RESPONSE TO

"HEALTH PROFESSIONAL REGULATION: PUBLIC CONSULTATION ON PROPOSALS FOR CHANGE"

NOVEMBER 2006

1 Introduction

Action against Medical Accidents (AvMA) is the UK charity promoting patient safety and justice. AvMA celebrates its 25th anniversary in 2007. During that time AvMA has advised and supported over 100,000 people affected by medical accidents, providing an understanding and supportive response through our helpline, and advising on the options for having incidents and concerns investigated and fully explained, possibilities of obtaining redress of various forms, including some assurance that things will be made safer as a result. Our more written casework service, provided by staff with nursing / medical experience and medico-legal training provides more in depth analysis and advice on the issues and options. The safety / fitness to practise of individual health professionals is often an issue which comes up and AvMA has experience both of supporting people with concerns about health professionals through the fitness to practise procedures and of working constructively with regulators themselves, and individual health professionals, their representative bodies and the Departments of Health in the UK.

AvMA is committed to the development of a genuinely 'open and fair culture', demonstrated by the *Code of Understanding between Health Professionals and People affected by Medical Accidents,* which we developed in partnership with the professions and has found widespread support. We see modernised regulation as critical safeguarding the safety of patients and also to the development of genuinely patient centred professionalism, where we can all be confident that a licensed health professional is a *good* health professional. Much of the current consultation and therefore our response deals with fitness to practise procedures. These procedures need to be fit for purpose in order to protect patients and maintain confidence in the professions - they are not a means to deliver punishment. Wherever realistic and safe to do so, we believe that opportunities should be taken to support health professionals to achieve or re-achieve the levels of professionalism required of them.

2 OVERVIEW and ISSUES NOT COVERED IN THE RECOMMENDATIONS

AvMA very much welcomes the main thrust and the principles underpinning both *Good doctors, safer patients* and *The regulation of non-medical health professionals.* In the next section we respond, where we feel able to, to the recommendations in *Good doctors, safer patients.* We welcome the proposed reforms to provide for a re-invigorated more clearly seen as fit for purpose and focussed on patient safety above all else; and more consistency across the different regulators (although we feel some of the recommendations are inconsistent in this regard). The right for patients to take complaints about GPs to PCTs rather than the GP practice itself is also something we have consistently called for and we were glad to see the recommendation.

However, we would like to draw our attention to what we believe is a fundamental omission from *Good doctors, safer patients,* and to a lesser extent *The regulation of non-medical health professionals.* We are disappointed that the suggestions that we, other patient/consumer organisations and other stakeholders had made about the need to inform and empower patients in the process of identifying and reporting health professionals has not as yet been taken up. We also highlight below some other issues we think should be addressed whilst we have this unique opportunity for reform.

2.1 An alternative to the 'single portal' concept – empowering patients

The need for something to make it easier for members of the public to direct concerns, complaints or reports about health professionals to the right place had been widely acknowledged by most stakeholders prior to the reviews of medical and non-medical health professionals' regulation. One concept which had become quite well known was the idea of a 'single portal' for all such matters. Some stakeholders, including AvMA articulated the needs differently in their responses to the consultation preceding these reviews. Rather than a literal 'single portal' for all such issues, we pointed out the need for an easily accessible source of advice and information for people to help them consider all the options which might be appropriate to deal with their concerns if they are not sure, direct them to the right place, and support them through the process of reporting to and acting as a witness in regulators' procedures, if needed,. The Foster report makes reference to the single portal concept and says it is something still being explored by the Department of Health. Sir Liam Donaldson's report contains no reference to addressing these needs in the conclusions and recommendations**. We believe there is an overpowering case for establishing a helpline and advocacy service for people who may have concerns which may be appropriate to report to a regulator, rather than the grander project of a 'single portal',** We set out some of the main arguments for this in the appendix.

2.2 Lack of clarity over 'GMC affiliates'

We are not clear what exactly is envisaged for the GMC affiliate role and whilst we agree that if appropriately designed it could be extremely positive, we do have some concerns about what it might end up being. In particular, we would be extremely concerned if concerns about doctors had to be filtered through GMC affiliates, especially as it is envisaged that the affiliates would be practising clinicians in the same locality. In other words, they would be assessing concerns about their own colleagues without the degree of rigour, independence and lay involvement that we expect of the GMC. This is discussed further under the recommendation.

2.3 Inconsistency

Whilst we appreciate that *the regulation of non-medical health professionals* attempts to create more consistency between regulators, the recommendations in *Good doctors, safer patients* would seemingly create rather different systems. . It would be easier for members of the public as well as health professionals to understand if there was maximum consistency to the approach to the different professions

2.4 Terminology of 'Complaints'

We believe the opportunity should be taken to find a different terminology for when members of the public bring fitness to practise issues to the attention of regulators. To describe this as 'making a complaint' confuses members of the public and creates unrealistic expectations. It is not surprising that members of the public often address their general complaints, which are not about fitness to practise, to the regulators. Neither is it surprising that people are surprised to find that if a regulator does take on a case, they do not have the status and rights that a 'complainant' would normally have, and are treated as a witness. 'Complaining' also has negative connotations for some people, when in fact

members of the public should be seen as doing a public service by bringing potentially dangerous professionals to the attention of the regulatory bodies. We recommend replacing the term 'complaint' and finding a suitable alternative which better describes what regulators want and expect to receive from members of the public. Possibilities include 'reporting' concerns about health professionals' fitness to practise.

3 RESPONSES TO THE RECOMMENDATIONS in *Good doctors, safer patients*

Recommendation 1

Strong views were expressed for and against this recommendation when it was considered by AvMA's trustees. At the moment, particularly without further information on how application of a civil standard would work in practice, AvMA does not feel able to support this recommendation to move from the criminal standard to a civil standard of proof for fitness to practise issues. We feel that whatever standard is used everything possible must be done both to protect patients and to ensure justice is done.

Recommendation 2

We would need more detail about the proposed role of local GMC affiliates before we would be in a position to approve or disapprove.

However, we have some concerns about the affiliates' role in investigating and determining fitness to practise issues locally. In particular, we would be extremely concerned if concerns about doctors had to be filtered through GMC affiliates, especially as it is envisaged that the affiliates would be practising clinicians in the same locality. In other words, they would be assessing concerns about their own colleagues without the degree of rigour, independence and lay involvement that we expect of the GMC. Given the close relationship with the local employers and doctors there may be a temptation not to refer on to full GMC investigation when it is warranted. Certainly, there is a strong danger that the public will perceive the idea of not only a fellow doctor but a local practising doctor determining what happens with concerns about doctors (albeit with the unspecified lay involvement) as being less rigorous and independent as the current GMC procedures.

This might be mitigated if the affiliates were less local and less connected to the local health structures – perhaps as part of an arms length regional team. Also, there could be a right for patients who are concerned about a health professional to take the concern direct to the regulator and if they think that an affiliate has underestimated the seriousness of a concern brought to their attention, to have it reviewed by the GMC.

We do think that there is positive potential in the GMC having more local or regional affiliates who could help quality assure local processes and pick up on some case dealt with local employers that need referring on to the GMC itself (rather than acting as the gatekeeper or filter).

Recommendation 3

Further to our comments under recommendation 2, we would like to point out potentially huge implications for the NHS Complaints Procedure if the recommendations for involvement of affiliates in local complaints and the conclusion in *the regulation of non-medical health professionals that* "there should be a single investigation at local level that would provide a report and evidence for these different processes" are accepted.

AvMA firmly believes in the potential of combining investigations of fact for the purposes of various processes. However, rightly or wrongly, the NHS Complaints procedures have been driven down a route which excludes the consideration of disciplinary matters. Is it intended that this is to be reversed and patients encouraged to complain through this route even if the matter is explicitly about their concern over the fitness to practise of a health professional? If so the complaints procedure will need more radical reform. Some will perceive this as a retrograde step, as it may lead to a return to what was seen as a more adversarial system. On the other hand, it is possible to see the taking away of the possibility of sanctions from a complaint about a GP for example in the old FHS system, has led to a dangerous black hole of unsatisfactory practise going on unchecked. It is hard to believe for example that the many breaches of contract which were often found as a result of that process suddenly stopped happening when the system changed. Yet the number of disciplinary actions or recording of unsatisfactory practice plummeted.

If the local complaints procedures are to be the main way of members of the public bringing serious concerns about health professionals there has to be more empowerment of patients in the process, It is unlikely that the public would have confidence that a local system run by the doctor's employer or a PCT, where discretion as to whether further action against a doctor is necessary rests with another doctor (the affiliate), indeed a doctor who practises locally.

We are not necessarily opposed to more joined up processes, indeed we think there is great potential in the idea, but we think it merits very careful consideration.

Recommendation 4

Agree

Recommendation 5

More detail is needed on the role and status of the lay member of the public. We believe that the lay member should have equal status to the affiliate and be paid as well as provided with the appropriate training to do the job. Consideration needs to be given to what would happen if the affiliate and the lay person disagree. One suggestion is that there might be a panel of three people in total.

Recommendations 6, 7, 8, 9 10

Agree

Recommendation 11

We are not necessarily convinced there is a need to separate adjudication from the investigation role. The main rationale for doing so would appear to be to create more confidence in the independence and rigour of the adjudication. This may not be necessary if the other reforms result in a rejuvenated GMC and other regulators, which the public can have confidence in. Critical to this is the quality of investigation, which is why we think that the GMC would need robust ways of quality assuring the investigations that may take place at the local level and invest in the quality of its own investigation procedures and staff. If the decision is made to separate adjudication, then it would seem to make sense to do it for all the regulators.

Recommendation 12, 13, 14, 15, 16, 17

Agree

Recommendation 18

The key to NHS appraisal successfully linking with revalidation will be robust quality assurance. The GMC should not in effect delegate its responsibility for licensing doctors to the NHS. Lay involvement should also be included in the oversight of appraisal systems. The GMC affiliates should have a role in quality assurance.

We believe that more attention needs to be paid to non-NHS doctors and health professionals, who are becoming far more common under the current policies. There must be more consistency across Europe and the GMC and other regulators need powers and flexibility to deal with health professionals from other European states and other countries.

Recommendation 19

We are not convinced of the merits of this recommendation. It would appear to be logical for the GMC to retain these roles.

Recommendation 20

AvMA agrees with this recommendation, but would like to add that it should also be made a requirement for providers of healthcare outside the NHS to ensure that doctors they contract have successfully completed an assessment of English language proficiency in the context of clinical practice (not just a matter of 'good practice' as the document states. This is particularly important in the current environment of more and more treatment being shifted to independent providers.

Recommendation 21

AvMA strongly agrees with this recommendation. We have previously raised concerns about the need to ensure that the public can expect doctors from overseas to meet the same standards as any doctor approved by the GMC. Steps also need to be taken to ensure that the same principle applies to nurses and other health professionals.

Recommendation 22

We are not clear of the perceived benefits of taking the PLAB tests away from the GMC. After all, they are the body who have to decide whether or not to issue a licence.

Recommendation 23, 24, 25, 26, 27,28, 29, 30, 31

Agree

Recommendation 32

If doctors fail to meet the requirements and concerns arise or come to light about fitness to practise, a referral to the GMC procedures for consideration of more serious action such as an interim order should be made.

Recommendation 33, 34,35, 36, 37, 38

Agree

Recommendation 39

We recommend that 'warnings' made as a result of fitness to practise procedures as opposed to 'recorded concerns' and previous restrictions made as a result of fitness to practise procedures should also be freely available to the public from the register.

Recommendation 40, 41, 42, 43, 44

We agree with these recommendations.

We would go further in the interests of giving the GMC a fresh start and producing an organisation which commands the confidence of the public. The composition of the Council should contain a majority of lay people. The whole council should be invited to re-apply and a new council appointed. This is not a criticism of the present council, who we feel have driven forward a commendable process of reform already. More, it is in recognition that the GMC needs to be seen to be as well as be reborn and reinvigorated in a form more fitting to its modern role.

APPENDIX: THE CASE FOR PATIENT EMPOWERMENT - AN ATERNATIVE TO THE "SINGLE PORTAL"

We believe the case is for making provision for a national helpline and advocacy service is overpowering. Several people within the regulators we have spoken to agree the need and certainly patients / consumer groups do. At a recent meeting of the GMC's Patient & Public Reference Group strong support for the principle was expressed both by patient representatives and council members present. In summary, here are some of the main arguments for the creation of such a service:

- In the experience of groups such as WITNESS and AvMA, many people with potential complaints which might have a bearing on whether a health professional is fit to practise without any restriction do not report their concerns to the regulator concerned. One of the reasons for this is that the process is so daunting. Consequently there can be unnecessary delay in identifying dangerous health professionals, if they are identified at all.. The availability of specialist advocacy support for vulnerable patients would improve patient safety by giving patients the confidence to report, helping ensure such cases come to the attention of regulators, and supporting patients through the harrowing experience of the fitness to practise procedures. Whilst some regulators have developed good practice in dealing with members of the public, they have to remain neutral and this can not substitute for independent advocacy and support which would enjoy the confidence of patients.

- Some cases which should really be reported to regulators are not simply because the patient concerned does not understand the system or know where to direct such concerns. Regulators also report considerable numbers of 'complaints' being made to them when they are not really about fitness to practise issues and would be more appropriately dealt with elsewhere such as through local complaints systems, another regulator, as part of a clinical negligence legal action, and/or a report to the National Patient Safety Agency. The availability of a national (UK) helpline staffed by specially trained staff and/or volunteers would help ensure patients made well informed decisions about which processes are most appropriate for their case. This would not only help patient safety and avoid the considerable frustration and loss of confidence which patients experience when they are 'bounced' from one body to another, but would also help save considerable resources for regulators who have to assess every report which comes to them, often only to refer to another body.

- The availability of specialist advice to help patients formulate their complaint/report to regulators would also both reduce the strain on the patient, and also make it easier for regulators to assess reports made to them.

- At the moment there is no similar service funded in any part of the UK (although some patients groups, including ours, do a little of this kind of work paid for by our own charitable fundraising). Ironically, there are sources of advice and support funded for general complaints through the NHS complaints procedures in each of the nations, which include important but not critically important issues

such as rudeness, waiting times, quality of food etc., but no funding is provided specifically to help vulnerable patients with serious complaints about the safety of health professionals. CHCs in Wales, ICAS in England, CABx in Scotland and Health & Social Service Councils in Northern Ireland are all restricted to their particular country and, in most cases to the NHS complaints procedure. It is not within their formal role nor do they have the resources or expertise necessarily to advise on all the options or support vulnerable patients through the regulators' processes.

- The provision of a specialist helpline and advocacy service need not be expensive and would both result in some savings for regulators and increased patient safety and public confidence. Ideally the service could be provided across the UK, which would help address cross border issues. Alternatively it could be provided on a country by country basis. The critical issues are that the providers should both be independent and have appropriate expertise and experience in this area. There is potential for this approach to dovetail with other initiatives in an even more cost effective way. For example, in England, the NHS Redress Bill makes provision for assistance to individuals with the forthcoming NHS Redress Scheme. The helpline & advocacy service proposed above could play a pivotal role with that scheme also. There are a number of existing voluntary organisations who either individually or collectively as part of a consortium / partnership could build on their existing expertise to provide such services in an economical way rather than 're-inventing the wheel'. The service should be specified and openly tendered for.