Morecambe Bay

Primary Care Collaborative

Consent Chaperone and Confidentiality Policy

Document Reference	POL003
Purpose	The purpose of this document is to set out our approach to consent and confidentiality to meet legal standards and satisfy patient and employee information handled sensitively and appropriately, alongside appropriate use of chaperones.
Author	Federation Support
Application/Scope	Organisation-wide
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Review Date (N.B: Review dates may alter if any significant changes are made)	01/03/2026
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Status	Approved

Morecambe Bay Primary Care Collaborative

CONTENTS

1. INTRODUCTION

1.1 Summary

Morecambe Bay Primary Care Collaborative (MBPCC) recognises the need to gain consent from service users and have clear standards on ensuring confidentiality. MBPCC recognises that Consent and Confidentiality are two separate, though related issues. They have been placed together in one policy for clarity and ease of use.

Gaining consent for treatment is a core foundation of building a trusting relationship between services users and those delivering their healthcare, this includes identifying that the individual being seen is the correct individual and ensuring that they are comfortable with the planned interaction to proceed, where they have capacity to do so.

Confidentially is an associated but separate requirement, and so this document should be read in conjunction with the Information Governance Policy and Data Protection Policy.

There is also an interaction between consent to treatment and the appropriate use of chaperones, where service users may not feel comfortable without the use of a chaperone and therefore refuse consent, the use of a chaperone can assist in this regard. Chaperone use also acts as a protection for employees to effectively and caringly handle difficult circumstances or potential perceptions of concerns. This Policy is designed to protect both service users and staff from abuse or allegations of abuse, and to assist service users in making an informed choice about their examinations and consultations.

1.2 Purpose

The organisation is fully committed to delivering high quality clinical services and recognises that in order to achieve this aim we must have robust mechanisms in place to handle consent, use of chaperones and sensitive information with proper care, we also recognise and fully support maintaining the confidences of our employees.

1.3 Scope

This policy applies to all MBPCC employees and directors.

From time-to-time MBPCC may utilise the resources of sub-contractors to deliver contractual obligations. For avoidance of doubt, where a sub-contractor is providing care to service users, as laid out in the contracts between MBPCC and subcontractors, they are solely responsible for delivery of the regulated activity they are providing and must ensure all their employees operate under their own policies which must meet the relevant CQC standards. MBPCC will seek assurance from all sub-contractors that suitable policies are in place and may at their discretion request copies of any relevant policies for review and for verification. In such cases this policy document does not apply.

2. PROCEDURE

2.1 Consent

Episodic care requires service users provide clear consent to have treatment, examinations or tests carried out, to provide informed consent they must be aware of the care they will receive.

Where consent has been refused, or given but withdrawn at a later stage this should be followed, and no treatment provided, unless in cases where consent is is not needed.

2.2 When consent is not needed

In some situations, it may not be possible for the clinician to gain consent from the individual, however, clinical employees must be able to evidence that interventions taken are in the service user's best interests in line with statutory frameworks. It may not be necessary to obtain consent if a person:

- needs emergency treatment to save their life, but they are incapacitated (for example, they're unconscious) – the reasons why treatment was necessary should be fully explained once they have recovered
- immediately needs an additional emergency procedure during an operation – there must be a clear medical reason why it would be unsafe to wait to obtain consent
- presents with a severe mental health condition, such as schizophrenia, bipolar disorder or dementia, lacks the capacity to consent to the treatment of their mental health (under the Mental Health Act 1983) – in these cases, treatment for unrelated physical conditions still requires consent, which the person may be able to provide, despite their mental illness
- needs hospital treatment for a severe mental health condition, but self-harmed or attempted suicide while competent and is refusing treatment (under the Mental Health Act 1983) – the person's nearest relative or an approved social worker must make an application for the person to be forcibly kept in hospital, and 2 doctors must assess the person's condition
- is a risk to public health as a result of rabies, cholera or tuberculosis (TB)
- is severely ill and living in unhygienic conditions (under the National Assistance Act 1948) – a person who is severely ill or infirm and living in unsanitary conditions can be taken to a place of care without their consent

2.3 Consent in the context of Mental Health

Capacity means the ability to use and understand information to make a decision, and communicate any decision made.

A person lacks capacity if their mind is impaired or disturbed in some way, which means they're unable to make a decision at that time.

Examples of how a person's brain or mind may be impaired include:

- mental health conditions – such as schizophrenia or bipolar disorder
- dementia
- severe learning disabilities
- brain damage – for example, from a stroke or other brain injury
- physical or mental conditions that cause confusion, drowsiness or a loss of consciousness
- intoxication caused by drugs or alcohol misuse

Someone with such impairment is thought to be unable to make a decision if they cannot:

- understand information about the decision
- remember that information
- use that information to make a decision
- communicate their decision by talking, using sign language or any other means

As capacity can change over time, it should be assessed at the time that consent is required. The 5 key principles of the Mental Health Capacity Act 2005 should be applied:

- Principle 1: Assume a person has capacity unless proved otherwise.
- Principle 2: Do not treat people as incapable of making a decision unless all practicable steps have been tried to help them.
- Principle 3: A person should not be treated as incapable of making a decision because their decision may seem unwise.
- Principle 4: Always do things or take decisions for people without capacity in their best interests.
- Principle 5: Before doing something to someone or making a decision on their behalf, consider whether the outcome could be achieved in a less restrictive way.

This will be done by an appropriately trained and experienced healthcare professional:

- recommending the treatment or investigation
- involved in carrying it out

If it is considered that capacity to make an informed decision is not possible, the healthcare professional should consider any advanced decision or formally appointed person and if neither are available use their judgement to consider the service users best interests. Whether the decision can be judged to be in the best interests of the individual should be assessed by:

- whether it's safe to wait until the person can give consent (if it's likely they could regain capacity at a later stage)
- involving the person in the decision as much as possible
- trying to identify any issues the person would take into account if they were making the decision themselves, including religious or moral beliefs – these would be based on views the person expressed previously, as well as any insight close relatives or friends can offer

Should there be no one available to support making a decision, then the matter should be discussed with the patients registered practice to develop a suitable approach to delivery of care, should the matter be life threatening, then the need for emergency treatment will be prioritised, in conjunction with contacting 999.

2.4 Consent in primary care

In most cases within a primary care setting, service users will be well known to the service, the appointments will be planned in advance, their medical records will be available for consultations and immediate emergency situations should be infrequent.

Additionally, the interventions being carried out will be primary care interventions, rather than specialist or complex interactions such as surgery, therefore consent should be verbally sought from the service user prior to beginning any intervention, but there is not a requirement for the service to gain written consent.

The taking of verbal consent to treatment should be captured within the clinical record.

2.5 Consent for Children and Young people

Like adults, young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise.

Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent.

Otherwise, someone with parental responsibility can consent for them.

This could be:

- the child's mother or father
- the child's legally appointed guardian
- a person with a residence order concerning the child
- a local authority designated to care for the child
- a local authority or person with an emergency protection order for the child

A person with parental responsibility must have the capacity to give consent.

If a parent refuses to give consent to a particular treatment, this decision can be overruled by the courts if treatment is thought to be in the best interests of the child.

By law, healthcare professionals only need 1 person with parental responsibility to give consent for them to provide treatment.

In cases where 1 parent disagrees with the treatment, doctors are often unwilling to go against their wishes and will try to gain agreement.

If agreement about a particular treatment or what's in the child's best interests cannot be reached, the courts can make a decision.

In an emergency, where treatment is vital and waiting for parental consent would place the child at risk, treatment can proceed without consent.

In the highly unusual situation where consent has been refused, and court proceedings are required, the person's decision can be overruled by the Court of Protection. Should employees find themselves in this situation, the matter should be raised to the Medical Director immediately, and support from the senior team, and legal support can be sought as required.

2.6 Confidentiality

The need to handle, process and store service user and employee information with due regard for the law are covered extensively within the information governance and data protection policies respectively, however the overriding principle is that service user's and employees can have confidence their data is treated with confidentiality.

If due to human, error, omission or misconduct there is a breach of confidentiality, or where systems or processes breakdown resulting in a breach, this will be escalated through the organisation immediately, and the appropriate notifications made locally and to regulatory bodies such as the information commissioner.

A thorough and robust review will be carried out to, followed by a board reported action plan to ensure there is no opportunity for a similar issue in the future.

In line with the organisations Safeguarding policy, there are occasions when it is appropriate to breach confidentiality, in these instances care is required to ensure the law is followed, both in relation to the person(s) being safeguarded and employees, with appropriate priority placed on safeguarding as a lawful justification for breaching confidentiality.

2.7 Why are Chaperones needed?

Clinicians (male and female) will consider whether an intimate or personal examination of the service user (either male or female) is justified, or whether the nature of the consultation poses a risk of misunderstanding.

- The Clinician will give the service user a clear explanation of what the examination will involve
- They will always adopt a professional and considerate manner and be careful with appropriate humour as a way of relaxing a nervous situation, as it can easily be misinterpreted
- The service user will always be provided with adequate privacy to undress and dress
- A suitable sign will be clearly on display in each Consulting or Treatment Room offering the Chaperone Service

The above guidelines are to remove the potential for misunderstanding. However, there will still be times when either the Clinician, or the service user, feels uncomfortable, and it would then be appropriate to consider using a Chaperone.

Service users who request a Chaperone will never be examined without a Chaperone being present. If necessary, where a Chaperone is not available, the consultation/examination will be rearranged for a mutually convenient time when a Chaperone can be present.

Complaints and claims against NHS organisations have not been limited to treating/examining patients of the opposite gender – there are many examples of alleged assault on people of the same gender.

Consideration will always be given by staff to the possibility of a malicious accusation by a service user, and a Chaperone will be organised if there is any potential for this.

There may be occasions when a Chaperone is needed for a home visit in which case this will be discussed with the service user and if this is not possible, a replacement time/date will be set for the home visit.

2.8 Who can act as a Chaperone?

A variety of people can act as a Chaperone, but employees undertaking a formal Chaperone role will have been trained in the competencies required. Where possible, Chaperones will be clinical and familiar with procedural aspects of personal examination.

Where it is determined that non-clinical staff will act in this capacity, the service user will be asked to agree to the presence of a non-Clinician in the examination, and to confirm that they are at ease with this. The employee will be trained in the procedural aspects of personal examinations, be comfortable acting in the role of Chaperone, and be confident in the scope and extent of their role. They will also have received instruction on where to sit/stand and what to watch and listen for. A Chaperone will document in the medical notes that they were present and detail any issues arising.

Where use of a professional chaperone is constrained, for example in a home visit environment, or where the service user wishes to use a personally selected chaperone, for example another member of their household to be present this will also satisfy the conditions listed above., A record of the chaperone should be captured in the notes.

2.9 For how long should a chaperone be present?

In the interests of providing a confidential service:

- The Chaperone will only be present for the examination itself, with most of the discussion with the service user should take place while the Chaperone is not present.
- Service users should be reassured that all employees understand their responsibility not to divulge confidential information.

2.10 Chaperone Procedure

a) The Clinician will contact reception/admin to request a Chaperone
b) Where no Chaperone is available, a Clinician may offer to delay the examination to a date when one will be available, as long as the delay would not have an adverse effect on the service user's health
c) If a Clinician wishes to conduct an examination with a Chaperone present but the person does not agree to this, the Clinician will explain clearly why they want a Chaperone to be present. The Clinician may choose to consider referring the person to a colleague who would be willing to examine them without a Chaperone, as long as the delay would not have an adverse effect on the person's health
d) The Clinician will record in the notes that the Chaperone is present, and identify the Chaperone
e) The Chaperone will enter the room discreetly and remain in the room until the Clinician has finished the examination
f) A Chaperone will attend inside the curtain/screened-off area at the head of the examination couch and observe the procedure
g) To prevent embarrassment, the Chaperone will not enter into conversation with the service user or GP unless requested to do so, or make any mention of the consultation afterwards
h) The Chaperone will make a record in the service user's notes after examination. The record will either state that there were no problems or give details of any concerns or incidents that occurred. The Chaperone must be aware of the procedure to follow if any concerns require to be raised
i) The service user can refuse a Chaperone, and if so, this must be recorded in their medical record.

3. DEFINITIONS/GLOSSARY OF TERMS

Abbreviation or Term	Definition
MBPCC	Morecambe Bay Primary Care Collaborative
CQC	Care Quality Commission

4. CONSULTATION WITH STAFF, PRACTICES AND PATIENTS

Name	Job Title	Date Consulted
Jane Jones	CCG Head of Safeguarding	27/08/2020

Emma O'Kane	Safeguarding and Quality Practitioner	27/08/2020

5. DISSEMINATION/TRAINING PLAN

Action by	Action Required	Implementation Date
Jo Knight/Boyana Konar	Upload policy to MBPCC website	Following approval of V1.1 end Sept 2020
Jo Knight	Delete out of date copies and host current copy on Federation G Drive (supporting induction process), updating Policy tracker	Following approval of V1.1 end Sept 2020
Andrew Giles	Ensure all employees are aware of the policy and are asked to read and understand it	MBPCC Board Meeting 22/09/20
Liz Stedman	Upload to TeamNet	Jan 2021

6. AMENDMENT HISTORY

Version No.	Date of Issue	Section/Page changed	Description of change	Review Date
V1.0	27/07/20	Approved Policy	Updated policy in line with latest guidance	22/10/2023
V1.1	20/09/20	All	New format	N/A
		2.2 Page 4	Requirement for best interests evidence when it's not possible to gain consent	
		2.3 Page 4-5	Reference to the MCA 5 key principles added	
		2.6 Page 7	Added when confidentiality can be breached for safeguarding	
V2.0	22/09/20	N/A	Approval by MBPCC Board	22/09/2022
V2.1	19/01/21	Page 8	Additional Definitions/Glossary of Terms added	
V2.2	12/01/23		"Service user" replaces "patient", minor amendments to wording	
V3.0	01/03/23			01/03/2023