people affected by trauma and seek to address the barriers that those affected by trauma can experience when accessing support. Adopting a trauma informed approach to adult support and protection work is good practice, even when applied to individuals who have not experienced, or been significantly impacted by, psychological trauma.

Professionals involved in the identification, support and protection of adults at risk of harm may wish to make use of the resources provided by the National Trauma Training Programme. For more information on trauma-informed practice, practitioners can also access the trauma-informed practice toolkit produced by Public Health Scotland.

Suicide Prevention

A new suicide prevention strategy is being developed for Scotland, and is due to be published soon.
As outlined already, adults who are – or may be - at risk of harm can present in complex circumstances. In some cases this may result in an individual seeking to cause potential or actual harm to themselves, and showing suicidal ideation. Acute and immediate intervention may be required to keep the individual safe at the time of crisis. In General Practice, your work centres on the things which matter to people, and things which have an impact on their everyday lives. If a patient may be at risk of harming themselves and shows suicidal ideation, there are resources available to help you support them.

Asist (Applied Suicide Interventions Skills Training) is widely available for anyone over the age of 16 years, and teaches participants to recognise when someone may be at risk of suicide and how to effectively work with them to create a plan that will support their immediate safety, until further appropriate intervention is available.

General Practices have access to a range of NHS Education for Scotland **Ask Tell Respond** resources which include responding to those with suicidal ideation (information on mental health and suicide prevention). These resources support practitioners to provide a trauma informed response to those in distress, whether that is from suicidal thoughts or as part of post-intervention support.

Undue Pressure

The principles in Section 2 of the Act require that regard, if relevant, be given to the views of others who have an interest in the wellbeing or property of the individual at risk of harm.
This would include the views of the adult's nearest relative, primary carer, a guardian or attorney, and any other person who has an interest in the adult's well-being or property. Cognisance, when weighing the merits of such views, must be taken of any possibility of undue pressure[1], or increase of risk, if the views of others are sought. It is important that the adult has the option to maintain existing family and social contacts, should they wish to do so.

The Act seeks to **provide support** additional to that of existent networks. Thus, a person, who may be an adult at risk, might have neighbours, friends or other contacts who have an interest in their wellbeing and are willing to give support (noting the caveat that consideration should be given to whether **undue pressure** from those contacts is a suspected or known risk factor). Every effort should be made to ensure that action taken under the Act does not have an adverse effect on the adult's relationships.

Are there indicators that the adult is being influenced by someone else they have trust in or depend upon? Is there someone who is either intentionally or unintentionally preventing them from protecting themselves effectively? Or someone who is suspected of harming the adult, of threatening them, or is there someone the adult is afraid of?
Undue pressure may be applied to prevent the person seeking help or to influence the decisions they make which leave them at risk of harm. The outcome may or may not be a direct benefit to the person applying the pressure.
If you know or believe that an adult is at risk of harm you should make a referral. Any subsequent ASP activity undertaken by the council will consider if undue pressure is having an impact on the adult. Any information you can provide about the external influences on the adult will contribute to inquiries and any further action.

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[1] Section 35(4) of the Act gives an example of what may be considered to be undue pressure. An adult at risk may be considered to have been unduly pressurised to refuse to consent to the granting of an order, or the taking of an action, if it appears that the harm which the intervention is intended to prevent is being, or is likely to be, inflicted by a person in whom the adult at risk has confidence and trust; and that the adult at risk would consent to the intervention if the adult did not have confidence and trust in that person.

Locations and sources of harm

Harm can occur in **any setting,** and can be **caused by anyone**:

Locations:

- the individual's own home;
- a care setting, hospital setting;
- respite setting;
- in a public space, in the wider community.

And be perpetrated by:

- a relative;
- spouse;
- carer (paid or unpaid);
- acquaintance;
- fellow service user;
- neighbour;
- fraudsters;
- member of staff;
- stranger;
- the individual themselves.

The harm may be intentional or unintentional but it will be important to speak with the adult at risk of harm alone. It may also be appropriate to speak with the carer. Prompts to such a conversation can include:
I'm quite concerned that you're not getting the support you need OR Is there anything I can help you with? OR Can you tell me how you're managing the situation? It may also be useful to speak about their carer's right to an adult carer support plan.

If you are refused access to the adult and your information causes you to *know or believe* that the adult is at risk of harm you should consider making a referral.

General Practice Role in the Adult Support and Protection Context

Risk assessment

The provisions of the Act are concerned with adults at risk of harm. After a referral is made, local procedures should concentrate on the following and, as part of the information gathering, General Practices may be asked to contribute knowledge concerning the individual in question:

- an assessment of whether the adult is at risk of harm;
- an assessment of the nature and severity of any risks identified, including when and where the adult may be placed at risk and an identification of the factors that will impact on the likelihood of risk;
- the identification of reasonable and proportionate timescales for undertaking inquiries and assessments;
- the development of a protection plan (that can be single or multi-agency), that identifies actions and supports that will eliminate or reduce the risks identified;
- reviewing and amending protection plans as risks and circumstances change;
- reviewing whether the adult continues to meet the criteria for an adult at risk of harm, and if not whether there are other supports that will still be required out-with the provisions of the Act.

Many referrals that are made concerning people who are believed to be at risk of harm will result in a determination that they are not at risk of harm and therefore require no further action under the provisions of the Act, though this does not preclude other support or involvement through other relevant legislation, local procedures or alternative services to respond to the individual's needs**.**

Note: A "no further action" outcome for one or more ASP referrals **does not change the obligation to make future ASP referrals** when you know or believe the adult is at risk of harm.

For other adults the inquiry and investigative process will determine that they are at risk of harm and will need continuing assistance with their support and protection. Such a determination will follow from an assessment process that should involve all relevant agencies. Some cases will involve few or single agency involvement. Others will require the involvement of a wide range of agencies.

Case Conference and other reports

GPs may be the first professionals to see signs of potential harm or may hold key pieces of information to contribute to understanding of risk to the individual. Therefore, **a collaborative approach is vital**.
GPs may be requested to participate, either in person or through a report to case discussions, ASP Case Conferences, or case reviews. This could include meetings relating to one individual or, indeed, to several individuals in the case of a Large Scale Investigation. Information may also be requested via Section 10 requests or to contribute to risk assessments, chronologies or safeguarding activity. A GP's contribution will enhance the knowledge-base and form a central part of the jigsaw for all parties concerned in order to support the individual in question.

When completing reports for other bodies, it is suggested that you:

- request specific guidance from your local services on the type of detail that is required;
- provide relevant and proportionate information to assist risk assessment and appropriate decision making.

Information Requests and Responses

The Adult Support and Protection (Scotland) Act 2007 gives councils, and other public bodies working with them, various powers to support and protect adults at risk of harm. It confers on 'Council Officers' a duty to investigate cases of suspected harm to an 'adult at risk'. Section 4 of the Act states that a council must make inquiries about a person's wellbeing, property or financial affairs, if it knows or believes that the person is an adult at risk of harm, and that it might need to intervene to protect their wellbeing, property or financial affairs.
To assist with such inquiries, professionals may receive requests for further information from the council. All responses should include relevant and proportionate information in relation to the risk of harm. Where there is any dubiety about the identification of the council officer, you should verify this with the agency directly. Guidance is offered below on responding to these requests.
Health records pertaining to the adult at risk can be requested under **Section 10** of the Act. Bodies holding these records have a legal duty to co-operate with inquiries, and health professionals may also be asked to examine and interpret these records.
It is worth noting that under Section 49 of the Act, a person commits an offence by, without reasonable excuse, refusing or otherwise failing to comply with a request made under section 10.

Support during ASP activity

In General Practice you may require support around these issues (and indeed in all aspects of Adult Support and Protection), e.g., making a referral; information sharing; attending a Case Conference; any other ASP-related activity. If appropriate, seek guidance (from the person making the request / local practice policy / local HSCP Primary Care team etc.) and discuss the situation and intended actions confidentially.
If applicable, you may also wish to seek assistance from your local Caldicott Guardian. A Caldicott Guardian is a senior role for an organisation which processes health and social care personal data. They make sure that the personal information about those who use the organisation's services is used legally, ethically and appropriately, and that confidentiality is maintained.
They will advise regarding sharing information under The Caldicott Principles .
Further information can be found in the UK Caldicott Guardian Council website.

Working with patients who are at risk of harm, and making decisions to protect them, can be stressful and have an emotional impact on the practitioner. Within your practice, it may be beneficial to establish an adult protection lead or champion who can advise as issues arise, and also assist with team debriefs as necessary.

Your Health Board will be able to signpost you to a range of wellbeing resources, alongside services such as occupational health if needed.

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Duty of Candour

The statutory duty of candour is very specific and only applies where there has been an unexpected or unintended consequence that causes harm or death to an individual (as defined by the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016) that is not as a consequence of the condition for which they are being treated. It is also set out by the GMC at The Professional Duty of Candour. The Scottish Government website also provides Duty of Candour FAQs.

Duty of Candour may be relevant when an adult at risk has been harmed.

Information Sharing

We all have a responsibility, individually and collectively, to protect vulnerable people in our communities. This cuts across all aspects of private life and professional business. Supporting individuals at risk of harm is best done through collaboration and with a sense of community responsibility.

The Referral Process

Adult protection referrals can be made in writing (to be submitted electronically) or over the phone to the council for the area in which the adult at risk currently is. For most ASP referrals, this will be to the council for the area where the adult is habitually resident (where they live). Prompt action is vital.
Relevant contact details can be found here: Find your local contact - Act Against Harm. If you are working out of office hours, your local procedures and contacts will advise you of the relevant out of hours procedure, e.g. the Duty Social Worker.

Referral forms (sometimes referred to as an "AP1") – or the electronic link to them – can be requested from your local adult services team in advance; the form can then be saved in a place convenient for future use.

Referral information requested, either on a form or over the phone, may include:

- Details of the person completing the referral;
- Details of the person subject to the referral, including name, date of birth, address;
- The primary user group or client category of the patient, if known (e.g. learning disability, mental health, dementia, substance misuse, acquired brain injury, physical disability);
- Any communication needs of the adult at risk;
- Harm type(s) suspected;
- Whether the adult at risk is aware of the referral;
- Details of the concern, including as much information as possible about the incident(s), dates, alleged harmer(s), previous concerns, any safeguarding activity undertaken;
- An overview of the "three-point criteria"**:**
  I. In your opinion, is the adult able to safeguard their own wellbeing, property, rights or other interests?
  II. In your opinion, is the adult at risk of harm?
  III. In your opinion, is the adult affected by disability, mental disorder, illness or physical or mental infirmity, making them more vulnerable to harm?
- Confirmation of whether police have been contacted if a crime is suspected;
- Any relevant relationships, proxy decision makers (guardian or Power of Attorney), and/or caring responsibilities of the adult.

Please note that this list is not exhaustive and a referral should still be made if you believe that the criteria are met for referral, even if lacking some of the information

noted above. **It is not your responsibility to confirm that the adult meets the three-point criteria;** it is enough that you believe them to meet the criteria to warrant an ASP referral. Any information that can be provided at the referral stage will assist the local authority in undertaking adult protection inquiries.
As part of the inquiry process, it is possible that you will be asked to assist the council making the inquiries.
If there is **immediate danger** to you or the adult at risk, do not hesitate to **call 999.** You can make a subsequent Adult Protection referral, if relevant.

Referrals – prompt action is vital.

As well as your local contact's details, the Act Against Harm website carries lots of useful information, including how to recognise when an adult may be at risk of harm and examples of the type of support that can be provided once a concern has been reported.

Steps to Take – The "Four Referral Rs"

Recognise — be aware of adult protection issues and how an adult at risk of harm may present. Consider trauma, undue pressure etc., and the adult's ability to safeguard themselves.

Report — where you have an internal adviser for adult protection report the matter to them, discuss with appropriate colleagues the need to make a referral *but* ensure this does not adversely delay referring.

Refer — Refer the individual and their circumstances through your local adult protection referral process. Where the matter is urgent contact the relevant emergency services without delay.

Record — use the individual's record to note the issues that arose, the circumstances, the decisions made/actions you took, and the rationale for your actions.

If the matter is urgent e.g. there is imminent risk of danger or significant harm has happened please contact the relevant Emergency Service – Police/Fire/Ambulance.

Information - To Share or Not To Share – Checklist

With specific reference to the circumstances of the case, before making a referral, consider:

- Is the sharing justified at this time?
- Does the duty to protect the individual outweigh the duty of confidentiality?
- What are the benefits to the individual of sharing, or the risks of not sharing, information?
- Are there wider risks from sharing or not sharing (to other family members etc.)?
- Are you sharing special category data? (see section below under Data Sharing)
- Are you able to identify a condition for processing from Article 9 UK GDPR that you can you rely on?
- Do you need to identify an additional condition from the DPA 2018? – see section below on special category data.
- Are there relevant exemptions ?
- Are there other relevant statutory requirements, legislation or restrictions to consider? e.g. Adults with Incapacity (Scotland) Act 2000 ; Mental Health (Care and Treatment) (Scotland) Act 2003 ; Child Protection; reporting a crime etc.
- Is there a legal obligation to share? (for example a statutory requirement or a court order)?
- Is there an organisational / in house protocol, e.g. a Data Sharing Agreement?
- Are there other similar, relevant, cases which ought to be considered?
- Is authorisation required within your organisation to make the decision?
- Should legal advice or other guidance be sought? E.g. ICO Helpline.

If you decide a referral is needed, and information is to be shared, consider:

- Has the individual's attorney or guardian, if relevant, been consulted?
- Should any other person be informed ahead of, or after, sharing?
- In terms of consent under UK GDPR see Why is consent important?
- Has the individual been consulted with openness and transparency? If not, reasons should be documented. Note that the controller's fairness and transparency obligations under data protection law must also be referred to
- Are there suspicions that alerting the patient to concerns could place them at greater risk?
- What information should be shared?
- What is fact and what is opinion?

- How should the information be shared / stored?
- **Record the decision, actions and reasoning.**
- What information was shared and for what purpose.
- Whom it was shared with.
- When it was shared.
- The justification for sharing.
- Whether the information was shared with or without the subject's consent.

Do you need the consent of the adult to make a referral?

No. Whilst adults with capacity have the right to consent or otherwise, there may be a lawful basis to share information under the 2007 Act without this consent.
There is a **difference** between **medical consent and data sharing consent**. It is important to be open and transparent with the adult, and vital that all decisions and rationale are recorded. Further information around UK GDPR and consent in respect of data sharing can be found here - Why is consent important? | ICO

Why do we need to share adult protection information?

Organisations need to share safeguarding information with the right people at the right time to:

- prevent death or serious harm;
- coordinate effective and efficient responses;
- enable early interventions to prevent the escalation of risk;
- prevent abuse and harm that may increase the need for care and support;
- maintain and improve good practice in safeguarding adults;
- reveal patterns of abuse that were previously undetected and that could identify others at risk of abuse;
- identify low-level concerns that may reveal people at risk of abuse;
- help people to access the right kind of support to reduce risk and promote wellbeing;
- help identify people who may pose a risk to others and, where possible, work to reduce offending behaviour;
- reduce organisational risk and protect reputation.

Where someone is suspected of being an adult at risk of harm, an Adult Support and Protection **referral should be made to the council within 24 hours** – any delay should be recorded with reasons.
Once you have made a referral this places a duty on the council to make inquiries where they know or believe that an individual may be an adult at risk of harm.

Information Sharing: Legalities and Cooperation

Duty to Co-operate

A number of bodies have a duty to co-operate under the Act (Section 5), e.g. Health Boards and Healthcare Improvement Scotland, Police and councils. Any information received in the course of an inquiry is treated with the utmost confidence and will not be disclosed to any third parties other than in accordance with the provisions of the Act.

(Section 5) applies directly to GPs and staff directly employed by Health Boards. The Code of Practice outlines a further number of service providers who contribute to the protection of adults at risk and this would apply to General Practice. As per Section 5 of the Act, GPs who are employed by Health Boards have unequivocal responsibilities to cooperate with the council undertaking ASP inquiries; to notify the council of an adult who may be at risk of harm; and to cooperate with others named in Section 5.

Data Sharing

Data protection law enables organisations and businesses to share personal data securely, fairly and proportionately. The Information Commissioner's Office (the "ICO") has a Data Sharing Code of Practice and the resources available at their Data Sharing Information Hub provide detailed guidance and tools to aid data sharing in compliance with data protection law.
A step-by-step guide to data sharing is available here.
There are many **misconceptions and fears** around data sharing, and the ICO have a helpful page exploring these at Data sharing myths busted.

Forward planning for sharing information

It is strongly recommended that organisations take the time to consider all of the scenarios in which they may need to share data about vulnerable adults in their care and associated third parties. Some of this sharing may take place under the 2007 Act but other sharing may take place out-with it. Practitioners should be clear about whether they are a data controller, joint controller or processor for the personal data that they intend to share. A data controller has the responsibility of deciding how personal data is processed - they are the main decision-makers and exercise overall control over the purposes and means of the processing of personal data. Both a council and the person making the referral are likely to be controllers. The data subjects will be the adults to whom the information relates, and about whom the

enquiry is being made/whose records are being examined.

Where data sharing is a regular occurrence there should be Data Sharing Agreements (DSAs), informed by Data Protection Impact Assessments (DPIAs), which will help to ensure that data sharing is carried out in compliance with the law. The ICO recommend that as a first step you carry out a DPIA, even if you are not legally obliged to. Carrying out a DPIA is an example of best practice, allowing you to build in openness and transparency.
A DPIA will help you assess the risks in your planned data sharing and determine whether you need to introduce any safeguards. It will assist you to assess those considerations, and document them. Having a DPIA in place will help to provide reassurance to both yourselves and those whose data you plan to share.
It is also recommended that GPs work with their local **Adult Support and Protection Committee** to plan for data sharing and develop local processes and templates etc. to reduce duplication and promote consistency. Some organisations may wish to develop processes and templates collectively, perhaps via a representative on the Adult Protection Committee, if applicable.

Data Sharing in Emergency Situations

Organisations can also carry out forward planning for emergency situations. In particular, organisations and practitioners should be confident that relevant personal information can be shared lawfully if it is to protect someone from serious harm, including safeguarding within a medical context. ICO guidance on Data sharing in an urgent situation or in an emergency emphasises that **in an emergency, practitioners should go ahead and share data as is necessary and proportionate**. It also advises what may constitute an emergency and that organisations should to plan ahead for such circumstances, i.e. consider training staff, consider DPIAs, assess the types of data that might be shared etc.
The key point is that the UK GDPR and the DPA 2018 do not prevent you from sharing personal data where it is appropriate to do so.
The ICO has a section on data sharing in an urgent situation or in an emergency in the Data Sharing Code of Practice.

The Code sets out that an emergency includes:

- preventing serious physical harm to a person;
- preventing loss of human life;
- protection of public health;
- safeguarding vulnerable adults or children.

In these situations, it might be more harmful not to share data than to share it.
It is strongly recommended that controllers plan ahead for urgent or emergency

situations as far as possible. Controllers should consider what data sharing might need to take place, what data should be shared and how this can be done in compliance with the law. This may involve preparing DPIAs and implementing DSAs to cover emergency situations which can include the relevant lawful bases and any conditions for processing as well what is likely to be necessary and proportionate in the context of the sharing. In an urgent or emergency situation, decisions have to be made rapidly and it can be difficult to make sound judgements about whether to share information. **Spending time forward planning is key**.

Special Category Data

What is special category data? This is personal data that needs more protection because it is sensitive and may affect an individual's rights and freedoms. This means data which:

- reveals racial or ethnic origin;
- reveals political opinions;
- reveals religious or philosophical beliefs;
- reveals trade union membership;
- is genetic data;
- is biometric data;
- is concerning an individual's health;
- is concerning an individual's sexual orientation or activity.

If you process special category data you must keep records, including documenting the categories of data. This does not include personal data about criminal allegations, proceedings or convictions, as separate rules apply (see below).
In order to process special category data, you must identify both a lawful basis to process under Article 6 of the UK GDPR **and** a separate condition for processing under Article 9. These do not have to be linked.

Where Criminal Offence data , including data relating to alleged offences and to victims, is being processed, official authority or an additional condition under Article 10 of the UK GDPR is required. The Data Protection Act 2018 contains specific legal gateways for processing special category and criminal offence data for safeguarding purposes, namely those at Data Protection Act 2018 Schedule 1 Part 2, Paragraphs 18 (Safeguarding of children and of individuals at risk) and Paragraph 19 (Safeguarding of economic well-being of certain individuals).

Exemptions

In some circumstances you may not have to comply with all of the rights and obligations usually applied – this is where there are circumstances which qualify for exemptions. The UK GDPR and the Data Protection Act 2018 set out what these circumstances might be and when exemptions may apply.

Note: You should not routinely rely on exemptions; you should consider them on a case-by-case basis.

How do exemptions work?

Whether or not you can rely on an exemption generally depends on your purposes for processing personal data. If an exemption applies, you may not have to comply with all the usual rights and obligations.
Some exemptions apply simply because you have a particular purpose.
However, others only apply to the extent that complying with the UK GDPR would:

- be likely to prejudice your purpose (e.g. have a damaging or detrimental effect on what you are doing); or
- prevent or seriously impair you from processing personal data in a way that is required or necessary for your purpose.

You should justify and document your reasons for relying on an exemption.
If no exemption covers what you do with personal data, you need to comply with the UK GDPR as normal.

Lawful Basis – resources and case studies

The ICO have a Lawful basis interactive guidance tool to help organisations determine the appropriate lawful basis for their data sharing, along with lawful basis resources , including slide presentations (lawful-basis-presentation), to refer to.
For processing to be lawful under the UK GDPR, controllers must identify (and document) a lawful basis for the processing.
The basis of consent is only one of six lawful bases and the UK GDPR sets a high standard for controllers to demonstrate that the conditions required for consent have been met. Thus, in this context, **consent is unlikely to be an appropriate lawful basis** for adult protection purposes, due to the perceived power imbalance between client and practitioner. However both Public Task and Legal Obligation would be more appropriate - through each link you will find detailed explanations and examples where each basis is appropriate. There are also a number of case studies showing different approaches to data sharing here: Case studies | ICO and here: Annex C: case studies | ICO.

Relying on a lawful basis other than consent does not prevent practitioners seeking the adult's input or views and being transparent about the sharing, indeed it is an important component of a controller's fairness and transparency obligations under data protection law.
General Practices should, in advance of potential need, determine and document which lawful basis they can rely on in different scenarios. This should be done in consultation with their Data Protection Officer where available.

Large scale investigations

The Act makes no reference to large scale investigations (LSIs), but these have become increasingly prevalent across Scotland since the implementation of the Act. Many partnerships have their own procedures, sometimes across a number of partnerships (e.g. within one Health Board area). LSIs frequently involve other agencies including the Care Inspectorate, the NHS and the police, but there are no nationally agreed definitions of what warrants an LSI, or guidance for conducting LSIs or for governance arrangements locally.
An LSI may be required where there is reason to believe that adults who are residents of a care home, supported accommodation, an NHS hospital or other facility, or who receive services in their own home may be at risk of harm due to another resident, a member of staff, some failing or deficit in the management

regime, or in the environment of the establishment or service. In such circumstances this means that there is a belief that a particular service or alleged harmer may be placing more than one of its residents or service users at risk of harm.
It would, therefore, be **prudent for GPs to be aware of their local partnership's LSI procedures**, as they may be asked to contribute to an LSI by way of a report, information sharing, attendance at meetings, or other contribution to investigation and/or protection activity. etc. The local APC could advise on this.

Consent

When considering whether to share concerns, **if possible**, the individual's consent should be obtained prior to sharing information. As a further resource, the British Medical Association have a downloadable seeking patient consent toolkit.

Do you need the consent of the adult to make a referral?
No. Whilst adults with capacity have the right to consent or otherwise to the GP making a referral, there may be a lawful basis to share information under the Act without consent.
There is a difference between medical consent and data sharing consent.
It is important to be open and transparent with the adult, and vital that all decisions and rationale are recorded.
Further information around UK GDPR and consent in respect of data sharing can be found here - Why is consent important? | ICO

Duty of Confidentiality

General Practices should also note that they should ensure they meet their obligations under the common law Duty of Confidentiality as owed, for example, by doctors to patients. The General Medical Council UK ("GMC") advise that "Doctors are under both ethical and legal duties to protect patients' personal information from improper disclosure. But appropriate information sharing is an essential part of the provision of safe and effective care. Patients may be put at risk if those who are providing their care do not have access to relevant, accurate and up-to-date information about them."
The GMC publish further information on this topic in their guidance at Confidentiality: good practice in handling patient information. There is also detailed information available in the Manual for Caldicott Guardians.

The **multi-agency approach** to ASP means that, where it is lawful and ethical to do so, the appropriate information should be shared between relevant agencies to ensure that support and protection that is right for the individual can be provided. A **case by case approach** should be taken to identify the lawful basis to be relied

upon in terms of UK GDPR. Given the inherent power imbalance, the ICO has advised that it may be difficult to demonstrate that consent was freely given to a public authority.
GPs should take a proportionate approach to make balanced decisions about whether to share information without consent. However, having decided to refer it is best practice to advise the patient of this unless you feel it will increase the risk of harm to them or others.

It is also highly recommended that **General Practices should be represented on Adult Protection Committees (APCs)** or, where this is not possible, committees should ensure that there are clear lines of communication established with local GPs. GP participation is invaluable when developing or refining local adult protection policy, procedure and strategy. APCs can act as a further source of guidance in terms of local frameworks and protocols for information sharing, and thus working with your local APC is highly recommended, ensuring you are aware of protocols before you may need to use them.

Patient Refusal to Consent to Information Sharing

An adult with capacity may refuse to consent to information sharing. Whenever doctors seek to discuss confidential information about competent adults, they should consider in the first instance whether they can obtain consent.

In their confidentiality and disclosure guidance, the BMA (British Medical Association) state that "as part of the consent-seeking process, where an **adult at risk is making a decision that is seriously at odds** with an objective assessment of his or her interests, health professionals should sensitively explore the reasons behind the decision".
GPs should implement their professional curiosity, considering the possibility of confidential referrals to groups or organisations that offer support to adults at risk. A refusal of disclosure by a patient should not result in them being abandoned by services, with appropriate care and support continuing to be offered.

An individual's Right to Object only applies in certain circumstances and can be exercised either verbally or in writing. Individuals can object where the processing is on the basis of 'public task'. An individual must give specific reasons why they are objecting to the processing of their data, and these reasons should be based upon their particular situation. In these circumstances this is **not an absolute right**, and **you can refuse to comply if:**

- you can demonstrate compelling legitimate grounds for the processing, which override the interests, rights and freedoms of the individual; or
- the processing is for the establishment, exercise or defence of legal claims.

In making a decision on this, you need to **balance the individual's interests, rights**

and freedoms with your own legitimate grounds. During this process you should remember that the responsibility is for you to be able to demonstrate that your legitimate grounds override those of the individual. the interests, rights and freedoms If you are satisfied that you do not need to comply with the request, you should let the individual know and inform them of their right to make a complaint.

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Capacity

Individuals can be supported and protected under the Act whether they have capacity or not, however it is often beneficial to assess the adult's safeguarding capacity to inform risk assessment and aid decision making.
When assessing **over-arching capacity** the relevant legislation is the Adults with Incapacity (Scotland) Act 2000 . For the purposes of the Adults With Incapacity (Scotland) Act 2000 , "incapable" means incapable of:

- acting; or
- making decisions; or
- communicating decisions; or
- understanding decisions; or
- retaining the memory of decisions.

However, **capacity is not all or nothing** in this context .

The Adult Support and Protection (Scotland) Act 2007 recognises that **a person may be capable of some decisions and actions and not capable of others**. A person lacks capacity to take a particular decision or action when there is evidence that he/she is unable to do so. Adult support and protection applies to those **with and without mental capacity.**
It is also important to bear in mind that an inability to safeguard oneself is **not the same** as an adult lacking mental capacity. For example a person may have relevant mental capacity, but also have physical limitations that restrict their ability to implement actions to safeguard themselves. Further, due to many situational factors in an individual's life, capacity to make an authentic decision is a fluctuating concept. One should consider then, that even where a person can make a free and authentic decision, are they able to action that decision to safeguard themselves?

Specifically with regard to the Act, General Practices are not assessing overall capacity (as per the Adults with Incapacity (Scotland) Act 2000) but instead an assessment of capacity in terms of being **able to safeguard oneself within a particular context.**
Triage questions to assist practitioners in reflecting whether fuller consideration of a person's capacity is required in relation to the specific risks may include:

- Does the person understand the situation they are facing?
- Does the person understand the options?
- Does the person understand the possible ramifications of choosing various options?

- Do they fluctuate in their understanding of choices?
- Are they able to act on stated safeguarding decisions?

For further information on assessing capacity, please refer to the Guide to Assessing Capacity.

The **principles** of the Adults with Incapacity (Scotland) Act 2000 must be followed to ensure that all decisions that are made are for the benefit of the adult. The underpinning principles for decision making that have to be followed in any decision taken for an incapable adult when deciding which measure will be the most suitable for meeting the needs of the individual.

In summary – in terms of the Act some of the key factors to consider when assessing capacity and an individual's ability to safeguard, *and they are not exhaustive,* are ;

- A person may not have the ability to make a particular decision at a certain time, but this does not mean that they will never have the ability to make that decision
- That you consider your patient's ability to safeguard with regard to each decision/task as to their ability to; act, or make a decision, or communicate decisions, or understand decisions, or retain the memory of decisions
- Ensure that the assessment is context, decision and task specific
- Listen to the adult and take their views into consideration
- If feasible, and appropriate, consult and take into consideration views of family members/carers.
- All practicable steps must be taken to assist the adult and help them understand and communicate.

Useful learning resources from **Think capacity/Think consent** offer helpful information, saying "Capacity to consent must always be assessed and incapacity should never be presumed because a person has a particular health condition or disability, for example mental health problems, learning disabilities, or dementia".

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Triage and Adult Support and Protection "Dos and Don'ts"

Do:

- See the patient in a safe and private space with appropriate professional support.
- Use a trauma informed approach and be sensitive to the individual's needs.
- **Discuss the limits to confidentiality e.g. where you know or believe that someone is at risk of harm you may have to refer on.**
- Consider specialist/trained interpreters where appropriate.

Apply a triage approach that ascertains all of the below:

- Are there any indicators that the adult is at risk of harm (from their own actions or those of others)?
- Are there any indicators that they are unable to keep themselves safe?
- Do they adequately self-manage their health and wellbeing e.g. their medication regime?
- Are there any indicators that they are unable to protect their own property and finances?

Consider the patient's overall safety:

- Are they able to assert and defend their own rights without being unduly influenced by others (are they suggestible or easily influenced)?
- Are there other aspects that indicate a vulnerability that concerns you e.g. using the internet safely, managing unsolicited telephone calls, preventing others from using their accommodation, finances or medications?
- Are there any adverse events in earlier life or current adversities that are impeding their ability to make informed choices or safeguard themselves?
- Are there indications that they are being or are *likely* to be harmed either through self-harm or self-neglect or; physically, psychologically, sexually, financially, or through their access to information and services being blocked.

Are they experiencing any of the below which is contributing to the risks in such a way that their ability to manage those risks is compromised:

- disability
- mental disorder
- illness
- physical or mental infirmity, (lack the power or ability to do something)

Are there issues which you cannot quite define? In such instances use your professional curiosity to explore them further using proactive questioning and challenge.

Don't:

- Let the person leave without having formed a view about their current and ongoing safety and what actions you intend to take
- Share, without legal basis, information with anyone other than the relevant statutory services as per Section 5 of the Act.
- Attempt to carry out an investigation or mediation e.g. contacting family etc.

Do not assume that you have to fully demonstrate that the three point criteria for action by the council is met. You need only "*know or believe"* that the criteria for support and protection under the legislation is met. **If you know or believe that an adult is at risk of harm and may meet the legal criteria – you should make a referral.**

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Glossary

This glossary is for illustrative purposes only and is not intended to be prescriptive. Full statutory definitions of many of the terms are contained in Section 53 of the Adult Support and Protection Act, and it is those that should be used in any process or situation where precise definition is required.

Adjacent place	A place near or next to any place where an adult at risk may be, such as a garage, outbuilding etc.
Adult	An individual aged 16 years or over
Adult at risk	An adult who meets the criteria in Section 3 (1). The three-point criteria is: An adult who is unable to safeguard their own wellbeing, property, rights or other interests; Are at risk of harm, and because they are: affected by disability, disorder, illness and infirmity are more vulnerable to being harmed than adults who are not so affected.
Adult Protection Committee	A committee established by a council under section 42 of the Act to safeguard adults at risk of harm in its area.
Council Officer	An individual appointed by a council (Local Authority) to perform certain specified function under the terms of the Act.
Doctor	A fully registered person within the meaning of the Medical Act 1983.
General Practice	(a) A person providing primary medical services under a general medical services contract (within the meaning of the National Health Service (Scotland) Act 1978) (b) A person providing primary medical services under arrangements made under Section 17c of that Act.
Health Professional	In terms of the Act, this refers to a doctor, nurse, midwife or any other type of individual prescribed by Scottish Ministers.
Inquiry	The overarching process, as per section 4, to gather information to establish whether or not an adult is at risk of harm (as per the three-point criteria of the Act); conduct risk assessment; develop risk management plans; determine what, if any, action is required to be taken to safeguard that adult.

Investigative powers (investigation activity)

Powers under the Act that enable or assist councils to determine whether or not an adult is at risk of harm and to

determine whether it needs to do anything to protect an adult at risk of harm (for example medical examinations under section 9 or the examination of records under section 10).

Proxy	A continuing or welfare attorney, or a guardian under the Adults with Incapacity (Scotland) Act 2000.
Undue Influence	Pressure by which a person is induced to act otherwise than by their own free will or without adequate attention to the consequences.
Undue pressure	Persuasion imposed on an individual by someone in whom the individual has confidence and trust.

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