Scottish Government consultation on a National Care Service for Scotland - GMC Response

1 We welcome the opportunity to respond to the Scottish Government’s consultation on *A National Care Service for Scotland*.

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. Additionally, our responses do not lend themselves to the ‘Yes-No/Agree-Disagree’ format used in the consultation questions. For these reasons, as well as for ease of reading, we are responding to the consultation 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.

Answers

*Using Data to Support Care*
Q.12 - Should legislation be used to require all care services and other relevant parties to provide data as specified by a National Care Service, and include the requirement to meet common data standards and definitions for that data collection?

5 At the GMC, we understand the importance of appropriate information sharing as an essential part of the provision of safe and effective care. We also acknowledge the role patient information can play in contributing to the overall delivery of health and social care, including via research, and we support data sharing where appropriate and with sufficient safeguards.

6 The consultation proposes introducing a legislative requirement for all primary and community health care and social care services in Scotland to provide data to the NCS. We appreciate that this aims to support efficient sharing of data across care settings, ultimately contributing to the delivery of safe and effective care.

7 We would, however, encourage the Scottish Government to consider how it can ensure that everyone understands how their data will be used. Our guidance for doctors, Confidentiality: good practice in handling patient information, is underpinned by principles that patients are able to exercise their legal rights 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.

8 Transparency and clear public communication about how any data sharing requirement associated with the NCS will work in practice, will be vital. Previous concerns over the initial rollout of the NHS Digital General Practice Data for Planning and Research (GPDPR) programme in England suggest that, even where safeguards are in place for people who use services, clear public communication about these is imperative.

9 A mechanism to opt-out if people don’t want their information to be shared, which the consultation document already recognises in relation to the planned integrated social care and health record, is also important to consider.

10 The consultation proposes that ‘the NCS should be able to require data that can be used locally and nationally for strategic plans, commissioning, delivery monitoring, and performance monitoring’. We understand that this refers to the use of patient data for purposes other than direct care. In our Confidentiality guidance we recognise (see paragraphs 77-80) that such information makes a valuable contribution to the overall delivery of health and social care. However, we are unsure whether the specific proposal is to give the NCS powers to collect such information from services, and if/to what extent doctors would be involved in disclosing information about their patients in these circumstances.
11 In any event, it is important that such approaches to data collection uphold the requirements of both data protection legislation and the common law duty of confidentiality. As our Confidentiality guidance highlights, doctors must satisfy the requirements of both legal frameworks when disclosing patient information. (For an overview of the circumstances in which doctors may disclose personal information without breaching duties of confidentiality, please see paragraph 9 of our guidance).

Complaints and Putting Things Right

Q.15 - Should a model of complaints handling be underpinned by a commissioner for community health and care?

12 In our response to the Scottish Government’s previous consultation on the establishment of a Patient Safety Commissioner (PSC) we advised that our research and experience show that patients struggle to navigate the healthcare complaints landscape. There is an acknowledged need for better communication between the different parts of the healthcare system as well as with other bodies with an interest in providing safe healthcare. Identifying the gaps, enhancing communications, and working collaboratively across organisations that aim to support patients raising concerns will improve the patient experience and help to resolve this widely acknowledged frustration.

13 Encouraging collaboration between the proposed PSC and the proposed Commissioner for Social Care will help guide patients through the health and social care complaints system in Scotland, thus improving patient experience and helping them to find timely resolution to their concerns.

14 If established, the Commissioner for Social Care may receive evidence which highlights a particular concern with the delivery of care that reflects an underlying systemic issue or may suggest impaired fitness to practise on the part of a health and social care professional. In such cases, and for the purpose of public protection, it will be essential to ensure that such information is disclosed in a timely manner to the relevant regulatory body to enable it to investigate these concerns further, where appropriate to do so. Equally, during the course of their investigations, regulators may in turn identify thematic issues that might be helpful to the Commissioner.

15 Therefore, we would welcome further clarification on how the Commissioner will interact and share relevant information with regulatory bodies and the arrangements that will be needed to support this. We would be happy to work with the Scottish Government and/or the Commissioner to consider this.

Healthcare
We note the ambition for the NCS to consider the Community Health and Social Care Boards taking responsibility for the commissioning and procurement of a range of health services, similar to (and potentially wider than) the range of services currently delegated to Integration Joint Boards.

Our experience of IJB’s has been that it is the culture in the respective organisations that causes the problems and gets in the way of making the arrangements work – i.e. professional rivalries, protectionism, poor multi-disciplinary working, cultures etc. It will be vital that a centrally led and controlled national care service is able to address these issues more effectively than in the past, through stronger governance and increased accountability.

Q.28 - If the National Care Service and Community Health and Social Care Boards take responsibility for planning, commissioning, and procurement of community health services, how could they support better integration with hospital-based care services?

We welcome the direction of travel towards a more collaborative approach with a focus on local needs, which we also stated in our response to NHS England and NHS Improvement’s consultation Integrating care – next steps to building strong and effective integrated care systems across England. Ongoing work on integration and better collaboration across the NHS is in line with our own ambitions to work better with other regulators, healthcare partners and to do more to embed patient experience in everything we do.

Sustainability of the workforce will be key to ensuring integrated services are delivered successfully and we are working with stakeholders to enable greater flexibility in medical education and training, helping to support the workforce needs whilst maintaining standards and expectations. We believe that greater collaboration will increase opportunities for delivering and receiving care.

As a regulator, we would be keen to see strong provisions in integration to give regard to both workforce, and education and training issues, in their leadership of local health and care systems. In particular, we would be considering what the new proposed structures would mean for:

- the skills, competencies and training of doctors,
- the role of CHSCBs in setting culture,
- the scope of their oversight of clinical governance systems and training environments for trainees and implications for our outreach teams,
- opportunities to develop regulatory alignment.

Q.30 - What would be the risks of Community Health and Social Care Boards managing GPs’ contractual arrangements?
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.

If Community Health and Social Care Boards were to take over the management of GP contractual arrangements, consideration will need 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.

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.

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 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.

Medical revalidation is also a fundamental part of clinical governance for doctors. It provides patients and the public with assurance that doctors in the UK are part of a governed system which checks their fitness to practise on a regular basis and supports their continuous improvement and development. It also supports the identification and management of concerns at an early stage.

The need for much closer working across regulators has been a consistent theme of public inquiries into serious failures in healthcare, in recent years. We are determined to act on what we’ve learnt by making collaboration our default way of working.

As proposed on page 109, we agree that it is important that the role of regulating both services and the workforce remains independent of the NCS. As outlined, this independence will also allow the regulator to operate and to regulate any services commissioned directly by a NCS which may include health services.
28 Major reform of systems and structures, as is envisaged by the new National Care Service, will also give opportunities to test the balance of regulatory oversight across the system and consider whether that balance is the right one, as well as giving an opportunity to examine how regulators and quality assurance can most effectively work together in the interests of patient safety. This is a debate we are happy to continue to contribute to.

29 Page 109 also outlines the core principles for regulation, and we welcome principle 5 around collaborative working. Improved information sharing across the health & social care regulatory system to both identify and address systemic concerns and/or areas of risk relating to patient safety is vital. The recent development of an emerging concerns protocol, enabling 6 monthly meetings of the professional and systems regulators across Scotland, is welcomed.

Enhanced Powers for Regulating Care Workers and Professional Standards

Q.83 - Would the regulator’s role be improved by strengthening the codes of practice to compel employers to adhere to the codes of practice, and to implement sanctions resulting from fitness to practise hearings?

30 We agree that employers play a vital role in ensuring practitioners are fit to practise and it is important to develop close liaison between regulators and those who hold responsibility for services at local level.

31 The introduction within healthcare organisations of the role of ROs who have statutory responsibilities in relation to fitness to practise, and the building of relationships between ROs and our employer liaison advisers (ELAs) are key components of how we regulate our registrants.

32 In addition to the RO responsibilities set out in response to Question 30, ROs also have a statutory responsibility in relation to a registrant’s compliance with GMC decisions. Under 13(2)(d) of the Regulations, where a doctor is subject to conditions or has agreed undertakings, ROs have a duty to monitor compliance with these. Some conditions and undertakings specify RO involvement, for example in the appointment of supervisors and by necessitating the RO’s approval of work environments. For more information, please see the undertakings bank and conditions bank.

Q.84 - Do you agree that stakeholders should legally be required to provide information to the regulator to support their fitness to practise investigations?
Section 35A of the Medical Act 1983 gives the GMC a power to request information from a doctor or any other person where that information may be relevant for investigating a doctor’s fitness to practise and we consider this power helps support effective fitness to practise investigations. A request for information under this section requires an organisation by law to provide the information listed in the request and, where that information is not provided, there is an option for the GMC to apply for a court order to enforce the notice.

We will only ask for information that is necessary and proportionate for our investigation, and, if an individual raises concerns about us obtaining information, we will consider if, in light of the concerns raised, it is in the public interest to go ahead and use our powers to request that information. By directing that the information be provided under our powers set out in the Medical Act, we hope to simplify and clarify the obligations of those from whom we are requesting information, as it allows them to provide the information in the knowledge that they are legally permitted and required to do so.

Finally, we welcome the opportunity to respond to this consultation. Given our expertise, our response has only focused on answering questions 12, 15, 28, 30, 83 and 84 as we believe other organisations are best placed to inform other aspects of the proposed service that are featured in this consultation.