Introduction

The BMA is grateful for the opportunity to provide written evidence to the Education Committee regarding the Protection of Vulnerable Groups (Scotland) Bill.

The BMA welcomes the publication of this Bill and supports the application of the recommendations of the Bichard Inquiry in Scotland, recognising that there is room for improvement in the protection of vulnerable groups.

BMA Scotland has contributed to early consultations on the introduction of a new vetting and disclosure scheme in Scotland and our previous position is reflected in this paper.

However, BMA Scotland has not, at any time, been involved in discussions about Part 3 of this Bill which considers requirements for information sharing for child protection purposes. While we acknowledge that the aims are to convert current good practice for the disclosure of information for child protection cases into law, the BMA is concerned about the lack of detail and clarity in the primary legislation and the lack of information on the proposed Code of Practice which will provide the detail of this Bill. The BMA considers any primary legislation which diminishes patient confidentiality to be of vital importance and we would want to be clear not just about the primary legislation at this stage but also the supporting Code of Practice. The BMA would therefore suggest that the Committee and relevant stakeholder organisations, such as ourselves, be consulted on the content of this Code of Practice, ideally prior to the conclusion of the Committee’s considerations of the Bill.

Part 1: The Lists

Information held by public bodies

Part 1, Section 19 gives ministers power to obtain information from other public bodies when deciding to list an individual. The BMA notes that organisations such as the General Teaching Council are included, to ensure that when a referral about a teacher from an educational authority is received, Ministers could access further information about the individual’s performance.

The BMA accepts the reasons for the openness between Ministers and these organisations in cases where vulnerable groups are at risk. Throughout this Bill, however, there is no mention of the requirement of Ministers to work with and co-operate with professional regulatory bodies, such as the General Medical Council, which have robust procedures and detailed information available to them about medical professionals working in Scotland (and the UK). It would seem to us that this reflects a missed opportunity to encourage greater partnership working and to learn from established systems which could lead to unnecessary duplication of effort.

Part 2: Vetting and Barring Disclosure

General

It is important that the public has trust in the various professionals and individuals who have access to children and other vulnerable individuals through the course of their work. Although rare, there are occasions when individuals abuse their positions and the proposed new system of disclosure should offer some peace of mind to those people responsible for caring for children or vulnerable groups of society.
During the Scottish Executive’s consultation on the Vetting and Barring Scheme earlier this year, the BMA commented that the proposed scheme covered a wider range of positions than those for which disclosure is currently required. The inclusion of those “who have substantial access to personal and sensitive information about vulnerable groups (e.g. database operators)” could increase considerably the number of staff affected, placing an increased workload and financial burden on the NHS and other public sector employers, particularly small employers such as GP practices.

In our view, the scope of the definition of ‘regulated work’ is not clear in the Bill. For example, it is unclear whether a medical receptionist or secretary, who would have access to confidential patient information for both children and vulnerable individuals, would have to take part in the vetting and disclosure process. Since employers will be committing an offence if they do not check the relevant list when employing an individual, it is vital that the scope of the Bill is clear.

The BMA also proposed that fees for disclosure be set as low as possible, with subsequent checks of barred status being free of charge. We are therefore disappointed that the cost of the initial fee for disclosure will be increased.

**NHS Scotland as ‘registered organisation’**

The NHS employs more than 130,000 staff across Scotland. It is current policy to promote for greater regional planning between NHS Board areas and, with the development of Managed Clinical Networks and to ensure services are available in local communities (particularly in rural Scotland), it is now commonplace for medical staff (and other groups of health professionals) to work in more than one NHS Board area. Under the requirements of this Bill, individuals would be required to undergo and pay for more than one disclosure fee, while NHS Boards would have to undertake the necessary checks, despite the fact that they are, technically, working for a single organisation.

General Practitioners are independent contractors providing services to the NHS, employing a range of health professionals and administrators in their practices. GPs may also work for out of hours services and may provide locum services in neighbouring NHS Board areas. One could argue that a doctor, guilty of causing harm to vulnerable groups, would find it easy to slip through the net by working as a locum in various health board areas. In our view a single procedure for all NHS employees (who undertake regulated work) would be more appropriate. The BMA therefore proposes an alternative approach.

The Bill creates a possibility for an ‘annual fee’ to be applied (section 67(2)a) for an organisations that undertake regulated work. The BMA would suggest that it may be appropriate for NHS Scotland to be considered as the registered organisation. The BMA believes that this approach would link in with the policy objective of the Bill to minimise bureaucracy within the NHS and of the developing roles of health professionals in primary care as well as create a single point of access to the disclosure process.

**Information from regulatory bodies**

In Part 2, section 46(1)d gives Ministers powers to obtain certain information as vetting information held by regulatory bodies and local authorities. As stated
previously, the BMA would welcome clarification as to the role of regulatory bodies such as the General Medical Council in this procedure.

**Part 3: Sharing child protection information**

As stated earlier in this report, the BMA has not been consulted on the proposals outlined in part 3 of the Bill and is concerned that very little detail is provided in primary legislation, given the sensitivity of the issue.

The BMA is concerned that the determination of a child at risk in the Bill does not allow for doctors to exercise their judgement when there is a low level of harm, or if they believe that when considering the potential harms and benefits, that it would not be in the child’s interests to share information. We are concerned about the diminution of the threshold of seriousness as it would mean that even very slight ‘harms’ could constitute a justification for disclosure of information. In the BMA’s view (and in line with GMC guidance), confidentiality has a high value and should not be overridden lightly.

To that end, we would propose an amendment that the use of the word ‘must’ in section 74 be softened.

Furthermore, the word ‘serious’ should be inserted in section 73 to read:

“Child protection information” is information relating to a child which the holder of information considers, or should reasonably consider, to be relevant for the purposes of protecting the child, or any other child from **serious** harm.

We would also propose that this amendment (i.e. the insertion of the word ‘serious’ before ‘harm’) be repeated in section 75a, 77(1)a and 79(1)b.

By making this amendment, the statutory requirement to share information would be much clearer to professionals and would link in with their professional duties, as outlined in the General Medical Council’s guidance on “Confidentiality: Protecting and Providing Information (2004)”.

Section 74(1) of the Bill proposes that doctors would be required to share information to a ‘council’ as defined by the Local Government etc (Scotland) Act 1994. This would require doctors to report child protection information to a committee of councillors and a convenor. It could be assumed that the responsibility would be delegated to an appropriate person or group in the Council, but the BMA would prefer that this be included in the Bill and propose the following amendment:

Section 74(1): “… report the information to the **person responsible for child protection issues** in the council for the area…”

The BMA also believes that in this section (s74) there should be a clear requirement in primary legislation on the need to try to obtain consent to share information, where appropriate. If not included in the Bill it is a matter that must be clearly defined in the Code of Practice. The BMA would also propose that clarification on the need for only relevant information to be shared for the purposes of protecting children from harm.
Section 76 considers the content of the Code of Practice about child protection information. Given the detailed guidance on particular issues that will be included in this Code of Practice, the wording should be made stronger. The BMA proposes that the use of the word “may” should be replaced with the word “will” (s.76(2)).

The items listed in section 76 are the minimum that should be covered by the Code of Practice. The BMA would suggest that this be extended to include:

- a process for informing (or not) the child/person with parental responsibility about the disclosure that is due to take place
- training of staff
- appeals and complaints

In section 81, which deals with enforcement, the BMA would recommend that any ministerial changes be carried out in consultation with relevant stakeholders.

Confidentiality and young people
The BMA is aware that this legislation could potentially raise debate on the requirement to report sexual activity of young people. It is clear that there is no requirement for mandatory reporting to the police of sexually active young people, irrespective of their age contained in this Bill. Any guidance should confirm best practice that decisions about sharing confidential information about sexually active young people must be made on the basis of an assessment of their best interests.

Under the Sexual Offences Act 2003, young people under the age of 13 are not capable of giving consent to sexual intercourse, and such sexual activity is therefore rape. Although sexual activity in someone under the age of 13 will always be cause for concern, the need to share information without consent to protect the young person must be balanced against the need to provide a service that encourages young people to seek help when they need it. It is clear that young people place a very high value on a confidential sexual health service. Without an underlying presumption of confidentiality, young people will refuse to access such services and their interests could therefore be seriously harmed.

Decisions in this area, which can often be challenging, must always be made on a case by case basis, taking into consideration all relevant information. Where health professionals believe that children may be subject to coercion or exploitation, existing child protection guidelines must be followed. Health professionals with concerns should seek advice and help, anonymously if necessary, from colleagues with expertise in child protection, such as named and designated professionals.

Health professionals working with very young people who are sexually active should be appropriately trained and should have ready access to expert child protection advice, such as from named or designated health professionals. Cases involving very young people are complex and should usually be discussed with colleagues, anonymously if necessary. In all decisions in this area, the focus of attention must be on promoting the best interests of the child or young person.

Conclusion
The BMA supports the principles of this Bill and welcomes moves to introduce legislation that takes into account the recommendations of the Bichard Inquiry in England.
The BMA recognises the need to improve the current disclosure process but believes that it also provides an opportunity for NHS Scotland to become the registered organisation rather than a more local process as this would take into account the changes to the ways that services are delivered in Scotland.

The BMA is concerned over the lack of consultation regarding Part 3 of this Bill. The requirement to share information for child protection is an important duty of a doctor however it is not always a clear cut process and there may be cases whereby disclosing an individual’s information could be contrary to the best interests of the child.

The BMA is concerned that much of the detail of this Bill will be contained in an accompanying Code of Practice and believes that the Committee should be allowed to consider this as part of its wider considerations of the Bill.