FORMAL RESPONSE

TO CHIEF MEDICAL OFFICER FOR ENGLAND'S PUBLICATION:

'AFTER SHIPMAN: A CALL FOR IDEAS'

May 2005

Introduction

Action against Medical Accidents ('AvMA') is an independent charity which has been promoting patient safety and justice for people harmed by health care since 1982. AvMA has extensive experience of helping and advising thousands of patients each year and of collaborative working with the Department of Health, NHS bodies and health profession regulators as well as fellow patients' organisations. Regulation of health professionals, fitness to practice investigations and revalidation are of central concern to AvMA and the people we serve. AvMA provided extensive evidence to the Shipman Inquiry and was prominently referred to in the Inquiry's report.

The 'call for ideas' raises a large number of questions many of which have been the subject of detailed submissions by AvMA to the Shipman Inquiry itself and to General Medical Council (GMC) consultation, for example on draft regulations for revalidation. Rather than repeating these points in detail here, we have provided relevant previous submissions as appendices. This document summarises some of the key points we would like the CMO's review to consider, providing some additional comments in the light of the questions asked and the Shipman Inquiry recommendations. We have used the headings and question numbers used in the 'call for ideas'.

Appraisal and Assessment

I. The annual NHS appraisal should be a key component in the assessment and revalidation of doctors' performance, but it cannot be the sole means. This is particularly so as some doctors work both privately and in the NHS and some only do private work. Appraisals are also only as good as the employing organisations make them. We have already expressed grave concerns about the GMC assuming that NHS organisations are all competent to conduct adequate appraisals. We have even less confidence in the private sector. There needs to be rigorous and independent quality assurance of the process. Whilst we appreciate that appraisal is chiefly a formative process concerned with development, we also feel appraisals need to be thorough enough to pick up on trends indicating sub-standard performance and initiate corrective action. This is a valid aspect of any system of appraisal, however it should never be assumed that the appraisal system alone will provide the information needed either to identify poor performance or provide the basis for revalidation. The revalidation process should be a more thorough assessment of the professional's ability to practice a good standard of care drawing on appraisals and on other data. The folder or portfolio concept is an important element.

   We are particularly concerned that systems should be in place to ensure regular appraisal of agency or locum doctors who may move from one place of work to another. The organisations in which these doctors work must have some responsibility for contributing to their appraisal and be party to appraisal and other relevant information before accepting a placement. In the case of GP practices, there should be PCT involvement in the appraisal of GPs, and the PCT should have responsibility for quality assuring the appraisal of locums in GP practices.

II. We support the requirement to record experience learning and education in a personal folder / portfolio, which should be assessed as part of the appraisal and revalidation processes. As discussed below, information on complaints about the professional, adverse incident investigations involving them, clinical negligence claims and clinical outcome data should all form part of the folder of evidence for appraisal and assessment for revalidation. Royal Colleges could be asked to suggest appropriate outcome data for different specialities, and IT systems need to be developed to record such data. We support the introduction of 360 degree reporting.

III. There should be good patient and public involvement in the setting of standards by the GMC and Royal Colleges. As part of the assessment of adherence to standards there should be patient and public involvement in the quality assurance of the appraisal and revalidation processes being used, and in the process for dealing with poor practice / corrective action. Doctors' should be required to provide evidence in their folder or portfolio of systems they use to elicit patient feedback and the results from them.

IV. Information not just from complaints but also from adverse event investigations and from clinical negligence claims should be included in doctors' folders and reviewed as part of the appraisal process. The existence of complaints or claims against the doctor or involvement in adverse incidents should not necessarily be taken as evidence of poor practice. Each investigation's findings as regards the practice of the doctor are what is important, together with the doctor's ability to take on board opportunities for learning which these incidents provide.

Other points about appraisals:

We believe that crucial to the success of appraisal systems and indeed patient safety in NHS trusts is strong clinical leadership. With regard to appraisals, it is vital that the line manager conducting appraisals is able to understand issues regarding the clinical practice of the doctor, and also that they have the authority to act upon issues of concern arising from appraisals. Appraisals should not be a tick box exercise. Training is needed for those involved in appraisal and embedded in each trust's clinical governance framework.

There are particular problems for strong clinical leadership and authority for dealing with appraisals and issues arising from them in general practice whilst GPs continue to have separate contractor status.

Revalidation

V. We agree that revalidation should be about raising standards and to protect patients by ensuring that doctors are up to date and fit to practise. Continuing professional development is more the outcome of the appraisal and the responsibility of the employer.

VI. As we argue in the appendices, revalidation must be the responsibility of the licensing body – the GMC – and there are grave dangers in abdicating responsibility for revalidation or over relying on local employers / the appraisal process without proper accountability and quality assurance. Revalidation should entail a credible and detailed assessment of competence, conduct and health. The Healthcare Commission should check that proper systems are in place for appraisals and local intervention, but the GMC must itself ensure that the process it is relying upon to revalidate doctors is robust. As in original plans for revalidation, there should be patient and public involvement in the quality assurance of the process.

VII. It is important that revalidation assesses doctors' competence for the jobs they are actually doing – not the level at which they were entered onto the register. Knowledge and skills should be at least at the level required at the time of revalidation by the Royal Colleges for registration of doctors for that discipline. Amongst the behaviours and attitudes looked for, as part of the revalidation should be those described in *'Good Medical Practice'.* AvMA is particularly concerned that doctors should be assessed for personal insight to their own fallibility and their ability to see and accept when their own behaviour or practice has put patients at risk or contributed to harming them. Evidence from complaints, adverse events and claims will help assess this.

VIII. Standards should be based on those in *'Good Medical Practice'* and those set by Royal Colleges for the level of responsibility / particular type of practice which the doctor is to perform.

IX. There should be a core evidence set, which the doctor's personal folder / portfolio could be used. Our answers to other questions suggest the evidence which should be collected and assessed.

X. Failure to revalidate should lead to immediate steps to identify why revalidation has not been undertaken. If the doctor is able to provide a reasonable explanation and wishes to remain on the register they should be given a tightly defined timescale by which the process will be completed, or the GMC should take it upon itself to conduct a detailed assessment to ascertain whether revalidation is warranted or not. By definition if revalidation can not be completed, the doctor should be removed from the register.

Fitness to Practise

XI. If a doctor's fitness to practise is in question there must be speedy steps taken to protect patients and also to investigate the concerns so that doctors are not unnecessarily suspended. Fitness to practise should mean that the practice described in '*Good Medical Practice'* is consistently adhered to. Too often, 'Good Medical Practice' is taken as 'best medical practice' to be aspired to, and failure to meet the standards is not treated with the seriousness it deserves. Failure to

meet the standards should not necessarily mean striking off or suspension, but where restrictions or retraining is identified as required the monitoring of compliance with the restriction or training must be closely and robustly monitored. Where such conditions are put in place, doctors should be required to report to the GMC regularly and the GMC should also conduct 'spot-checks'.

XII. Retraining will not be an option for all doctors. Where it is, the cost of the training should be met at least in part by the doctor and where appropriate their employer. Doctors who move to other duties should have to notify the GMC and their previous record should be disclosed.

XIII. Public confidence in the GMC will only realised when the GMC's actions with regard to errant doctors is seen to be robust and consistent and when the GMC can be perceived as acting for patients rather than doctors.

XIV. A single national database should be created. Information on doctors' fitness to practise should be publicly available. Other information should be available to employers, regulators such as the Healthcare Commission and the GMC.

XV. Employers should be required to take on more responsibility for the discipline of their own employed doctors, rather than relying always on the GMC or NCAA. However, the GMC should be accessible to anyone who wishes to question the fitness of a doctor to practise and there should also be checks on employers to ensure that as well as having their own disciplinary procedures which are fit for purpose, that they *do* refer cases to the GMC when there is any suspicion of unfitness to practise.

Consideration should be given to the disciplinary procedures of NHS bodies, and in particular PCTs. This should include how they should interface with complaints, adverse events, and clinical negligence procedures. It is vital that PCTs are involved in any such investigation about GPs if they are to fulfil their clinical governance role. It is of concern that since the introduction of a new complaints procedure and abolition of the old Service Committees the number of disciplinary findings against GPs reduced to a trickle overnight. It is inconceivable that the problems that were being identified disappeared and it is not evident that they are being dealt with by clinical governance procedures.

A balance needs to be struck between the desire for less adversarial and punitive approaches and the need for rigour. Whilst it may remain desirable to separate out complaints from disciplinary procedures, there should be a transparent link. Someone lodging a complaint should have a right to know whether issues raised by their complaint are to be referred for disciplinary or fitness to practise investigations and the outcome, without compromising confidentiality of the parties involved. Members of the public would be less likely to complain directly to the GMC if they could have confidence that their concerns would be dealt with locally and that there was a direct link between

their complaint and any necessary referral to the GMC or local disciplinary action. In other words, we advocate a more joined up approach which is more user-friendly and more confidence inspiring for the public. Issues raised from a complaint, adverse events or other clinical governance monitoring or indeed a clinical negligence claim should be fully investigated locally. Any appropriate local disciplinary action should be taken locally. Where fitness to practise is in question the matter should be referred to the GMC, and any complainant should be informed of what action is to be taken.

'Clinical governance monitoring' should include any information from clinical negligence actions, whether or not a civil case is successful in obtaining damages or not, as negligence is often found in these cases if not causation as well. At present we can see no link between clinical negligence cases brought against GPs which feed into the clinical governance function of the PCT. Even in the case of NHS Trusts, this information is not necessarily captured about individuals who can move from one trust to another repeating the same errors.

XVI. We believe in there being value in some form of complaints portal as a resource for the public and advisors but believe that of greater priority is the creation of joined-up approaches as described above and the development of appropriate specialist independent advice for members of the public about complaints, safety and fitness to practice issues. At present there are only temporary, fairly inconsistent arrangements for Independent Complaints Advocacy (ICAS) in England. ICAS is restricted to the NHS complaints procedure and the temporary providers do not necessarily have the expertise , capacity or indeed remit to deal with complex clinical complaints, fitness to practise, clinical negligence or patient safety issues. Members of the public who are considering taking a complaint to the GMC (or other regulatory bodies) have no specialist independent advice provided for, nor if they go through the regulatory bodies' procedures do they have any specialist independent support provided unless that happens to be through the charitable work of bodies like AvMA or POPAN (Prevention of Professional Abuse Network).

Consideration should be given to funding appropriate agencies to provide information and advice to potential complainants to regulatory bodies, to signpost where appropriate to the most suitable procedure, and to support members of the public going through the procedures of the bodies.

XVII. We want to see a regulatory system which can be seen by patients and the public to serve them rather than the professions which are being regulated. Consideration should be given to ways in which public perception and confidence can be improved including the way in which the regulatory bodies are paid for; their lines of accountability; and the ways in which professional and lay members are appointed. The bottom line will be whether regulators can be seen to be genuinely patient centred and patient friendly, and whether appropriate action is consistently taken in cases where a professional's fitness to practice is in question.

XVIII. We have decided not to comment on the detail of the structure of the GMC and stress instead that whatever structures and roles are set should be defined by the above principles.

XIX. Protection of patients must take precedence. However, we appreciate that there are dangers for patients in an over bureaucratic system of regulation.

XX. We do not have suggestions to make here which are not already covered in our other answers.

XXI. See our answer to XVII.

Further comment:

Foreign Doctors:

We have concerns about how the system will work with respect to foreign doctors, particularly those from European countries who may have freedom to practise in the UK. How will the system of registration, and revalidation apply to them?

Viability of the approach:

Whilst firmly favour of protecting patients and improving the quality of healthcare by improving regulation and introducing revalidation, we are also conscious that such an ambitious programme will need resources if it is to work. We are concerned about the capacity of doctors to not only demonstrate continuing professional development and fitness to practise, but to play an active part in the system to appraise and revalidate others. We would like to see proposals as to how this will be addressed.

Other Health Professions:

Lastly, the same principles which apply to doctors apply to other health professionals, and we would like to see this reflected in the way they are regulated.