

Health, Social Care and Sport Committee - Call for Views on National Care Service (Scotland) Bill

GMC Response - 1 September 2022

- 1** We welcome the opportunity to respond to the Health, Social Care and Sport Committee's call for views on the National Care Service (Scotland) Bill.
- 2** Some of the questions posed by the Committee fall outside our regulatory remit or areas of expertise. We have therefore restricted our comments to a specific number of areas and to ensure ease of reading, we have set these out in the form of a submission.

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.
 - We set the professional standards that doctors need to follow and work to 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** The GMC is not responsible for planning or, delivering health or adult social care services, but our regulatory functions and the professional standards that we set for doctors are expected to shape the way they practise within their working environment.

Comments

Section 13 - Independent Advocacy

- 5** We welcome the provision in section 13 of the draft Bill to enable the provision of independent advocacy services. As we set out in our responses to the Scottish Government's previous consultations on both the establishment of a Patient Safety Commissioner and setting up the National Care Service (**attached**), our research and experience shows that patients struggle to navigate the healthcare complaints landscape, and the provision of independent advocacy services in relation to the services which the NCS provides could therefore be very beneficial.

Sections 14 - Complaints Service

- 6** As set out in section 14(3) of the draft Bill, we agree that complaints should be referred to those best placed to address them. It is important that complaints are dealt with at the right level taking into account the seriousness of the issues and who is best placed to take appropriate action.
- 7** Where concerns are very serious and could raise the need for action from a regulator to restrict a professional's practice or take action in relation to unsafe providers, it is important that those are passed on to the appropriate regulator without delay. However, where issues could be best addressed by service providers, then they should not be sent as a matter of course to regulators as this can significantly delay their resolution and could cause unnecessary duplication or frustration if they are referred back to the provider at a later stage.
- 8** It is crucial therefore that there is appropriate guidance for everyone navigating the complaints landscape, in particular decision makers, on determining who is best placed to take appropriate action in relation to a complaint and to ensure that concerns are passed on in a timely way, particularly where regulatory action may be needed to restrict individual professionals or address unsafe providers.
- 9** To achieve this, there should be consultation with regulators when developing any secondary legislation or guidance which sits underneath these high-level provisions, and ongoing collaboration and close working with regulators to ensure that concerns are being raised appropriately with them as the service develops.

Section 31 - Transfers of Staff

- 10** We welcome the provision which will prevent Community Health and Social Care Boards from managing GPs contractual arrangements and instead ensure that the current system remains in place.
- 11** As noted in our response to the Scottish Government’s previous consultation on setting up the National Care Service, developing, operating and quality assuring clinical governance for doctors is a key responsibility for organisations and Boards. It includes making sure there are clear lines of accountability throughout organisations and visible leadership from Boards. Encouraging and actively supporting the professional development of doctors is also an important feature.
- 12** If Community Health and Social Care Boards were to take over the management of GP contractual arrangements, consideration would have to be given to ensuring that each Board has effective clinical governance measures in place, particularly the responsibilities outlined in the [Medical Profession \(Responsible Officers\) Regulations 2010](#).
- 13** The Responsible Officer (RO) Regulations give specified senior doctors (ROs) in certain organisations (Designated Bodies (DBs)) functions that will ensure that all doctors work within a managed environment, in which their performance, conduct and behaviour are monitored against agreed national standards.
- 14** Where there are concerns about a doctor’s fitness to practise, the Regulations empower ROs to instigate investigation of the doctor’s performance and to ensure that the appropriate action is taken. Where concerns are raised but are not of the degree at which referral to the GMC is considered necessary, ROs have a duty to investigate and to ensure that the appropriate local action is taken. If the cause of concern is found to relate to the systems, team or processes as well as, or rather than, an individual doctor, the RO has a duty to ensure that the DB takes action to address any issues.

Sections 36 & 37 - Health and Social Care Information

- 15** Section 36 of the Bill gives the Scottish Ministers powers to establish a scheme that allows information to be shared, so that services can be provided efficiently and effectively by, and on behalf of, the NCS and the NHS. Any regulations made under this power may be used to require one person to supply information to another, and to create sanctions for those who fail to comply with the regulations’ requirements.

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- 16** Section 37 also allows the Scottish Ministers to produce ‘information standards’, which set out how certain information is to be processed.
- 17** We understand that these provisions aim to support efficient information sharing across care settings, ultimately contributing to the delivery of safe and effective care. We also recognise that these provisions represent enabling powers rather than detailed arrangements. However, we’d like to highlight some issues that we think it important for the Scottish Government to consider as it develops more detailed proposals for sharing patient information. The Committee may also want to explore whether the Scottish Government is currently considering these issues as it develops policy in this area.
- 18** Above all, we would encourage the Scottish Government to consider how it can ensure that everyone will understand how their information will be used. Our guidance for doctors entitled [Confidentiality: good practice in handling patient information](#), is underpinned by principles that patients are able to exercise their legal rights and to be informed about how their information will be used. Patients should also be provided with information about disclosures of personal information that they wouldn’t reasonably expect, in ways that they can understand. In the absence of these principles, patients’ expectations of confidentiality will likely not be met.
- 19** We also note that previous concerns over the initial rollout of the NHS Digital General Practice Data for Planning and Research (GPDPR) programme in England have delayed its implementation and demonstrate the importance of transparency and clear public communication about how patients’ personal information will be used.
- 20** Finally, we’d like to comment on the proposed powers that would ‘require one person to supply information to another person’ (s.36(2)(a)). While this doesn’t specifically refer to doctors, it’s important that any future provisions that require medical professionals to disclose information about patients takes account of their existing duty of confidentiality.
- 21** Our guidance (see paragraph 1 of [Confidentiality](#)) highlights that trust is an essential part of the doctor-patient relationship and confidentiality is central to this. Patients may avoid seeking medical help, or may under-report symptoms, if they think their personal information will be disclosed by doctors without consent, or without the chance to have some control over the timing or amount of information shared.

Conclusion

- 22** Finally, we welcome the opportunity to respond to this call for views. Given our expertise, our response has only focused on referring to sections 13, 14, 31 and 36 as we believe other organisations are best placed to comment on other aspects of the proposed Bill.
- 23** We hope these comments are helpful and we would be happy to explore or clarify any aspect of our response with you further.