General Medical Council

3 Hardman Street
Manchester M3 3AW

Email: gmc@gmc-uk.org
Website: www.gmc-uk.org
Telephone: 0161 923 6602
Fax: 0161 923 6201

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Department of Health
Adult Safeguarding Unit
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

To whom it may concern,

Legislative options to inform the development of an Adult Protection Bill for Northern Ireland: GMC response

1 We welcome the opportunity to comment on the consultation: 'Legislative options to inform the development of an Adult Protection Bill for Northern Ireland'.

2 Some of the questions in the consultation fall outside our regulatory remit or areas of expertise. We have therefore restricted our comments to a specific number of areas. For these reasons, as well as for ease of reading, we have chosen to respond to the consultation in the form of a letter.

The GMC's role and remit

3 The General Medical Council (GMC) is an independent regulator that helps to protect patients and improve medical education and practice across the UK.

- We decide which doctors are qualified to work here and we oversee UK medical education and training. There are approximately 337,000 doctors on the UK medical register. Of these, approximately 299,000 have a licence to practise.
- We set the standards that doctors need to follow, and make sure that they continue to meet these standards throughout their careers.

- We take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

4 Every patient should receive a high standard of care. Our role is to help achieve that by working closely with doctors, their employers, and patients to make sure that the trust patients have in their doctors is fully justified. We expect doctors to be familiar with and follow our ethical guidance and be willing and able to justify any departure from it.

Key comments

5 The GMC is not responsible for planning or delivering health or adult social care services, but we have an important role in setting professional standards for doctors. This includes setting the standards that doctors respond appropriately to risks to safety, and take prompt action if they think that patient safety, dignity or comfort is or may be seriously compromised. In responding to this consultation our aims are to understand:

- whether any obligations or responsibilities imposed on doctors will be consistent with the standards we set for their professional practice;
- how the proposals will impact patients' trust in the medical profession and engagement with health and social care services; and
- how we can support the development and implementation of an Adult Protection Bill and any future statutory guidance related to this.

6 We agree with the Department of Health (NI) that adult safeguarding is about protecting an adult's right to live in safety, free from abuse, exploitation and neglect. It involves people and organisations working together effectively to ensure this, as well as empowering individuals to make choices about how they want to live.

7 A general theme in our response is that it is vital that health and social care professionals, the public and other stakeholders clearly understand any new statutory duties and powers, or approaches, and how they will work in practice. We are aware that the Department intends to produce statutory guidance to accompany the legislation. We are keen to work with the Department on its development to help ensure a good fit with the expectations set out in professional standards.

8 We encourage the Department to consider how any changes introduced by the legislation will be incorporated into the education and training of health and social care professionals who encounter vulnerable adults. For instance, medical students and doctors in training will need an explicit understanding of their responsibilities when they suspect a patient is an adult at risk. It is critical that any change to the threshold for adult protection from 'exposure to

harm' to 'exposure to serious harm' is clearly explained, alongside the impact on their professional practice.

9 Communicating the changes to education providers will be essential so that they can update preventive safeguarding training for staff to recognise and report abuse, under the duties and definitions of the new legislation. Given our responsibilities for medical education and training, we are willing to work with the Department and local education providers to explore this aspect of implementing any new requirements.

10 We encourage the Department to consider how any statutory duties they intend to apply to organisations will relate to, and interact with, professional duties and the exercise of professional judgement. In advance of the legislation, we are keen to work with the Department and other relevant regulatory bodies in Northern Ireland to explore this further. We also welcome the opportunity to provide comments on this during the development of any future statutory guidance.

11 As the consultation recognises, when fully commenced, the Mental Capacity Act (Northern Ireland) 2016 will give new protections for individuals who lack capacity to make decisions for themselves about their care, treatment or personal welfare. There is therefore a clear and significant connection with the areas the Department is currently considering. It is important that health and social care professionals understand how the provisions in the adult protection legislation will interact with the requirements of the Mental Capacity Act.

Question 2 Definition of 'adult at risk and in need of protection' and threshold for adult protection

12 The Department's definition of 'adult at risk and in need of protection' should help decision-makers focus on the question of whether an adult needs protective action. This seems consistent with the 'empowerment' approach that also underpins the MCA 2016.

13 We are aware that the proposal to change the existing threshold for adult protection from 'exposure to harm' to 'exposure to serious harm' would be different to other parts of the UK.

14 We understand one of the reasons for this change is to mitigate against a potentially significant increase in adult protection reports after a statutory duty to report is implemented, and an anticipation that not all of these reports would be appropriate. However, it is essential to fully consider the implications of this change for patient safety. The Department may want to consider whether there is any learning from how England, Scotland and Wales apply their thresholds for adult protection (and where there is already a statutory duty to report adult protection issues in the last two jurisdictions).

15 It is critical that the meaning of the threshold, and when it may be triggered, are clearly understood by health and social care staff, the public and patients. This is even more important given that the consultation is contemplating changing the existing threshold. We encourage the Department to consider how any changes in definitions and thresholds can be communicated to education providers so it can be reflected in the training of doctors.

Questions 3 & 4 Principles for adult protection

16 The proposed adult protection principles are consistent with the four principles that we highlight in our online learning material for doctors on adult safeguarding: proportionality, protection, partnership and empowerment. We believe that having a clear set of principles to guide the implementation of the legislation will be useful.

17 We do not have specific views on whether the principles should be set out on the face of the legislation or in Statutory Guidance. However, a key issue is that health and social care professionals, patients, the public and others are aware of the principles and understand how they apply in practice.

Question 5 Statutory duty to report cases where adults are at risk and need protection

18 We appreciate that there is currently no general legal requirement to report adult protection issues in Northern Ireland. We note that implementing a statutory duty for organisations to report will align with the approach in Scotland and Wales.

19 Our guidance, Confidentiality: good practice in handling patient information, recognises that there are various legal requirements for doctors and others to disclose information about adults 'who are known or considered to be at risk of, or to have suffered, abuse or neglect'. We expect doctors to satisfy themselves that the disclosure is required by law and only to disclose information relevant to the request and in the way required (paragraph 53).

20 We do not have specific comments about the merits of introducing mandatory reporting in general, or the specific statutory duty being considered. But we encourage the Department to continue exploring with stakeholders the potential (unintended) consequences, risks and benefits of this approach. It may be useful to consider any learning from the application of an equivalent statutory duty in Scotland and Wales, and comparisons with England which has decided not to follow this approach.

21 The consultation highlights evidence of confusion among health and social care staff about what issues to report. It also suggests that those referring issues to adult protection have not always exercised their professional judgement to determine whether this is appropriate. If there is a relevant statutory duty for organisations to report adult protection issues, there should

be a clear explanation of how the duty to report will work practically and what the threshold is for professionals to report. This includes how professionals should act in cases where the relevant individual who is at risk may have objected to information about them being disclosed.

22 The proposed statutory duty will be placed on Health and Social Care (HSC) Trusts and other agencies. Where legal duties are set at an institutional level, it is essential to clearly set out how these will interact with professional responsibilities for staff in health and social care. In particular, we encourage the Department to consider how an organisational duty will interact with doctors' and other professionals' existing duty of confidentiality, and their scope to exercise professional judgement about whether and when to make a disclosure.

23 As previously mentioned, we are happy to explore further with the Department the relationship between its proposals and professional responsibilities and judgement. We also appreciate that the Department intends to produce statutory guidance. This could be an opportunity to provide clarity about organisational and professional duties, and to refer to relevant existing materials such as the GMC's Confidentiality guidance.

Question 6 Statutory duty for HSC Trusts to make enquiries

24 We do not have specific comments on the merits of introducing a statutory duty on HSC Trusts to make follow-up enquiries into an adult's case. We note that broadly equivalent duties exist in England, Wales and Scotland.

25 However, there should be a clear explanation of how the proposed duty will work practically, and when it will be appropriate to carry this out. We also reiterate our earlier comments about considering how organisational statutory duties will interact with the professional responsibilities and judgement of frontline staff.

Question 7 New power of entry to allow a HSC professional access to interview an adult in private

26 As the consultation rightly recognises, this proposal involves a very sensitive and complex area.

27 We appreciate that, at this stage, the Department is looking for more high-level views in relation to introducing a power of entry. However, given the complexity and sensitivity, we welcome the opportunity to see more detailed proposals that set out how health and social care professionals might be expected to exercise a power of entry (and any additional powers considered) in Northern Ireland. This will help us better understand how this proposal might impact on professional duties and responsibilities, patient confidence

and trust in professionals and services, and whether there are other relevant considerations.

28 As a professional regulator, we particularly welcome further details about the extent to which the Department would envisage doctors exercising a power of entry.

29 We also encourage the Department to continue to carefully explore with a range of stakeholders how the exercise of such a power (and any additional powers) could impact on public trust and confidence in health and social care professionals and services.

30 The consultation does not explicitly mention whether the courts will have a role in authorising the use of a power of entry in Northern Ireland (as is the case in Scotland and Wales). It would be helpful to clarify this as such a requirement could provide safeguards for those affected by such a power.

31 It may be helpful for the Department to continue exploring with its UK counterparts any learning from the exercise of equivalent powers of entry in these jurisdictions (and from the UK Government's previous consideration and rejection of these powers in England).

Question 11 Introduction of Serious Case Reviews

32 We do not have any substantive comments about the proposed introduction of Serious Case Reviews. But if the Department intends to produce guidance to support the effective implementation of Serious Case Reviews, it would be helpful to reference our guidance for doctors.

33 We say doctors must cooperate with formal inquiries. They must consider seriously all requests for information needed for formal reviews that are established to learn lessons and to improve systems and services (paragraph 73, Good medical practice; paragraph 71, Confidentiality guidance).

Question 12 Statutory duty on specific organisations to cooperate

34 We appreciate that effective cooperation between organisations is vital to ensuring timely intervention when individuals are at risk and in need of protection. We also note that previous reviews have repeatedly found that organisations often do not cooperate or share information effectively. This not only includes health and social care providers, but also commissioners, regulators and others.

35 We are committed to working effectively with other agencies, including RQIA and our fellow professional regulators, to ensure effective and timely information sharing and public protection. As stated elsewhere in our response, we are keen to promote a shared understanding among regulators and others, about any new legal duties on professionals and how we can

support professionals to meet their responsibilities towards adults at risk of harm.

Question 13 New power for designated organisation to access an adult's financial records

36 As the Department recognises, the proposed power for a designated organisation to access a person's financial records is a sensitive matter. Implementing such a power will require careful consideration.

37 We encourage the Department to provide further clarity on how this power will work in practice and what safeguards will be included. This will allow health and social care professionals, their representative bodies, patients, members of the public and the advice and voluntary sector to fully consider the implications.

38 For instance, it will be helpful to clarify issues such as:

- Whether those providing care, such as doctors, will be expected to exercise the powers on behalf of their organisations? (While we understand that Scotland provides some precedent powers, it appears that council officers have powers to examine financial records relating to adults at risk);
- If they were expected to exercise these powers, will health and social care professionals have the appropriate skills or training to be able to identify and act on potential financial abuse and other issues?;
- Will this be a power of 'last resort'?; and
- Will other agencies be required to authorise the use of the power? For instance, will the courts have a role in this process?

39 While we will need to study any proposals in more detail, doctors (or other health and social professionals) accessing patients' financial records, especially without their consent, could have significant (and unintended) consequences for patient and public trust and confidence in professionals and health services. A relevant issue to consider is that, even if such a power was rarely exercised by health and social care professionals, the notion of it could have significant implications.

40 We hope these comments are helpful. We are happy to explore or clarify any aspect of our response with you further.

Yours faithfully,

Professor Colin Melville,
Medical Director and Director, Education and Standards