Agenda Item 5

EAST AYRSHIRE CHIEF OFFICERS GROUP: 22 JUNE 2010

GETTING IT RIGHT FOR EVERY CHILD AND PRE REFERRAL GROUP

GOOD PRACTICE GUIDANCE – INFORMATION SHARING

1. PURPOSE

1.1 To inform the Chief Officers Group of the development of “Good Practice Guidance to Information Sharing” and request that the guidance is endorsed.

2. BACKGROUND

2.1 The Getting It Right For Every Child (GIRFEC) Group is now well established in East Ayrshire. It provides a multi agency forum for effective information sharing relating to the concerns/circumstances of a child/young person, and for agreeing the lead agency which will ensure support is available to the child/young person.

2.2 During 2009, the group revised its key processes and arrangements, and it was decided that referrals to social work would not be routinely tabled at the GIRFEC Group. This reflected a need to ensure that any referral to social work was responded to in a timely way, with information gathering/sharing being central to screening activity.

2.3 This approach has also enabled more effective targeting of the group’s resources, enabling more time to be focused on children coming to the attention of other agencies, where concerns may not have previously been identified.

2.4 This approach relies on good information sharing between staff, which is central to effective child protection/child care practice.

2.5 Strathclyde Police are not a signatory to this document, due to issues relating to the use of intelligence. Strathclyde Police are however committed to the general principles of sharing information in the best interests of children, thus ensuring that they are appropriately protected.

2.6 This guidance has been developed to support this approach and was approved by the Child Protection Committee on 8 June 2010.

3. RECOMMENDATIONS

3.1 It is recommended that the Chief Officers Group: -

- (i) endorse the implementation of “Good Practice Guidance to Information Sharing”.
- (ii) note the contents of this report;

Susan Taylor
Chair of the Child Protection Committee
14 June 2010

Report prepared by Elaine Wright, Child Protection Co-ordinator

Item 5 Guidance

DRAFT

CHILD PROTECTION COMMITTEE
KEEPING OUR CHILDREN SAFE
IN
EAST AYRSHIRE

GETTING IT RIGHT FOR EVERY CHILD GROUP

GOOD PRACTICE GUIDANCE – INFORMATION SHARING

Date:	
Approved by EACPC:	8 June 2010
Reported to Chief Officer’s Group:	22 June 2010
Date for Review:	June 2011

1. PURPOSE OF REPORT

1. PURPOSE OF REPORT

1.1 The purpose of this guidance is to ensure staff collate all available information from agencies when assessing children in need or at risk of harm. It will give staff an understanding of all the information held by individual agencies on children and their families, and the key contact people and telephone numbers. (Appendix 1).

1.2 This guidance is set within the context of the Pan Ayrshire and NHS Ayrshire and Arran Information Sharing Protocol and the East Ayrshire Child Protection Procedures. Both procedures should guide practice in considering the sharing of information relating to children in need of protection from harm.

1.3 This guidance builds on the success of the improved information sharing within the “Getting it Right for Every Child Group” (GIRFEC).

2. BACKGROUND

2.1 The GIRFEC group was set up in June 2008. The main purpose of the group was to ensure a timely, multi agency response to referrals relating to vulnerable children and young people.

2.2 The group was evaluated in December 2008 and the final report was presented to Chief Officers. The success of the initiative was recognised and the continuation of the resources which supports the work of the group was continued.

2.3 In June 2009, a meeting was held with social work, health, police and (SCRA). The group considered the merit of referring all social work referrals to the group. It was recognised that this was duplication of effort, and agreed by all that open cases to social work would no longer be considered at weekly meetings. In order to highlight the need for good practice in information sharing, it was agreed that a guidance note would be provided for all staff.

2.4 The meeting concluded that any agency could continue to make a referral to the GIRFEC group if they considered it necessary, including social work.

3. GOOD PRACTICE IN INFORMATION SHARING

3.1 In 2005, East, North and South Ayrshire Council’s in partnership with NHS Ayrshire and Arran developed an Information Sharing Protocol. This was developed as an agreement between agencies within the Data Sharing Partnership. The protocol was updated in December 2008 and is available on East Ayrshire Council and NHS Ayrshire and Arran websites.

3.2 In 2003, Lord Laming, in his enquiry into the death of Victoria Climbé highlighted the need for information sharing, and how it was crucial to ensuring the safety of children:

"…*Improvements in the way information is exchanged within and between agencies is imperative if children are to be adequately safeguarded*…" Laming (2003)

3.3 When staff are considering the needs or risks affecting children and young people they shall collate information from the following agencies:

- Social Work
- Education
- Early Years
- Neighbourhood Services
- Police
- Health
- Third Sector/Private Providers

3.4 Information should be analysed using the "Getting it Right for Every Child" well being indicators:

- Safe
- Health
- Active
- Nurtured
- Achieving
- Respectful
- Responsible
- Included

3.5 The information should be recorded where applicable, on the integrated assessment framework paperwork. The agency must determine what intervention is required to meet the needs of the child or young person. If any barriers to information sharing are evident, advice should be sought from the agency's legal advisor.

4. CONSENT TO INFORMATION SHARING

4.1 There is a legal duty to share information when it is in the best interest of the child or young person and consideration should also be given to vulnerable adults. In doing so, information sharing should be in compliance with the requirements of the Data Protection Act 1998 and the Human Rights Act 1998.

4.2 The Good Practice Guide – Information Sharing (Appendix 2) produced by the Pan Ayrshire Getting it Right, Integrated Assessment Framework, should be used routinely by all agencies to consent to information being shared.

4.3 For the purpose of this guidance, individuals are presumed to have a sufficient level of understanding of the nature of consent and its consequences.

4.4 Who can consent to the sharing of information:

a) For the purposes of the guidance, individuals are presumed **(subject to b below),** to have the full mental capacity to take decisions in their own right from the age of 12 years. **Note: It is necessary to consider the other issues below in this section.**

b) Children 12 – 15 years are presumed to have a sufficient level of understanding of the nature of consent and its consequences and their consent should be sought. But if this is not the case, consent should be sought from the parent or person with legal authority to act on behalf of the child/young person.

c) Parental rights and responsibilities largely cease when the child is age 16. The exception to this is a parent's responsibility to continue to provide guidance to their child from age 16 – 18. So practitioners should seek to keep parents/guardians involved in issues affecting their children, but only to the extent that this is compatible with the rights and autonomous choices of the young person.

d) If any information is disclosed about a young person, who has the requisite mental capacity, to their parent or guardian without that young person's consent, this would need to be justified in the same way as any other disclosure of information without consent.

e) For young people over the age of 16, consent should be sought from the individual themselves, in line with the rights of the child.

f) In circumstances where there may be a question about an adult's capacity to give consent to sharing personal information, consideration should be given to their understanding of the issues. If it is believed that the person understands the nature and consequences of consent, then this should be sought. If it is believed that the person is not able to do this, then reference to other relevant persons and the context around the need to share the information should be made.

4.5 Seeking, Obtaining and Recording Consent

a) When it is appropriate for us to seek consent, to ensure that this is given on an informed basis, it needs to be explained:

- The purpose for which it is to be shared
- What information is to be shared
- With whom it is to be shared.

b) It is essential to obtain the consent of the service user to share their individual information when seeing them for the first time or when we decide that another partner agency's services/input are required.

c) The IAF leaflet "Information Sharing" and the consent form should be explained, completed and left with the individual for future reference, but should **never** be used as the sole means of explaining and obtaining informed consent. This should be achieved by means of good verbal communication between the service user and the member of staff who wishes to share their information with another agency.

d) Although written consent may have been obtained, verbal permission to share is acceptable in practice in certain circumstances. This should be followed up by obtaining written consent or the individual should be advised in writing that their verbal consent has been recorded as given.

e) It should be recorded in the individual's case notes:

- The purpose of sharing information
- What information is to be shared
- With whom the information is being shared
- That consent has been given.

f) In the case of existing protocols and procedures, this may also entail recording or indicating information is to be shared, by opening up a 'sharing box/pick list' on an agency's electronic service user/patient data base/system.

4.6 Refusal of Consent

a) In some cases, the individual may refuse to give consent. Unless there are other factors about a person's **ability to understand the implications** of refusal, **or risk factors exist**, in the first instance the individual's refusal must be accepted. Where doubt about the person's understanding, or risk exists, the balance must be weighed between the person's right to privacy and their or others wellbeing and safety, which will be caused by not sharing information.

b) In the latter circumstances, it should be considered whether there remains a need and justification to share without consent, despite permission to share being withheld.

c) Indicators which may override refusal to share:

- Failure to share information appropriately may constitute a serious breach of the duty of care
- Sharing information without consent may be necessary and appropriate under some circumstances, such as:

    - when a child or 'vulnerable adult' is believed to have been abused or at risk of significant harm
    - when there is evidence of serious public harm or risk of significant harm to others
    - where there is evidence of a serious health risk to an individual
    - for the prevention, detection or prosecution of a serious crime
    - when instructed to do so by the court
    - where there is a statutory requirement, e.g. where information is required by a Children's Reporter as part of their investigation of a child referred to them.

d) It should be less difficult for us to make a decision to share personal or sensitive information without consent in circumstances such as those noted above. The issue of sharing information will arise in a wide variety of situations. Issues of actual or potential risk needs treated with particular care.

e) If an individual refuses to give their consent to their information or that of their child being shared, the consequences of our not sharing information with them or their carer must be explained. For example, a service from social work can not be provided, on request from a health practitioner unless information is shared between the two agencies so that social work staff understand the person's needs and how to meet these.

f) If it is decided to ignore a service user/parent/carer's refusal to agree to information being shared, this needs to be recorded in the individual's file indicating:

- Why information was shared
- What information was shared
- With whom the information was shared

g) If permission to agree not to share information with other agencies is refused, this needs to be recorded. The practitioner needs to discuss this decision with their line manager and have it endorsed. **Failure to share may result in serious consequences for the practitioner in some circumstances.**

h) **It is important that the basis for sharing or not sharing is recorded and noted in the case notes and the service user is informed of the decision.**

Note: Anyone who receives information, which has been disclosed without consent should be made aware of both this fact and the basis on which the decision to disclose was made.

4.7 Withdrawal of Consent

a) If the individual withdraws their consent to sharing their information, the considerations about sharing without consent still apply.

b) If a service user/parent/carer withdraws consent, the practitioner needs to explain fully the consequences of this action, advise their line manager and record the decision in the case notes. (This may also require practitioners to 'switch off' permission to share on the agency's electronic data base). The practitioner should advise the agency receiving the information that consent has been withdrawn and that they should cease processing and sharing the information from that point onwards.

Note: An individual can not withdraw consent to sharing retrospectively i.e. if information has been shared already it cannot be unshared.

c) If wrong information has been shared an individual has the right to ask for wrong information to be corrected. The receiving agency should be notified accordingly and the information should be corrected and this recorded, but information previously shared cannot be withdrawn.

4.8 Inability to Provide Consent

a) If an individual cannot give consent to sharing information at the point when consent is required, the practitioner should ask three basic questions:

- Does the person, (including children aged 12 – 15) understand the nature of consent and its consequences?
- Is there a legitimate need to share?
- Will failure to share mean that care will not be appropriate or will the person be at risk?

b) In general, the practitioner should discuss sharing without the individual's consent with a relevant person (depending on the person's family and social circumstances) e.g. a parent, carer, 'named person', GP or the practitioner's line manager. For example, in the case of an older person who seems confused and tells a health practitioner that they do not want their information shared with the social work department but needs domestic or personal care services and has no other access to these.

Note: Reference to a third party should apply, so long as this does not leave the person at risk, while debating this issue!

c) In the case of a child or children, consent may rest with the parent if the child or children are under 12 years of age or not 'deemed to have capacity'. In such cases, the parent's capacity to understand needs to be considered and the nature and consequences of consent being withheld. Serious concerns about the child or children's welfare (see below) would override parental withholding of consent.

d) Where an adult or child is deemed not to have capacity, the practitioner should record in the individual's case notes:

- Why the decision was made
- Who was involved
- The purpose of sharing information
- What information is to be shared, with whom and the date

e) We should inform the service user and/or their carer of the decision. We need to inform the recipient of the information of the basis on which the decision to share was made.

4.9 Information Sharing Without Consent

a) In cases of abuse or risk of harm to a child or vulnerable adult, consultation about sharing should not apply e.g. in the case of a 5 year old child, who may be at risk of abuse by a parent, the parent's consent is not a deeming factor.

b) In the case of child protection, any requirement to obtain a child's/young person's consent should also be discounted in normal circumstances. For example, if a 13 year old child, "who is deemed to have capacity", tells a practitioner about information which merits child protection procedures being applied, the issue of consent is not relevant.

c) Equally, if it is believed the child has been abused, or is at risk of abuse or serious harm, or that other children may be at risk, the withholding of consent by the child should not prevent any decision to share information. The issue may require sensitive and supportive handling but consent to allow sharing should not be a barrier.

d) The decision to share information without an individual's consent is a difficult one and can pose challenges for staff. This may apply in relation to circumstances which may arise when staff have a primary involvement with one member of a family or extended family but concerns arise about the safety of another family member e.g. a child, because of that individual adult's behaviour. An example of this would be where an Addiction Worker becomes aware that a service user has bought no food for their young family and has spent all their income on drugs.

e) In such circumstances, practitioners must make an assessment of the risk of significant harm which the child may face and whether this risk is greater than the risk of any breach of privacy, which sharing information about the parent may pose.

In all circumstances, the legal test contained in the Children's (Scotland) Act 1995 – **"the welfare of the child is paramount"** should apply.

f) Any practitioner who makes a considered decision to share information about a child or vulnerable adult without their consent should consider:

Is it in the best interest of the child or vulnerable adult? If it is:

- We all have a duty of care
- Is the risk to the child or vulnerable adult heightened by not sharing?

g) On this basis, the practitioner will be acting within the spirit and intention of the legislation, national guidance and local guidance regarding information sharing among partner agencies.

h) Staff need to record why the decision was made, what information is being shared, with whom and who was involved in the decision. This should include notification to the receiving partner of the decision to override consent to share information.

5. INFORMATION SHARING – PRE BIRTH

a) Practitioners should involve parents to be in decisions about sharing information, unless this would increase the risk to the unborn child.

b) Practitioners caring for a pregnant woman should always consider if the unborn child may be endangered by the adult's condition, behaviour or lifestyle. This includes sharing information prior to the birth of a child to ensure protective plans are in place from the moment of birth.

   In these circumstances when a pregnant woman refuses to information being shared, health professionals must discuss this refusal with their line manager, who must then discuss this refusal with the Nurse Consultant for Child Protection, the Caldicott Guardian and the Executive Director responsible for Child Protection. In all instances, the decision to share information does not rest with one individual.

c) The decision process together with why, what and when and with whom information has been shared should be recorded in the individuals notes. The recipient of the information should be informed of why it was decided to share the information.

5.1 Information Sharing – Staff Safety

a) If a practitioner wishes to share an individual's information in order to protect employees and others then this should be discussed in the first instance with their line manager and progressed via their agency's procedures. These procedures should be compliant with The Data Protection Act (DPA) provisions and guidance, as well as the agency's general duties as contained within the Health and Safety at Work Act and obligations under the Management of Health and Safety at Work Regulations (Regulation 10 and 12).

5.2 Review of Consent

a) There needs to be a formal review of the receipt of consent at least annually and this consent should be an ongoing part of the individual's care during their case review or care plan review. Where the consent status changes, this needs to be updated on the appropriate system and the individual's case notes should be updated accordingly.

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Early Information and Decision Making Report

Date & Time of Discussion:	

CHILD(REN)

Name(s) of Child/ren: (this should include previously known as, also known etc,)	**DOB:**	**Gender M / F**	**GP and/or Family HV:**	**Nursery / School Attended:**
1.				
2.				
3.				
4.				
5.				
6.				

Address(es) of Children: (include any known previous addresses)

PARENTS/CARERS/SIGNIFICANT OTHERS

Name(s) of Adults: (this should include previously known as, also known etc,)	**DOB:**	**Gender M / F**	**GP:**	**Relationship to children:**
1.				
2.				

Address(es) of Adults: (include any known previous addresses)

LEAD PROFESSIONAL

Name	**Base**	**Contact details**

OTHER PROFESSIONALS INVOLVED IN DISCUSSION/MEETING

Name	**Profession / Agency**	**Contact Details**

SUMMARY OF CONCERNS/REASON FOR MEETING

1. AGENCIES/PROFESSIONALS CURRENTLY INVOLVED WITH THE CHILD/FAMILY

Agency/Profession	Name	Address	Contact No./E-mail

2. CURRENT / HISTORICAL FAMILY INFORMATION

Agency	Information Known
Police	
S.W.D	
Health	
Ed Dept	
Housing	

4. OTHER RELEVANT INFORMATION

5. ANALYSIS OF CHILD PROTECTION ISSUES/CONCERNS FOR CHILDREN
Actions Agreed- Including Review Date:

Notes from Review:

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getting it right for every child

Ayrshire Integrated Assessment Framework
FOCUSED ON CHILDREN

AYRSHIRE & ARRAN GOOD PRACTICE GUIDANCE ON INFORMATION SHARING

NHS
Ayrshire
& Arran

south
AYRSHIRE
COUNCIL

East Ayrshire
COUNCIL

NORTH AYRSHIRE
COUNCIL

OBTAINING CONSENT – GOOD PRACTICE GUIDANCE

INTRODUCTION

We have prepared this guidance to assist front line staff who work in Partner Agencies in Ayrshire. The Partners are East, North and South Ayrshire Councils Social Work, Education and Housing, NHS Ayrshire & Arran, the Voluntary Sector Strathclyde Police and the Scottish Children's Reporter Administration. All of the partners have different functions and responsibilities but we need to share information between and among ourselves at different times and for different purposes. We can do this electronically, verbally or in writing.

In line with our Information Sharing Protocol, each agency's staff have different access and 'input' permission levels to shared information. This will vary according to the roles of different staff, in order that only information which needs to be shared, is shared. The guidance relates to sharing information about children and adults who may require intervention from different partner agencies to meet their health, social care, educational, or housing needs. It covers sharing information with and without the person's consent. It is clearly unacceptable for inter and intra agency information sharing processes to fail children, young people and vulnerable adults.

This document sits beneath the Scottish Executive's 'Gold Standard' Protocol. The Gold Standard is a 'high level' document designed to deal with the overall legal and technical elements that are needed.

BACKGROUND

Significant information sharing already exists in areas such as: referrals for assessment of need because of difficulties in learning; for assistance/support because of concerns about a child's welfare, health or behaviour, a family's homelessness; etc. All of these circumstances routinely require us to share some information among some or all of the partner agencies.

In some circumstances, we have a duty to share information. A decision not to do so, or failure to do so, would require to be justified and recorded by the individual concerned. We have a legal duty to share information when it is in the best interests of the child or young person and similar considerations can often apply to vulnerable adults. To do this correctly, we must share information in compliance with the requirements of the Data Protection Act, the Human Rights Act, professional standards and the common law duty of confidentiality.

In cases of abuse or risk of harm to a child or vulnerable adult, consultation about sharing does not apply.

THIS IS SUB DIVIDED INTO AREAS WHICH OUTLINE THE GOOD PRACTICE PROCESSES FOR STAFF

1) **Who can consent to the sharing of personal information?**
2) **How to seek, obtain and record consent (in appropriate circumstances)**
3) **How to deal with consent being refused**
4) **What to do if consent is withdrawn**
5) **What to do if someone is unable to provide informed consent**
6) **Sharing information without seeking consent, or ignore a refusal to allow information about a vulnerable child or adult to be shared (in appropriate circumstances)**
7) **Information Sharing pre-birth**
8) **Review process**
9) **Sharing information about a person who may pose a risk to staff**

1) WHO CAN CONSENT TO THE SHARING OF PERSONAL INFORMATION

a) For the purposes of guidance, individuals are presumed ***(Subject to b below)***, to have the full mental capacity to take decisions in their own right from the age of 12 years. Children under the age off 12 may be deemed to have capacity depending on their level of understanding and level of maturity.

b) Children 12-15 years are presumed to have a sufficient level of understanding of the nature of consent and its consequences. Staff should be clear that they believe the young person has the capacity to consent. Where they do not believe this is the case staff should seek consent from the parent or person with legal authority to act on behalf of the child/young person.

c) Parental rights and responsibilities largely cease when the child is age 16. The exception to this is a parent's responsibility to continue to provide guidance to their child from age 16-18. So practitioners should seek to keep parents/guardians involved in issues affecting their children, but only to the extent that this is compatible with the rights and autonomous choices of the young person.

d) If we disclose any information about a young person, who has the requisite mental capacity, to their parent or guardian without that young person's consent, we require to justify this in the same way as any other disclosure of information without consent.

e) For young people over the age of 16, we should seek consent from the individual themselves, in line with the rights of other adults.

f) In circumstances where there may be a question about an adult's capacity to give consent to sharing personal information, we should consider their understanding of the issues. If we believe that the person is not able to do this, we should make reference to other relevant persons and the context around the need to share the information (see 5 below).

Note: An individual cannot withdraw consent to sharing retrospectively i.e. if information has been shared already it cannot be un-shared. If information has been shared, an individual has the right to ask for wrong information to be corrected. The receiving agency should be notified accordingly and the information should be corrected and this recorded, but information previously shared cannot be withdrawn.

2) HOW TO SEEK, OBTAIN AND RECORD CONSENT (IN APPROPRIATE CIRCUMSTANCES)

When it is appropriate for us to seek consent, we need to make sure that consent is given on an informed basis by explaining:

- The purpose for which it is to be shared
- What information is to be shared
- With whom it is to be shared

We need to obtain the consent of the service user to share their individual information when seeing them for the first time or at the point when we decide that another partner agency's services/input are required.

The leaflet 'Information Sharing' and the consent form should be explained, completed and left with the individual for future reference but should ***never*** be used as the sole means of explaining and obtaining informed consent. We must obtain this by means of good verbal communication between the service user and the member of staff who wishes to share their information with another agency.

Although we may have obtained written consent, verbal permission to share is acceptable in practice in certain circumstances. We should follow this up by obtaining written consent or we should advise the individual in writing that their verbal consent has been recorded as given.

We should record in the individual's case notes:

- What information is being shared
- With whom the information is being shared
- That consent has been given

In the case of existing protocols and procedures, this may also entail recording or indicating that information is to be shared, by opening up a 'sharing box/pick list' on an agency's electronic service user/patient data base/system.

3) DEALING WITH CONSENT BEING REFUSED

In some cases, the individual may refuse to give consent. Unless there are other factors about a person's **ability to understand the implication** of refusal, **or risk factors exist**, in the first instance we must accept the individual's refusal. Where doubt about the person's understanding, or risk exists, we must weigh the balance between the person's right to privacy and their or others wellbeing and safety, which will be caused by not sharing information.

In these latter circumstances, we should consider whether there remains a need and justification to share without consent, despite permission to share being withheld.

Indicators which may override the refusal to share:

- Failure to share information appropriately may constitute a serious breach of the duty of care
- Sharing information without consent may be necessary and appropriate under some circumstances such as:-
- When a child or 'vulnerable adult' is believed to have been abused or at risk of significant harm
- Where there is evidence of serious public harm or risk of significant harm to others
- Where there is evidence of a serious health risk to an individual
- For the prevention, detection or prosecution of a serious crime
- When instructed to do so by the Court
- Where there is a statutory requirement e.g. where the information is required by a Children's Reporter as part of their investigation of a child referred to them.

It should be less difficult for us to make a decision to share personal or sensitive information without consent in circumstances such as those noted above. The issue of sharing information will arise in a wide variety of situations. Issues of actual or potential risk needs treated with particular care. (See section 6)

If an individual refuses to give their consent to their information or that of their child being shared, we must explain the consequences of our not sharing information to them or their carer. The professional should explain that the person may have to provide the same information to several professionals and delays in service may occur as a result. For example a service from Social Services cannot be provided, on request from a health practitioner unless information is shared between the two agencies so that social work staff understand the person's needs and how to meet these.

If we decide to ignore a service user/parent/carer's refusal to agree to information being shared, we need to record this in the individual's file indicating:

- Why information was shared
- What information was shared
- With whom the information was shared

Equally, we need to record a decision to agree not to share information with other agencies if permission to share is refused. The practitioner needs to discuss this decision with their line manager and have it endorsed. **Failure to share outwith legitimate, agreed and recorded circumstances may result in serious consequences for the Practitioner in some circumstances**. (Refer to Data Protection Act 1998)

It is important that the basis for not sharing is recorded and noted in the case notes and the service user is informed of the decision.

Note: Anyone who receives information, which has been disclosed without consent should be made aware of both this fact and the basis on which the decision to disclose was made.

4) CONSENT IS WITHDRAWN

If the individual withdraws their consent to sharing their information, the considerations about sharing without consent still apply.

If a service user/parent/carer withdraws consent, the practitioner needs to explain fully the consequences of this action, advise their line manager and record the decision in the case notes. (This may also require practitioners to 'switch off' permission to share on the agency's electronic database). The practitioner should advise the agency receiving the information that consent has been withdrawn and that they should cease processing and sharing the information from that point onwards.

5) SOMEONE MAY BE UNABLE TO PROVIDE CONSENT

If an individual cannot give consent to share information at the point when consent is required, the practitioner should ask 3 basic questions:

- Does the person, (including children aged 12-15) understand the nature of consent and its consequences?
- Is there a legitimate need to share?
- Will failure to share mean that care will not be appropriate or will the person be at risk? In general, the practitioner should discuss sharing without the individual's consent with a relevant person (depending on the person's family and social circumstances) e.g. a parent, carer, 'named person', GP or the practitioner's line manager. For example, in the case of an older person who seems confused and tells a health practitioner that they do not want their information shared with the social work department but needs domestic or personal care services and has no other access to these. (See appendix 3 Adults with Incapacity Guidance).

In the case of a child or children, consent may rest with the parent if the child or children are under 12 years of age or 'not deemed to have capacity'. In such cases, we will need to consider the parent's capacity to understand the nature and consequences of consent being withheld. Serious concerns about the child or children's welfare (see below) would override parental withholding of consent.

Where an adult or child is deemed not to have capacity, the practitioner should record in the individual's case notes:

- Why the decision was made
- Who was involved
- The purpose of sharing information
- What information is to be shared, with whom and the date

We should inform the service user and/or their carer of the decision. We need to inform the recipient of the information of the basis on which the decision to share was made.

Serious concerns about the child or children's welfare (see below) override parental withholding on consent.

6) SHARING INFORMATION WITHOUT SEEKING CONSENT, OR IGNORING A REFUSAL TO SHARE INFORMATION ABOUT A VULNERABLE CHILD OR ADULT (IN APPROPRIATE CIRCUMSTANCES)

In cases of abuse or risk of harm to a child or vulnerable adult, consultation about sharing should not apply e.g. in the case of a 5 year old child, who may be at risk of abuse by a parent, or is suffering lack of care, the parent's consent is not a determining factor.

When the Child Protection Concerns arise, any requirement to obtain a child/young person's consent should also be discounted in normal circumstances. For example, if a 13 year old child, "who is deemed to have capacity", tells a practitioner about information which merits child protection procedures being applied, the issue of consent is not relevant.

Equally, if it is believed the child has been abused, or is at risk of abuse or serious harm, or that other children may be at risk, the withholding of consent by the child should not prevent any decision to share information. The issue may require sensitive and supportive handling but consent to allow sharing should not be a barrier.

The decision to share information without an individual's consent is a difficult one and can pose challenges for staff. This may apply in relation to circumstances which may arise when staff have a primary involvement with one member of a family or extended family but concerns arise about the safety of another family member e.g. a child, because of that individual adult's behaviour. An example of this would be where an Addiction Worker becomes aware that a service user has bought no food for their young family and has spent all their income on drugs.

In such circumstances, practitioners must make an assessment of the risk of significant harm which the child may face and whether this risk is greater than the risk of any break of privacy, which sharing information about the parent may pose.

In all circumstances, the legal test contained in the Children's (Scotland) Act 1995 – "**the welfare of the child is paramount**" should apply.

Any practitioner who makes a considered decision to share information about a child or vulnerable adult without their consent should consider:

Is it in the best interest of the child or vulnerable adult?
Is the risk to the child or vulnerable adult heightened by not sharing?

If it is:

- We all have a duty of care

On this basis the practitioner will be acting within the spirit and intention of the legislation, national guidance and local guidance regarding information sharing among partner agencies and is supported by this.

Staff need to record why the decision was made, what information is being shared, with whom and who was involved in the decision. This should include notification to the receiving partner of the decision to override consent to share information.

7) INFORMATION SHARING PRE BIRTH

Practitioners should involve parents to be in decision about sharing information, unless this would increase the risk to the unborn child.

Practitioners caring for a pregnant woman should always consider if the unborn child may be endangered by the adult's condition, behaviour or lifestyle. This includes sharing information prior to the birth of a child to ensure protective plans are in place from the moment of birth.

In these circumstances when a pregnant woman refuses to information being shared, health professionals must discuss this refusal with their line manager and the Service Manager, Women's Service Directorate. Who must then discuss this refusal with the Nurse Consultant for Child Protection, the Caldicott Guardian and the Executive Director responsible for Child Protection. In all instances, the decision to share information does not rest with one individual.

The decision making process together with why, what and when and with whom information has been shared should be recorded in the individual's notes. The recipient of the information should be informed of why we decided to share information.

8) REVIEW PROCESS

We need to formally review the receipt of consent at least annually and this consent should be an ongoing part of the individual's care during their case review or care plan review. Where the consent status changes, we need to update the appropriate system and the individual's case notes should be updated accordingly.

9) SHARING INFORMATION ABOUT A PERSON WHO MAY POSE A SIGNIFICANT RISK TO STAFF

If a practitioner wishes to share an individual's information in order to protect employees and others then this should be discussed in the first instance with their line manager and progressed via their agency's procedures. These procedures should be compliant with The Data Protection Act (DPA) provisions and guidance, as well as the agency's general duties as contained within the Health & Safety at Work Act and obligations under the Management of Health and Safety at Work Regulations 1999 (Regulation 10 & 12).