CALL FOR IDEAS – CLINICAL PERFORMANCE AND MEDICAL REGULATION: CHIEF MEDICAL OFFICER'S REVIEW FOLLOWING THE SHIPMAN INQUIRY REPORTS

MAINTAINING HIGH STANDARDS OF PROFESSIONAL PRACTICE

Appraisal and Assessment

I. Should doctors' performance be assessed in addition to, or as part of, the annual NHS appraisal? What purpose should appraisal of clinical practitioners have: should it be primarily for governance, with a primarily summative structure and handling; or should it be, as at present, primarily for developmental purposes, with a primarily formative structure and handling? Can it be on both of these bases at the same time? How might small practices and departments be supported in this area? What form should assessment take?

Q1: Should doctors' performance be assessed in addition to, or as part of, the annual NHS appraisal?

No comment.

Q2: What purpose should appraisal of clinical practitioners have: should it be primarily for governance, with a primarily summative structure and handling; or should it be, as at present, primarily for developmental purposes, with a primarily formative structure and handling?

No comment.

Q3: Can it be on both of these bases at the same time?

No comment.

Q4: How might small practices and departments be supported in this area?

The system should be consistent whatever the working environment of the health professional.

Q5: What form should assessment take?
There are a range of options.

II. What practical measures would assist with establishing that a doctor continues to be able to provide competent and safe services? Should 360° reporting be introduced by the NHS as part of appraisal? Should there be a confidential reporting system? Should doctors record their experience, learning or educational events in a log-book? Who should be involved in the assessment process?

Q1: What practical measures would assist with establishing that a doctor continues to be able to provide competent and safe services?

Three processes. They are as follows:

1. Fitness to practise
2. Continuing professional development
3. Revalidation

Q2: Should 360° reporting be introduced by the NHS as part of appraisal?

360° appraisal is appropriate for all employees.

Q3: Should there be a confidential reporting system?

When a health professional's performance is below expected standards, then the first steps of the Fitness to Practise process should be confidential. Thereafter an additional confidential reporting system is not required.

Q4: Should doctors record their experience, learning or educational events in a log-book?

CPD activity should be recorded. Revalidation will require an assessment.

Q5: Who should be involved in the assessment process?

If revalidation is adopted, as opposed to CPD, then involvement will depend on the process used. For example independent assessment centres using peer group review, or employee/employer three year appraisal.

III. How can patients and the public contribute to the maintenance of standards and competence? Should their views about their medical treatment be sought routinely? Or on a sample basis?

Q1: How can patients and the public contribute to the maintenance of standards and competence?

A number of methods should be adopted. The GMC should adopt lay participants at Council, Committee and Panel level along the same lines as required of the NMC and the HPC.

Q2: Should their views about their medical treatment be sought routinely?

Informed consent should be at the core of any relationship between a health professional and their patient.

Q3: Or on a sample basis?

Appropriate market research from all stakeholders should be routinely gathered. In addition, like the NMC and the HPC, before setting standards or publishing guidance, consultation should be adopted by the GMC.

IV. How should lessons learnt from patient complaints be fed into the appraisal system? How can staff be encouraged to identify and report poor performance or unacceptable conduct?

Q1: How should lessons learnt from patient complaints be fed into the appraisal system?

The GMC should adopt the process that is required of the NMC and HPC. Namely Article 44 (1) of the Health Professions Order 2001 states "The Council shall publish at least once in each calendar year a statistical report which indicates the efficiency and effectiveness of the arrangements it has put in place to protect the public from persons whose fitness to practise is impaired, together with the Council's observations on the report."

In effect an annual report is produced that indicates to all stakeholders where registrants are failing to maintain appropriate standards.

Q2: How can staff be encouraged to identify and report poor performance or unacceptable conduct?

By establishing a climate of trust and confidence, a statutory regulator of health professionals will encourage all its stakeholders to communicate with it.

Please refer to the answer to question XIII to see how this can be achieved.

Revalidation

V. What should be the core purpose(s) of revalidation? Are the GMC correct when they say that the purposes are to contribute to raising standards by requiring doctors to demonstrate that they have reflected on their practice; and to protect patients by securing confirmation that doctors are up to date and fit to practise, by providing a backstop where local systems do not exist, or exist but are inadequate; and through robust quality assurance mechanisms?

Q1: What should be the core purpose(s) of revalidation?

The purpose of revalidation should be to ensure that statutorily regulated health professionals' existing scope of practice is safe and effective, not just the threshold standards of proficiency.

Q2: Are the GMC correct when they say that the purposes are to contribute to raising standards by requiring doctors to demonstrate that they have reflected on their practice; and to protect patients by securing confirmation that doctors are up to date and fit to practise, by providing a backstop where local systems do not exist, or exist but are inadequate; and through robust quality assurance mechanisms?

All regulators of health professionals should be precise in what they believe the core purpose of revalidation is, the purpose of Continuing Professional Development and appraisal.

VI. In the light of this, what should the broad structure of revalidation be? Should it be a screening ('assessment level 1') process aimed at identifying practitioners at risk of having a fitness to practise problem; or aimed at actually identifying dysfunctional practitioners (case finding, or 'assessment level 2'); or, as the legislation currently provides, aimed at evaluating fitness to practise (diagnostic or 'assessment level 3')?

It should be a cost effective methodology of ensuring that health professionals are safe and effective.

This is based on the assumption that only a very small percentage of health professionals will fail a revalidation process.

VII. What attributes (knowledge and skills), behaviours and attitudes should doctors have to demonstrate to maintain their registration? Are there any other relevant attributes which should be assessed?

Q1: What attributes (knowledge and skills), behaviours and attitudes should doctors have to demonstrate to maintain their registration?

All health professionals should be able to meet the Standards of Proficiency of their respective profession.

All health professionals should be in good health (physical and mental).

All health professionals should be of good character.

All health professionals should be able to demonstrate that they are undertaking CPD.

All health professionals should be able to pass a revalidation assessment, if one is required by the statutory regulator.

Where a health professional has undertaken a post registration qualification, and the award of the qualification allows only those who hold the qualification, to undertake a specific task, then they must be able to meet the Standards of Proficiency and CPD for the post registration qualification.

Q2: Are there any other relevant attributes which should be assessed?

No.

VIII. How should the required standards be set? Should there be objective criteria? How should these be identified and measured?

Q1: How should the required standards be set?

The statutory regulator must set the standards if as a consequence of a health professional failing to meet the Standards, their registration either lapses or they are removed from the register.

Q2: Should there be objective criteria?

The criteria must be objective.

Q3: How should these be identified and measured?

The GMC should consult with all its stakeholders.

IX. Should there be a core evidence set for revalidation? How should it be defined?

Q1: Should there be a core evidence set for revalidation?

Yes

Q2: How should it be defined?

Following consultation with stakeholders.

X. How should 'failure to revalidate' be handled, in the light of topics I and II above? How can we avoid 'double jeopardy', with repeated assessments?

Q1: How should 'failure to revalidate' be handled, in the light of topics I and II above?

Failure to revalidate should result in the registrant being unable to renew their registration.

The legislation should be amended along the lines of Article 19 (1) and (2) of the Health Professions Order 2001.

Q2: How can we avoid 'double jeopardy', with repeated assessments?

No comment.

Fitness to Practise

XI. When a doctor's fitness to practise has been called into question what arrangements should there be to protect the public? How should the GMC monitor the compliance of conditions it has imposed on a doctor? Are there any extra safeguards for a doctor being retrained above those required for a doctor in training?

Q1: When a doctor's fitness to practise has been called into question what arrangements should there be to protect the public?

They should be referred to the Fitness to Practise process of a statutory regulator.

The process should be the same as that used by the NMC and the HPC. Namely an investigating stage held in private followed by a Conduct and Competence or Health tribunal as appropriate. In addition, interim orders should be available and the possibility of mediation.

Council members should not participate in the tribunals.

Q2: How should the GMC monitor the compliance of conditions it has imposed on a doctor?

Any conditions of practice imposed on a registered medical practitioner must be measurable and if imposed for a length of time, must be periodically reviewed by the regulator.

Q3: Are there any extra safeguards for a doctor being retrained above those required for a doctor in training?

All registered medical practitioners and other statutory regulated health professionals should have to meet the same standards laid down by the statutory regulator. Therefore no extra safeguards are required.

XII. What arrangements are needed for doctors whose fitness to practise fails to meet the necessary standard? Is retraining a realistic option for all doctors? Who should pay for this? What arrangements should be for doctors to move to other duties and to provide exit strategies?

Q1: What arrangements are needed for doctors whose fitness to practise fails to meet the necessary standard?

The process used by the GMC should be brought into line with the process used by the NMC and the HPC.

Q2: Is retraining a realistic option for all doctors?

Yes – retraining is an option for some health professionals who have been found to be below expected standards. However, if they fall below expected standards they should not remain on the register.

Q3: Who should pay for this?

The cost of retraining should either be the health professional's, or the employer, or both.

Q4: What arrangements should be for doctors to move to other duties

Conditions of practice whereby a health professional is restricted from operating in a particular area is an appropriate option for a fitness to practise tribunal.

Q5: and to provide exit strategies?

The decision for a registered medical practitioner, or any other health professional, to be removed from the register should occur when they are unable to meet approved standards and there is limited possibility that they can regain those standards within a reasonable time frame.

XIII. What else is needed to provide patients and the public with the assurance they need to maintain confidence in the competence and safety of medical practice?

Persons using or needing the services of all health professionals will probably focus on the following six issues.

- Communication – who, how and when to contact the regulator
- Independence of process
- Timeliness of process
- Transparency of process
- Number and frequency of reversal of decision by courts
- Percentage of lay members of Council, Committees and Tribunals

XIV. How should information on practitioners' fitness to practise be held and made available, including information from appraisal, revalidation and fitness to practise (including local disciplinary procedures)? Should this be a single national database or a collation of local NHS and other databases (eg the GMC register)?

Q1: How should information on practitioners' fitness to practise be held and made available, including information from appraisal, revalidation and fitness to practise (including local disciplinary procedures)?

It should be available by a number of processes, including:

- hard copies for inspection at the statutory regulator
- websites
- fax
- telephone

It should be made available to the public.

Q2: Should this be a single national database or a collation of local NHS and other databases (eg the GMC register)?

Decisions about a health professional's fitness to practise, refusal to undertake CPD and failure to revalidate should be made available to the public on a single database managed by the GMC or relevant regulator of other health professionals.

XV. Should the GMC continue to be a complaints-handling body which receives complaints directly from any source, or should it be a body to which complaints are normally only referred by healthcare organisations and other public bodies where they have passed a threshold indicating that the doctor may be unfit to practise?

All complaints should be referred to the appropriate statutory regulators of health professionals.

The regulator should then consider at the investigating stage whether or not they should go to the Conduct and Competence or Health tribunal.

The GMC should then forward complaints to other organisations if they are unable to deal with them.

In effect, the GMC should act as the portal for all complaints about registered medical practitioners.

XVI. Will the complaints portal recommended by Dame Janet, together with appropriate public information about the differing aims of complaints procedures and fitness to practise procedures, resolve current public uncertainty about how and where to make a complaint; or is better role-definition for the various organisations involved, expressed where necessary in legislation, essential?

Q1: Will the complaints portal recommended by Dame Janet, together with appropriate public information about the differing aims of complaints procedures and fitness to practise procedures, resolve current public uncertainty about how and where to make a complaint;

Public uncertainty will be resolved if they are confident in the process used by the statutory regulator. The type of issues that they will be concerned about are listed in the answer to question XIII.

Q2: or is better role-definition for the various organisations involved, expressed where necessary in legislation, essential?

The GMC legislation should be amended to follow the NMC and the GMC. Namely Article 3 (13): "The Council shall inform and educate registrants, and shall inform the public, about its work."

FUTURE DESIGN OF MEDICAL REGULATION

XVII. What should the regulation of the medical profession look like?

The GMC legislation should be amended to bring it into line with the NMC and the HPC.

XVIII. What should be the role and structure of the General Medical Council in the future? What should the primary purpose of the Council (which is currently composed of 35 members) be – governance and policy development, i.e. more like a publicly accountable Board – or delivery, ie directly involved in exercising the GMC's powers and functions? In either of these settings, what should its size be and how should members be appointed? If its function is governance and policy development, who should carry out the work of the Council on delivery? If its function is delivery, how should these powers be delivered? In fitness to practise, the following key components - setting standards of conduct, policy and procedural rules; investigation of complaints; case presentation; adjudication - are currently delivered by the GMC. How should these elements be organised in the future?

Q1: What should be the role and structure of the General Medical Council in the future?

The GMC role and structure should be amended to reflect those of the NMC and the HPC.

Q2: What should the primary purpose of the Council (which is currently composed of 35 members) be – governance and policy development, i.e. more like a publicly accountable Board – or delivery, ie directly involved in exercising the GMC's powers and functions?

The GMC should have the same primary objective as the NMC and the HPC. It should be:

"The main objective of the GMC in exercising its functions shall be to safeguard the health and well-being of persons using or needing the services of registered medical practitioners."

It should continue to have four integrated processes, as detailed in the introduction.

Q3: In either of these settings, what should its size be and how should members be appointed?

It should reflect the NMC and HPC. The number of Council members should be around 25. The ratio of registrant to lay should be 13:12. Registrants should be elected. Lay Council members should be appointed by the NHS Appointments Commission.

Q4: If its function is governance and policy development, who should carry out the work of the Council on delivery?

The Executive.

Q5: If its function is delivery, how should these powers be delivered?

No comment.

Q6: In fitness to practise, the following key components - setting standards of conduct, policy and procedural rules; investigation of complaints; case presentation; adjudication - are currently delivered by the GMC. How should these elements be organised in the future?

They should remain an integrated process. The Council should establish the strategy and policy and the Executive should then deliver it.

XIX. Do we have the right balance between regulation and freedom to practise (including innovation)?

No comment.

XX. What alternative models are there in other fields of endeavour in the UK or elsewhere? How could these be adapted for the medical profession in the UK?

The GMC's legislation should be compared against the NMC's and the HPC's statutory instruments and brought into line with the more up to date UK regulatory models.

XXI. Should the regulation system be made more accountable and intelligible to the public? What should be the relationship between the GMC and Council for Healthcare Regulatory Excellence (CHRE)? How should the effectiveness of that relationship be evaluated? Should the GMC be made directly accountable to Parliament, as Dame Janet has recommended?

Q1: Should the regulation system be made more accountable and intelligible to the public?

Research should be undertaken to establish what the public's expectations are. If the findings are that increased accountability is required and/or the regulatory system is intelligible, then steps should be taken to correct the situation.

Q2: What should be the relationship between the GMC and Council for Healthcare Regulatory Excellence (CHRE)?

It should remain as it is. Firstly to refer Fitness to Practise cases to the High Court if CHRE has evidence that a GMC Tribunal has been too benign to a registered medical practitioner. Secondly, CHRE should continue to encourage best practice for all UK regulators of health professionals.

Q3: How should the effectiveness of that relationship be evaluated?

An organisation independent of the GMC and CHRE should evaluate the effectiveness of the relationship once CHRE has been operating for three years.

The National Audit Office may be an appropriate organisation.

Q4: Should the GMC be made directly accountable to Parliament, as Dame Janet has recommended?

The GMC and all UK regulators of health professionals should report to the Privy Council unless there is clear evidence that this is inappropriate.

Article 44 of the Health Professions Order 2001 should be adapted by the GMC.

However, if it is decided that the GMC should be made directly accountable to Parliament, the same relationship should apply to all statutory regulators of liberal professions.

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