**Newham Substance Use Complex Needs Panel**

**Terms of Reference and Operating Procedures**

1. **Introduction**

The perception exists that if a problem drinker or substance user does not show clear motivation to change, nothing can be done to help until the person discovers some motivation. Alcohol Concern’s *Blue Light[[1]](#footnote-2)* project has challenged this perception, with a particular focus on alcohol users. It has shown that harm reduction, risk management and motivation enhancement strategies exist and can be used with change resistant alcohol and drug users.

More importantly, employing a holistic, joined-up multi-agency approach aims to support and reduce adverse outcomes for some of the most risky, at-risk, vulnerable and resource-intensive individuals in society.

Newham Council and its partners aim to work together, by adopting the Blue Light philosophy, to reduce the burden on our community from high impact problematic drinkers or drug users who are ambivalent about changing their substance use, or are unable to engage with support services due to multiple needs and barriers.

More importantly, we aim to reduce the potential harms and risk of harm to these individuals.

1. **Purpose of the meeting**

The borough has established a multi-agency framework for managing the highest risk, change resistant substance users. At the heart of this process is the Substance Use Complex Needs Panel; a multi-agency way of supporting work around complex and / or high risk cases.

An intensive response cannot be offered to the vast number of substance users who are not engaging with services. Alcohol Identification and Brief Advice, and the offer of support services including opioid substitution treatment (OST) prescribing are a reasonable approach to a large swathe of these individuals. However, a small group of individuals with complex or multiple needs will require a more targeted approach and a holistic, wrap-around offer of support.

The purpose of the Substance Use Complex Needs Panel is to work in partnership with a group of multi-agency professionals; to manage, reduce, or eliminate risk of harm to (or from) these most vulnerable individuals. The Panel will adopt a person-centred, trauma informed and solution focused approach to supporting these individuals with the aim of improving their outcomes and identifying system barriers (e.g. gaps in services, pathway challenges)

1. **Aim**

The aim of this group will be to:

* Provide an effective multi-agency response to drug and/ or alcohol users with multiple or complex needs, and whose engagement with support services is poor
* Improve the management of change resistant substance users who have been assessed at a high level of risk, or there is a level of risk that is likely to rapidly escalate to a high level or where risk mitigation actions have previously been unsuccessful and the risk is ongoing.
* Manage, reduce or remove the risk of serious harm to the individual, or the impact that they are having on the community generally and public services specifically.
* Develop and agree joint care plans which offer a coordinated targeted and consistent approach to engaging individuals in appropriate support interventions; including substance misuse, primary care and housing.
* Promote partnership working and offer a holistic approach to managing individuals with multiple or complex needs
* Work with individuals, with their consent, to understand their challenges and desired outcomes and to ensure their involvement and awareness of care plans developed
1. **Frequency of Meetings**

Meetings will take place monthly. The Panel may also call extraordinary meetings where required, to address urgent cases.

1. **Membership**

The Panel will have core membership of:

* Public Health Commissioning Team – Substance Misuse\*
* Newham Rise, Substance Misuse Service\*
* Police\*
* Project ADDER
* Hospital – Safeguarding\*
* Probation Service
* Adults’ Social Care\*
* Safeguarding Adults\*
* Community Safety / ASB Team\*
* Mental health services, psychiatric liaison, talking therapies\* (as appropriate)
* Housing and homelessness providers\*, including supported accommodation
* Domestic Abuse Services, IDVA
* London Ambulance Service
* London Fire Service (where required)
* DWP (where required)

A quorum of 5 members (see membership above, marked with an (\*) will be required for the meeting to proceed.

In the event that a quorum is not met, an extraordinary meeting will be organised to discuss cases referred, and this meeting will take place as close to the original meeting date as possible.

Additional attendees from specialist areas and organisations e.g. Age UK, community organisations, will be invited to the meeting on an ad-hoc basis as necessary, to support discussion around specific client needs.

1. **Level of attendance**

Each member organisation should identify a lead contact and a deputy to represent their organisation at Panel meetings.

It is vital that the person representing each agency is of the appropriate level to engage with this process, i.e. operational but with sufficient seniority to commit their agency to actions and support decisions that will need to be made on behalf of their organisation.

If Panel members are unable to attend, a deputy should be briefed to attend the meeting. Where this is not possible, written feedback on cases being presented should be provided prior to the meeting, to help inform discussion and actions.

In addition to the Panel’s core membership, guest attendees (e.g. front-line workers, mental health worker) may be invited to attend to offer their expertise.

1. **Identifying the clients**

Partner agencies can refer a case to the Substance Use Complex Needs Panel where they identify a complex or challenging concern of risk for an individual who is a drug and/ or alcohol user. As assessment may be made that conventional safeguarding interventions have been unsuccessful and a single-agency approach is no longer sufficient, raising the need for strategic guidance and joint intervention.

Partner agencies will individually be responsible for identifying and referring individuals that they want to see being discussed at the meeting.

A single definition of this client group is not possible but the people to be managed by the group are likely to meet the following criteria:

1. Problematic drug or alcohol use
	1. Have an enduring pattern of problem drinking, dating back at least ten years **&**
	2. Score 20+ on AUDIT **or**
	3. Be classified as dependent on SADQ (16-30 = moderate dependence/30 is severe dependence range is 0-60) **or**
	4. Have other markers of dependence on alcohol (Ethanol levels or biomarkers such as LFT scores may also be used)
	5. Drug use with multiple complexities, including high-risk behaviour, high risk injecting behaviour
2. Physical or mental health
	1. Severe and enduring mental health or physical health concerns
	2. Severe self-neglect or self-harm
3. Vulnerabilities including
	1. Being at risk, or subject to neglect or abuse (e.g. financial abuse, sexual abuse, neglect)
	2. Repeat victimisation, such as cuckooing
	3. Domestic abuse
4. A pattern of not engaging with or benefiting from alcohol or drug treatment. Clients will
	1. Have been subject to alcohol Identification and Brief Advice (IBA)
	2. Have been referred to services, usually on more than two occasions (in the last 6 months), and have not attended; attended and then disengaged; or remained engaged but not changed.
	3. Have prolonged periods of disengagements or no-contact with support services
5. A burden on Public Services. Clients will either directly, or via their effect on others e.g. their family, be placing a burden on the following services:
6. Health
7. Social care (including adults involved with children’s services)
8. Criminal Justice / ASB / Domestic violence Services
9. Emergency services (999)
10. Housing and homelessness agencies
11. The burden will be mainly due to multiple use of individual services but in a few cases may be due to placing an exceptional burden on these services because of a single risk (e.g. a sex offender released from prison with a pattern of problematic drinking.)

**Exceptions**

If an individual is already engaged with another multi-agency group e.g. MARAC or MAPPA, DAPP they will not be taken on by the Substance Use Complex Needs Panel without a clear decision from the other group. The assumption will usually be that management will remain with the existing group supporting that individual.

It is recognised that this group can only manage a small number of high risk clients at any one time. Therefore, as a check and control on the process, when a new client is presented to the meeting it will be down to the partner agencies to agree that this is an appropriate and manageable referral at that point in time.

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| **Indicative activity suggesting possible Blue Light / High Risk client** *(this data is indicative, not absolute or exclusive)* |
| 3-4 + hospital admissions per year |
| 12 + A&E attendances per year |
| 4-5 arrests / crime reports per year |
| 3 ASB reports per year |
| 3 failed tenancies in two years |
| Multiple 999 calls each week over an extended period  |
| Non-engagement with support services |
| Non-engagement, or multiple episodes of unsuccessful engagement with substance misuse treatment |
| Multiple overdoses (accidental or deliberate)  |

1. **Chair and note taking**

The Chair of the meeting and a deputy Chair will be agreed by the members of the group.

Notes of the meeting will be in the form of a spreadsheet which will be updated each meeting and circulated to attendees within 3 days.

Each partner agency who is involved with the client will be expected to update their notes on the client after each meeting.

1. **Process**

This section sets out a process for managing the multi-agency meeting.

* Each Panel meeting will review a maximum of 8 cases, allocating a slot of 15 minutes for presenting, discussing and seeking views and actions on the case
* The Chair will set out the confidentiality and information sharing agreement and highlight purpose of the meeting.
* The chair will ensure that all present partner agencies and representatives are identified clearly, to ensure that all are covered by the information-sharing protocol.
* A record of attendance will be kept and attendees’ contact details recorded.
* At the start of each meeting, the Panel will head whether cases presented at the previous meeting have been resolved and receive an update on any continuing actions. Any outstanding actions from the previous meeting will be revisited and new actions or deadlines agreed.
* New clients for the process will be presented by the lead agency supporting the individual being referred.
* The chair will ensure the information-sharing permissions are in place for this person.
* The referring agency will present a short case history of the individual, focusing on relevant facts and risk of harm. Presentations should also reflect the client’s experience and perspective (service user voice).
* Partner agencies will share any available information on that person. To facilitate this, a list of clients being presented will be circulated to partner agencies 1 week in advance of the meeting.
* The Panel Chair will invite professional opinion and actions from partner agencies, who will together formulate and agree a joint action plan and agree specific and timed actions.
* Although this care plan will be jointly owned, lead responsibility will lie with the agency who brought the client to the group. They will draft and store the care plan. A copy will be held by the chair of the group and by other agencies who may be involved with this person. They will retain the lead on this until the case is closed or it is passed to another agency in the group.
* The care plan will use the multi-agency group checklist in appendix 3 to provide a framework for the plan and to ensure that the key opportunities are being addressed.
* A learning log of effective resolutions and other systemic learning, along with a record of outcomes will be maintained.  Colleagues will be invited to share best practice and any changes to policies, protocols and pathways.
* Partner agencies will ensure that, where relevant, their staff are aware that when this service user is identified a specific response is required e.g.:
* Positive encouragement will be given to promote client self-belief.
* Harm reduction and risk management advice will be given.
* This should draw on the approaches set out in the *Blue Light* manual[[2]](#footnote-3).
* If an individual is not already engaged with drug and alcohol treatment services, it should be clarified whether consent (verbal or signed) for substance misuse services to make contact has been secured. If not, all agencies who come into contact with this person should be seeking this consent.
* If consent is secured, substance misuse services should be contacted within one working day
* If consent is not secured, the multi-agency meeting will ensure that referring-agency staff continue to seek opportunities to engage and the group will consider alternative approaches e.g.
* Barriers which may be preventing engagement in services.
* Alternative approaches to engaging the person.
* Other local resources, such as faith groups, which could be utilised to work with the individual.
* Involving family members.
* Identifying incentives to engage the person in treatment.
* The possible use of compulsory powers.
* In some cases it will be decided that a small sub-group (or conference-call) will be set up involving a group of workers more specific to the individual referred. This will operate under the same confidentiality / information-sharing protocol and will report back to the Substance Use Complex Needs Panel.
* However, a ‘caseload’ of clients will not be held by the Panel and clients can be re-referred if necessary.
* In some cases this group will be responsible for identifying, recording and reporting unmet need to commissioners. In light of this data, the Substance Use Complex Needs Panel will review whether specific service development is required e.g. an expansion of outreach capacity.
* If appropriate, the group will:
* Ask Adults’ Social Care to consider an expedited process to assess the person for community care resources.
* Consider the use of legal powers such as civil injunctions.
1. **Drug & Alcohol Treatment Service’s role**

Once the substance misuse service has consent to make contact:

* The Service will offer an assertive response including a swift appointment, a home visit or a meeting at a convenient location.
* Wherever possible the referring agency should undertake an initial joint visit.
* The substance misuse service will require the provision of relevant risk information.
* The service will make consistent and assertive efforts to reduce risk and harm and engage the person into service.
* Partner agencies will work in concert by reinforcing messages to the person about harm reduction and encouraging change.
* All agencies involved with the person will report back to the Substance Use Complex Needs Panel meeting on progress and next steps.

If consent is secured and substance misuse services successfully engage the person, they will work within their existing resources to:

* maintain engagement
* assess risk
* reduce harm and manage risk
* encourage engagement with general services such as primary care
* encourage engagement with specialist services.

Where appropriate, the substance misuse services will engage other agencies to support their work. This involvement should be agreed wherever possible, e.g. the ambulance service jointly visiting a client.

1. **Information sharing**

This guidance is based on HM Government’s *Seven golden rules for information sharing*. The phrases in bold below are quotes from the *rules* (See appendix 1).

The multi-agency group operates within the borough’s information sharing protocol which is available on the council website. All participating agencies must be signatories to this protocol.

Information cannot be shared about these clients unless the basis on which the sharing occurs is clear and agreed by the members. This will be either because:

* Client consent has been secured; or
* The Data Protection Act recognises that public interest allows the sharing of information, as do other laws such as the Human Rights Act. The public interest generally lies in the prevention of abuse or harm, or the protection of others, including the protection of public safety.[[3]](#endnote-2)

*Many services will have their own client consent forms. These will be acceptable to the group as long as it is clear that appropriate information sharing is permitted with the group. Alternatively, the consent form attached at appendix 5 can be used.*

Confidential person-identifiable information that is disclosed in the public interest will be proportionate and relevant and not excessive to the case concerned.

As a result, the following process is followed:

* **Information will be ideally shared with consent:** The referring agency will secure consent to share information with the members of the multi-agency group.

If this is not possible:

* Outline but anonymous details of the client will be presented to the group in order to consider **safety and well-being** concerns which might allow information sharing. Discussion and agreement will take place as to whether: considerations of the safety and well-being of the person and others who may be affected by their actions create a public interest case can be made for sharing the information.

If this is agreed

* **Keep a record:** The agreement will be recorded in the minutes with the reason for the decision and the relevant legal framework. The three key legal frameworks are listed in appendix 2.
* Inform the service user who is the subject of that information of the decision to disclose. This will happen even where their consent is not required, unless it would not be safe to do so or would otherwise undermine the purpose of the disclosure e.g. allow a perpetrator to avoid detection.

If there are any doubts about the legality of sharing a particular set of information further advice should be sought from the relevant organisation’s Information Governance Lead or Caldicott Guardian.

1. **Security and data management**

Confidentiality of data must be maintained when case details need to be circulated for panel meetings.

At all stages of the exchange the principle that the information should be available only to those who have a specific and legitimate need to see it must be maintained by all parties.

Data must only be sent if the means of transmission is secure and it can be established that the appropriate recipient’s access to the transmission is equally secure. Only the original paper copies of papers are retained by the coordinator. All other copies are returned and destroyed.

Data must be stored securely, regularly reviewed and disposed of in accordance with the receiving organisation’s Retention and Disposal policy and procedures when no longer required for the purpose it was originally obtained.

1. **Facilitating data collection and performance management**

The performance of the group will be measured by looking at whether the process has reduced the burden on public services. Therefore:

* at entry into the process, the referring agency will provide details on service usage over the last 6-12 months e.g. number of arrests, ASB complaints, 999 calls, hospital admissions. This will allow monitoring over time and will also allow a judgement about the appropriateness of the client for the group.
* The group will also review individual clients’ engagement with substance misuse services from point of referral and throughout the process
1. **Terminating or concluding the process**

The group’s oversight will be concluded:

* If the person is successfully engaged with specialist services and it is agreed by the group that client’s behaviour is more stable.
* If the person is sentenced to prison or enters hospital as a long stay patient.
* If the person moves away from the area. However, in these circumstances, the group will ensure that information has been shared, if appropriate, with local agencies in the new area.
* In some cases a decision will be taken to remove the person from the group’s consideration if it is felt that no further benefit will be gained from the process. In this case the group needs to be sure that at least one agency has ongoing oversight.

If the person dies during the process, consideration will be given to whether a drug or alcohol related death review process should be recommended.

1. **Measuring the impact**

To help assess the effectiveness of this process, the Panel will review:

* The number of clients identified by the multi-agency group who then engage with support service, and the period of engagement
* The reduction in the behaviours which had brought the client to the attention of the multi-agency group e.g. hospital attendances, arrests, 999 calls etc.
* A reduction in the cost burdens (to public services) presented by these clients by 20% per year.
* Trajectory of positive change or stability measured through the Outcomes Star, Treatment Outcomes Profiles (TOP), or other tools used by service providers to measure change. This will include substance use, physical health and mental health outcomes
* Change measures and outcomes will be reviewed after 1 year of the individual’s referral date.
1. **Equality and diversity**

The organisations participating in this process are committed to ensuring that it treats service users fairly, equitably and reasonably and that it does not discriminate against individuals or groups on the basis of their ethnic origin, physical or mental abilities, gender, age, religious beliefs or sexual orientation.

1. **Reviewing these arrangements**

These arrangements will be reviewed after 6 months and annually thereafter. This review will ensure the process is relevant and fit for purpose.

**Agreement to Terms of Reference**

**I confirm that our agency will be a partner to the Substance Use Complex Needs Panel and will adhere to the Terms of Reference above and the associated information sharing protocol indicated.**

**For and on behalf of the Client**

Signature

Name

On behalf of (Agency)

Date

Position

Address

Email

Telephone number

**Appendix 1 - HM Government - Seven golden rules for information sharing**

1. Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

2. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice if you are in any doubt, without disclosing the identity of the person where possible.

4. Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, that lack of consent can be overridden in the public interest. You will need to base your judgement on the facts of the case.

5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

6. Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.[[4]](#endnote-3)

**Appendix 2 - Frameworks within which information sharing may happen**

Where there is concern that a child may be suffering, or is at risk of suffering harm, the child’s safety and welfare must be the first consideration. In these circumstances the Safeguarding Children Boards Child Protection Procedures, must be followed.

Where there is concern that a vulnerable adult may be suffering, or is at risk of suffering harm, the individual’s safety and welfare must be the first consideration. In these circumstances the local Multi Agency Safeguarding Policy and Procedure, must be followed.

If the purpose is

* primary or secondary health care use and
* the care and treatment of the patient is central to the purpose and
* the patient identifiable data is shared only between those responsible for the delivery of that care and treatment

then consent can be reasonably implied.

Three pieces of legislation allow information sharing in different settings:

* The European Convention on Human Rights, incorporated into English law from October 2000, by the Human Rights Act 1998: Article 8: Right to respect for private and family life states that:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

* The Crime and Disorder Act 1998 - Section 115 as amended by the Police Reform Act 2002 gives power to any person to disclose information to police authorities and chief constables, local authorities, probation committees, various health authorities, various fire and emergency authorities, and (since 2005) registered social landlords, or persons acting on their behalf so long as such disclosure is necessary for the purposes of any provision of the CDA. These purposes include a range of measures, such as: local crime audits, anti-social behaviour orders, sex offender orders and local child curfew schemes. In addition, the CDA requires local authorities to exercise their own functions with due regard to the need to do all that it reasonably can to prevent crime and disorder in its area.
* The Criminal Justice Act 2003 extended the scope of MAPPA by imposing a duty on public bodies outside the criminal justice system, including NHS Trusts, to co-operate with the responsible authority for MAPPA.

In practical terms this duty imposes the following obligations:

* A general duty to cooperate in the supply of information to other agencies in relation to risk assessment and risk management.
* A duty on professionals to consider, as part of the care planning process, whether there is a need to share information about individuals who come within the MAPPA criteria.
* The need to develop protocols between agencies for exchanging information and other forms of cooperation.

**Appendix 3 - A process checklist**

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| 1 | Have people been spoken to about agency concerns, the impact of their presenting problems and been given relevant brief advice about changing their situation and seeking help? |
| 2 | Have people been referred to relevant specialist services.  |
| 3 | Has someone assessed the client to identify barriers to change and engagement. Are there reasons why this person will find it difficult to change? These could include low self-esteem, physical health problems, or peers who sabotage change. |
| 4 | Has someone undertaken a specific assessment of risks e.g. fire risks, trip hazards in the home, noise nuisance.  |
| 5 | Has the client had a physical health check with their GP and/or a dental or other physical check. |
| 6 | Have motivational interventions or a motivational interviewing approach been used with the person? |
| 7 | Has the client been offered ongoing enhanced personalised education, i.e. highlighting the very specific risks?  |
| 8 | Have efforts been made to promote self-efficacy, i.e. encouraging the client to believe that change is possible? |
| 9 | Have efforts been made to involve family members, significant others or relevant carers, where appropriate, in care planning?  |
| 10 | Has contingency management been used, i.e. incentivising engagement with treatment through the offer of food vouchers, or other small incentives? |
| 11 | Have efforts been made to reduce any potential harms to the client or other people e.g. ensuring a smoke alarm is fitted, thinking about trip hazards in the home?  |
| 12 | Has a single care coordinator been identified to manage and coordinate the care? |
| 13 | If the client shows motivation to change have arrangements been put in place to enable a fast track into care?  |
| 14  | Have community care resources been considered for purchasing outreach, befriending or other support? |
| 15 | Have assertive outreach or peer support approaches been used? Could a PCSO make contact with this person?  |
| 16 | Has consideration been given to whether anything is supporting the negative behaviour, e.g. is a family member buying alcohol? |
| 17 | Are there legal powers which can be used to contain the behaviour? |

**Appendix 4 Confidentiality Statement for meetings**

**Name of meeting: Date/time:**

 **Venue:**

**Confidentiality Statement:** I agree that information shared at this meeting is only to be used in relation to working with adults as outlined within the Newham Substance Misuse Complex Needs Panel’s terms of reference. Information shared at this meeting will not be used outside of this group for any other purpose than that agreed within this meeting. All personal information shared should be treated as highly confidential and all data should be transported and stored in accordance with each agency’s information security policy and procedures.

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| **Name** | **Organisation** | **Contact details** | **Signature**  |
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Signature of the chair as witness to the above signatures

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**Appendix 5 Complex Needs Panel Multi-Agency Information Sharing Protocol - Consent Form**

The professional stated below, believes that you may be at risk of harming yourself or other people and is seeking your consent to make a referral to the Newham Complex Needs Panel.

If you agree to give your consent, some or all of the following information may be shared - your personal details, information about your carers, your current environment and details of the risk. This may be shared with a multi-agency group, which could include representatives from health, police, emergency services, the local authority, housing providers and substance misuse services.

These people are qualified and will consider the information put forward and make recommendations on how the care you receive might be extended to support you further with any difficulties you may be experiencing. The professionals involved are trained to protect your rights to privacy and confidentiality and this will be respected at all times.

(If we believe you are at significant risk, or if other people are at risk, professionals can still disclose information under common law “Duty of Confidence” without your consent, or if we have a legal obligation to do so, such as under the Crime and Disorder act 1998)

**Please provide the relevant information below:**

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| Is this information about you? Yes NoIf ‘No’, who is the information about? Name of data subject:Address:DOB (ddmmyyyy):Are you are acting as: Parent/Guardian/CarerOther (please describe)  |

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| Have the reasons for requesting consent been explained to you? Yes NoI give (name of agency/person)……………………………………….. consent to process information in relation to a safeguarding concern in relation to myself and I am the above named person.Client signature…………………………………………………………………………….Date…………………………………………………………………………………………. |

***To be filled out by the relevant professional the information is being obtained by.***

Organisation:

Name of professional:

Professional’s role:

Contact details:

If consent was not obtained please state why below: (e.g. not given, not practicable due to risk, mental capacity)

1. The Blue Light Approach [The Blue Light approach | Alcohol Change UK](https://alcoholchange.org.uk/help-and-support/training/for-practitioners/blue-light-training/the-blue-light-project) [↑](#footnote-ref-2)
2. A copy of the Blue Light Manual can be downloaded from [The Blue Light approach | Alcohol Change UK](https://alcoholchange.org.uk/help-and-support/training/for-practitioners/blue-light-training/the-blue-light-project) [↑](#footnote-ref-3)
3. The Public Interest test applies when consent cannot be obtained or has been sought and refused. Circumstances that meet the public interest test are as follows:

• Promoting the welfare of children

• Protecting children or adults from significant harm

• The prevention, detection or prosecution of serious crime.

NB The Public Safety test applies when consent should not be sought The public safety test is met when to seek consent, or delay the information sharing while consent is sought would heighten the risk of significant harm to a child or adult at risk. [↑](#endnote-ref-2)
4. HM Government – Information Sharing – Pocket Guide - 2008 [↑](#endnote-ref-3)