



Amicus section

5th September 2007

HPC CONSULTATION –
CONFIDENTIALITY: GUIDANCE FOR REGISTRANTS

This response is submitted by Unite Amicus Section. Unite is the UK's largest trade union with 2 million members across the private and public sectors. The union's members work in a range of industries including manufacturing, financial services, print, media, construction, transport and local government, education, health and not for profit sectors.

Unite Health Sector has members across all the professions regulated by HPC as well as members of "aspirant" professions such as health care chaplains, non-nurse sexual health advisers, genetic nurses and counsellors, family and systemic therapists and other counsellors and psychotherapists as well as the family of psychology.

Below are detailed responses from two of the union's professional groups within Unite.

Community Practitioners' and Health Visitors' Association (CPHVA)
Pages 2 - 3

Speech & Language Therapists Occupational Advisory Group
Pages 4 –7

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CPHVA

1. In general

1.1. We think that the language used needs to be stronger i.e. 'must' rather than 'should' – this will imply to the registrant that the actions are required rather than open for consideration and personal choice.

1.2. The document does not appear to recognise any line of accountability that the registrant will have i.e. not all registrants on the list provided in the document will be autonomous practitioners. They will be employed by an organisation e.g. a health organisation and will have a line of accountability to the employer, the public and their colleagues as well as to the HPC (their professional body). This is not made clear in the document i.e. **'as an autonomous health professional you still need to make personal decisions about the best way in which you can meet our standards'**. P6, para 3

2. In particular

2.1. P5. **Principles – 'take reasonable steps to keep information about service users safe'** There is a need acknowledge the Caldecott principles about information governance because these principles need to be more than just taking 'reasonable steps'.

2.2. P5 **'always disclose the minimum amount of identifiable information possible'** This is not the best course of action in every situation and should not be stated as a principle i.e. these principles must also take into account the safe guarding children agenda, i.e. 'to share information on a need to know basis' as well as the safe guarding / protecting vulnerable adults agenda. At least 5 out of the 13 professions registered on the HPC will be working with children and at least 9 out of the 13 professionals will have direct patient contact (e.g. children's centres / trusts / multi professional teams) Minimal disclosure is not the principle for action in all situations and will not protect the client / service user.

2.3. P7. **The document needs to make it clear that the registrant is a custodian of the information and people who give it to them.** Service users trust them to keep it safe. Even people who run their own practice need to abide by the Data Protection Act, and the Freedom of Information Act.

2.4. P8. **Consent and confidentiality.** Disclosing information. This section needs to acknowledge the Research Governance agenda / requirements. **There is a need to link this to the department of health guidance or at least acknowledge that this exists especially as the majority of the registrants on the list may well be employed by the NHS and will be working with clients and other professionals through the NHS.**

2.5. P8. **Implied consent.** The terminology is misleading / incorrect. 'Express consent' is not recognised in the DH guidance and refers to verbal consent. There needs to be a clearer explanation about implied consent – i.e. if people attend the appointment and give information willingly as the health professional writes it down or types it into the computer etc.

2.6. P9, para 3 The document should refer to health and social care professionals because registrants will be liaising with professionals from these fields in practice.

2.7. P9, para10 What about when the issue relates to a 3rd party who may be vulnerable or at risk of harm e.g. if the service user is the parent and the registrant believes the child to be at risk of harm?

2.8. P9, para 11 This should acknowledge that it is important to keep accurate records of events, decisions, judgements and all actions, not just keeping clear records.

2.9. P11, para 4 This should refer to the Fraser Competence

2.10. P11 **Public interest disclosure.** This needs to identify the Public Health Act (i.e. disclosure when the person has a notifiable disease e.g. Tuberculosis etc.

3. Legislation

The document must identify the legislation in relation to confidentiality e.g. Caldecott, Data Protection Act, Freedom of Information Act, The Children Act.

More examples would be useful.

Community Practitioners' and Health Visitors' Association

Speech and Language Therapy Occupational Advisory Committee

1. Introduction

1.1. We have strong concerns regarding the guidance on 'Disclosing Information'. **Our view is that the guidance here is significantly out of step with recognised good practice on child protection and promoting the welfare of children.**

1.2. We would have similar concerns in areas where vulnerable adults may be at risk (for example, older people, or adults with learning disabilities). **Our view is that a stronger emphasis is required on safeguarding the welfare of the individual, where this may mean sharing information or – where there is a public interest – breaching confidentiality without explicit consent.**

2. Immediate Protection Required

2.1. **The example given on page 12 of the consultation document we feel is inappropriate.** The example is of an occupational therapist visiting an adult service user who sees images (photographs?) of the service user abusing a child.

2.2. The recommended action given here is for the occupational therapist to discuss the situation with her line manager, wait for the line manager to convene a multi-disciplinary team meeting, and – following agreement of the multidisciplinary team – report the matter to police.

2.3. **In fact the evidence seen by the occupational therapist strongly indicates that a child has already suffered significant harm, could be at immediate risk of further harm, and could be in need of immediate protection. The time delay of contacting the line manager and waiting for the collective decision of a multidisciplinary team is unacceptable in this context.**

2.4. **The responsibility of the occupational therapist (or any other health professional) is to alert an agency with statutory child protection powers immediately,** so that the agency may assess the degree of risk to the child, and – if necessary –take steps to secure the immediate safety of the child. We would therefore expect the occupational therapist to immediately telephone Social Services, or to telephone the police if this were not possible for some reason. We assume that the therapist would subsequently seek the support of her line manager and/or wider team and/or child protection lead, and would receive it – but the occupational therapist has a *personal* accountability in this situation that if necessary would over-ride the views of colleagues.

2.5. It is irrelevant in this context that the occupational therapist is not working directly with the child. Current guidance places an explicit obligation on *all* health professionals. For example, 'Working Together to Safeguard Children' notes the responsibility of health professionals to

safeguard and promote the welfare of children even when they do not directly work with them.

2.6. The Victoria Climbié enquiry highlighted a number of shortcomings, including a failure to intervene early enough, a failure to share information, poor management, and the absence of anyone with a strong sense of accountability. **Child protection practice post-Climbié has very much led to a changed emphasis in which the welfare of the child is paramount. Relevant recent guidance here would include ‘Working Together to Safeguard Children’ (2006), ‘Information Sharing: Practitioners’ Guide’ (2006), and the work streams around ‘Every Child Matters’.**

2.7. The ‘Information Sharing: Practitioners’ Guide’ (paragraph 3.12) gives a useful outline on the circumstances in which sharing confidential information without consent will **normally** be justified in the public interest. These are:

- ***when there is evidence that the child is suffering or is at risk of suffering significant harm; or***
- ***where there is reasonable cause to believe that a child may be suffering or at risk of significant harm; or***
- ***to prevent significant harm arising to children and young people or serious harm to adults, including through the prevention, detection and prosecution of serious crime.***

For the purposes of this guidance, serious crime means any crime which causes or is likely to cause significant harm to a child or young person or serious harm to an adult.

2.8. We would hope to see the HPC guidance on confidentiality quite significantly revised to place it in line with recognised good practice on the safeguarding of children and vulnerable adults.

3. Sharing Information Routinely

3.1. It is now recognised in working with children that the sharing of information across agencies is essential. For example, ‘Information Sharing: Practitioners Guide’ comments, *‘Sharing information is essential to enable early intervention to help children, young people and families who need additional services to achieve positive outcomes, thus reducing inequalities between disadvantaged children and others’*. Information sharing is seen as fundamental in preventative work and in offering targeted services.

3.2. Increasingly, in this era of evolution towards integrated services, consent for this would be implied. Practitioners also have a clear responsibility to carefully explain from the outset the ‘joined up’ way in which services operate, to gain explicit consent for information sharing on an ongoing basis.

3.3. Joined up working and the routine sharing of information are necessary not just to promote the welfare of children and seek to ensure the provision of integrated services, but **also** to safeguard children who are known to be at risk of significant harm. Again, the same considerations will apply to vulnerable adults.

3.4. The draft HPC guidance acknowledges the need to share information within the *healthcare* team, and rightly comments on the typical existence of implied consent for this, but makes no acknowledgement of multi-agency working.

3.5. ‘Working Together to Safeguard Children’ (paragraph 1.16) comments:

All agencies and professionals should:

- *be alert to potential indicators of abuse or neglect*
- *be alert to the risks that individual abusers, or potential abusers, may pose to children*
- *share and help to analyse information so that an assessment can be made of the child’s needs and circumstances*
- *contribute to whatever actions are needed to safeguard and promote the child’s welfare*
- *take part in regularly reviewing the outcomes for the child against specific plans*
- *work co-operatively with parents, unless this is inconsistent with ensuring the child’s safety.*

3.6. **The identification of *potential* indicators of abuse or neglect requires the sharing of issues that may not pose an immediate threat to a child’s welfare.** This would include domestic violence against a parent, for example, or a parent with mental health or substance misuse problems, or a family with a chaotic routine in which access to healthcare, education or family support services may be harder. There may be ‘low level’ concerns more directly around a child’s welfare: a child with faltering growth, or a child who is often dirty or inappropriately dressed, or a child with unusual behaviours. It is the sharing of this information that enables an appropriate assessment to be made of a child’s overall needs, and the services required by the family to ensure the child’s welfare going forward.

3.7. The sometimes complex issues around confidentiality, consent, and public interest disclosure are discussed carefully and well in Section Three of ‘Information Sharing: Practitioners Guide’.

4. Conclusion

4.1. A great deal of work has been done already around information sharing and confidentiality. The best current guidance for health professionals registered with the HPC is ‘Information Sharing: Practitioners’ Guide’. We strongly recommend that any HPC guidance makes explicit reference to this document, and draws heavily on the

overall approach within it. Health practitioners will require further knowledge of disclosure issues in their own professional realm, an understanding of any relevant profession-specific code of practice, and a sound knowledge of policies and procedures in their own workplace.

4.2. The current draft guidance from the HPC does not adequately reflect the complexities of this area, nor does it reflect the changes in child protection work and children’s services more generally. In particular, the explanation of ‘public interest’ is inadequate. As currently written, the guidance would make it significantly harder for health professionals to adhere to recognised best practice, and – at worst – could contribute to vulnerable children and adults being placed at risk.

Speech and Language Therapy OAC