FIPO
federation of independent practitioner organisations

HEALTHCARE PROFESSIONAL REGULATION

Good doctors, safer patients

PUBLIC CONSULTATION ON PROPOSALS FOR CHANGE

Response by

The Federation of Independent Practitioner Organisations

November 2006

Executive Summary

The Federation of Independent Practitioner Organisations (FIPO) represents specialist professional organisations in the UK involved in the provision of healthcare in the independent sector.

The Healthcare Commission regulates hospitals and doctors in terms of the Care Standards Act to a far greater degree than in the NHS. By their inspections and detailed analyses of clinical audit data they add a robust control to all aspects of medical practice and the process of governance that (currently) only occurs in the independent sector.

Where a practitioner's livelihood is at stake, there must be a high level of confidence that the accusations levelled against the doctor are proven.

The GMC's role in investigating complaints and concerns about a practitioner should be extended to the local level, by the universal establishment of effective clinical governance procedures. The introduction of GMC affiliates to the independent sector would be a retrograde step.

The concept of a 'recorded concern' could, in our view, undermine the necessary co-operation between personnel undertaking a local clinical governance function and doctors against whom concerns have been raised.

Complaints management should be separate from the clinical governance role so that judgments made about a doctor's performance, and any requirement for further action utilizes information gleaned from the complaint process to inform those decisions.

NHS appraisal does need to be standardised and regularly audited but the appraisal also needs to take note of practice outside the NHS.

FIPO agrees that professional and linguistic proficiency are pre-requisites to good medical care.

To avoid further delay in the introduction of revalidation, FIPO suggests that the GMC's current proposals for revalidation are accepted as an interim measure with a longer term aim of introducing re-licensure and recertification as suggested in the CMO's report.

FIPO recommends that the concept of 360 feedbacks is abandoned for medical practitioners and the appraisal system constructed to allow for the introduction of feedback that is both available and reliable.

FIPO agrees that specialist re-certification should be renewed at intervals of no longer than five years

Care must be taken to ensure that any information to be made available publicly is properly explained to all those having access to it.

The Medical Register should be the key national list of doctors entitled to practice in the United Kingdom, and each doctor on the Register should have a unique and permanent identifier.

The GMC should be accountable to parliament.

Introduction

The Federation of Independent Practitioner Organisations (FIPO) represents the following specialist professional organisations in the UK involved in the provision of healthcare in the independent sector.

Association of Anaesthetists of Great Britain & Ireland
Association of Coloproctology of Great Britain & Ireland
Association of Independent Radiologists
Association of Surgeons in Training
Association of Surgeons of Great Britain and Ireland
British Association of Otorhinolaryngologists - Head & Neck Surgeons
British Association for Surgery of the Knee
British Association of Plastic, Reconstructive and Aesthetic Surgeons
British Hip Society
British Orthopaedic Association
British Orthopaedic Trainees Association
FIPO - National Medical Advisory Committee (FIPO Nat-MAC)
Hospital Consultants and Specialists Association
London Consultants' Association
Society of British Neurological Surgeons
Sussex Association of Consultants
UK & Ireland Society of Cataract and Refractive Surgeons

In preparing this response on behalf of the FIPO membership, there has been wide consultation with a large number of independent sector hospital providers.

Formed in 2000, FIPO is committed to:

- promoting the highest standards of patient centred care;
- promoting clinical governance in the independent sector,
- providing advice and guidance to specialist associations, and,
- working constructively with all independent hospital providers and medical insurance companies constantly to improve standards of healthcare provided within the sector.

Through its National Medical Advisory Committee (NAT-MAC), FIPO provides professionally structured advice to assist MAC chairs in their statutory functions, and has produced guidelines for use in the independent sector, with input from the General Medical Council, medical defence organisations, hospital providers and the Healthcare Commission. These Guidelines are included with this submission together with another FIPO document which lays out the Rights and Responsibilities of Patients within the Independent Sector.

In 2006, FIPO established its Clinical Governance Advisory Committee (FIPO CGAC), an expert body providing a national professional interface and clinical guidance to the independent sector (Medical Advisory Committees, hospitals, governance personnel and consultant groups) on relevant topics, including: data collection, audit, trend analysis, national guidelines and their interpretation, benchmarking performance according to professional databases and comparative patient satisfaction scores. Through CGAC, FIPO liaises with all relevant bodies including the General Medical Council, Healthcare Commission, Medical Defence Associations, Royal Colleges and Specialty Associations and other interested professionals, and with independent hospital providers and their medical advisory committees.

Preamble

In responding to the Department of Health's consultation document on healthcare professional regulation, FIPO has concentrated on the application of the Chief Medical Officer's recommendations to the independent sector.

FIPO concurs with the CMO's notion of medical regulation being directed at ensuring that patients and everyone involved in the delivery of healthcare can expect the doctors involved in that process to be good doctors. Consequently, regulation cannot solely be the responsibility of the General Medical Council. It must involve appropriate local bodies.

In the acute independent hospital sector, clinical governance procedures are efficient and robust, based on close liaison between Medical Advisory Committee (MAC) Chairman, the MAC itself and the hospital Chief Executive.

This system was established because of the stringent requirements of the Care Standards Act which is implemented rigorously by the Healthcare Commission. The Act clearly sets out the responsibilities of the MAC Chairman (who is *de facto* a "Medical Director" although not employed by the hospital). The CEO carries the ultimate responsibility for the standards within his/her hospital but the MAC Chairman is required to advise the CEO on all professional issues. In most small hospitals the Clinical Governance role is carried out by the MAC Chairman but in larger hospitals there is commonly a separate Clinical Governance lead clinician, who sits on a Governance and Risk Management Committee. This committee filters and co-ordinates any complaints or incidents. Ultimate responsibility, however, lies with the hospital Chief Executive who must take professional advice from the MAC Chairman and the MAC.

There are substantial differences between the independent sector and the NHS in terms of the type of work performed. In the independent sector there is no Accident and Emergency service, far less paediatrics and obstetrics (apart from some selected and approved hospitals), fewer acute admissions and fewer social problems. The operations and care are provided by consultants. Responsibilities and accountability are more clearly delineated and accepted within the independent sector as it is a consultant based and led service. This leads to a simpler system than pertains in the NHS.

Governance in the independent sector is of a high standard supported by well developed IT systems and regular clinical governance review based on available data. The clinical performance indicators that are now required to be submitted to the Healthcare Commission have been routinely captured for some years. Whilst these are generic at the hospital level and not risk adjusted, the manner by which they are captured ensures that performance at both speciality and individual consultant level is closely monitored in a timely fashion. This enables robust clinical governance that is evidence based.

It should be stressed that the Acute Independent Sector has proved that it can act in the event of clinical problems by a variety of means including suspension or partial suspension of practising privileges, internal and external reviews, referral to the GMC and by the appropriate retraining of individuals. Two brief examples serve to illustrate this:

Example 1

Laparoscopic bowel injury during gynaecological procedure followed by immediate suspension of laparoscopic privileges by MAC Chairman. Internal specialist review by Medical Advisory Committee. External specialist review requested from nominees of the relevant Royal College. Consultant recommended for retraining under Royal College supervision. Practising privileges withdrawn to the private hospital. Re-training completed and consultant re-certified by Royal College assessment panel. Consultant then returned to duty with limited laparoscopic privileges and under close supervision by nominated senior colleague acting as mentor. Healthcare Commission informed. GMC informed and following their initial review, no further action was required.

Example 2

Three complications from bowel surgery over a one-year period raised the question of whether this was a trend or a statistical aberration. A full external review of all complications by a Royal College of Surgeons nominee gave a clear report and that the surgeon was practising within normal and "acceptable" complication rates.

FIPO is aware of the changes introduced by the General Medical Council to its constitution, fitness to practise procedures and other aspects of its work, and agrees with the CMO's conclusion that local (hospital based) and central (GMC) procedures should be integrated to from a spectrum of procedures, which are speedy, proportionate and appropriate to the circumstances.

FIPO also agrees that public and professional confidence in the procedures in place is essential.

Against that background, FIPO and the independent hospital providers named above, offer the following observations on specific recommendations and groups of recommendations pertinent to the independent sector.

Recommendation 1

In adjudicating concerns about a doctor's performance health or conduct, the standard of proof should be the civil standard rather than the criminal standard.

It is imperative that all concerns relating to a doctor's fitness to practise are investigated thoroughly. Where a practitioner's livelihood is at stake, there must be a high level of confidence that the accusations levelled against the doctor are proven, and we do not believe this to be achievable through application of the civil standard of proof.

Recommendation 2

The General Medical Council's role in investigating concerns or complaints about a doctor's standards of care or conduct should be extended to a local level by the creation of medically qualified licensed General Medical Council affiliates within each organisation (or group of organisations) providing healthcare.

We agree that the GMC's role in investigating complaints and concerns about a practitioner should be extended to the local level, by the universal establishment of effective clinical governance procedures. Effective procedures are already in place, in the independent sector (as described above).

The present culture is not one of "name and shame" but one which encourages participation and transparency. The Acute Independent Sector has proved that it can act in response to significant clinical problems by a variety of means (suspension or partial suspension of practising privileges, internal and/or external reviews, referral to the GMC and by the appropriate retraining of individuals).

Introducing GMC affiliates to the independent sector would be a retrograde step, with doctors being less open to discussing concerns and immediate remedial action, if they believe that doing so could result in a 'recorded concern' being placed on their registration. Consequently we believe that the introduction of GMC affiliates, within the independent sector, will prove detrimental rather than useful, both in quality assurance and in promoting public confidence.

Recommendation 3

General Medical Council affiliates should be authorised to deal with some fitness to practise cases locally (according to detailed guidelines and definitions) and refer cases at the more severe end of the spectrum to the General Medical Council centrally. Affiliates should have the power to agree a 'recorded concern' (but not to impose sanctions affecting registration). The affiliate should inform a doctor's employer or contracting organisation and any complainant when a 'recorded concern' is accepted. 'Recorded concerns' should be reported to the General Medical Council centrally for collation

The concept of a 'recorded concern' could, in our view, undermine the necessary co-operation between personnel undertaking a local clinical governance function and doctors against whom concerns have been raised. If this proposal were adopted, the doctor could refuse to agree a 'recorded concern', but (under Recommendation 4) that would simply mean the matter was referred on to the GMC, which then focuses the debate on the fairness of the judgment made on the doctor's fitness to practice and the validity of the evidence on which that judgment was made, as opposed to the constructive dialogue to address issues as currently exists in the independent sector.

FIPO believes that the notion of 'recorded concerns' inevitably introduces an adversarial element, which will promote defensiveness on the part of respondents.

Recommendation 5

Each General Medical Council affiliate should be paired with a member of the public, who should be trained in regulatory and disciplinary procedures. Together, they should operate as part of a wider team within each organisation. This team should include existing complaints management staff and should have administrative support.

FIPO does not support he proposal to introduce GMC affiliates, or the recommendation to pair each GMC affiliate with a member of the public. Whilst this may be superficially appealing, we question whether this is a recipe for success. The majority of the issues being considered will be directly related to medical care in one form or another and consequently a medically qualified individual will have to take the lead in decision making. In the independent sector this is the job (the statutory responsibility) of the MAC Chairman, supported by the Medical Advisory Committee, the hospital Chief Executive and perhaps other members of staff. The requirements of the regulator (The Healthcare Commission) have to be met and this provides another layer of control that is more

stringent than the NHS. We question what external lay people, with no previous experience in the field, can bring to the process.

Recommendation 6

A national committee should routinely review all 'recorded concerns' entered on the Medical Register. This committee should be able to discuss individual cases with the relevant General Medical Council affiliate if necessary and, in exceptional circumstances, may choose to refer a practitioner for further assessment or investigation.

It is impossible to know in advance how many recorded concerns might be entered against the names of doctors on the Medical Register, if this proposal were accepted. But the idea that a national committee (possibly external to the GMC) should routinely review all these concerns and be able to discuss individual cases with the relevant affiliate and, in some cases, refer the practitioner for further assessment and investigation seems unnecessarily centralist and bureaucratic. The key to effective governance is speedy examination of the facts surrounding an adverse event and empowerment of competent locally based individuals to take appropriate action, with prompt referral to the GMC in serious cases.

Recommendation 7

Each healthcare organisation should identify, and bring to the attention of the relevant General Medical Council affiliate, those complaints that raise concerns about the performance or conduct of a specific doctor.

This recommendation speaks about complaints that raise concerns about the performance or conduct of a specific doctor being brought to the attention of the relevant affiliate. The recommendation does not address the question of who would make the judgment that the complaint does in fact raise a concern about performance or conduct. We suggest that it is inappropriate for there to be a pre-affiliate screening process by an individual or individuals, who have not been properly trained and could, therefore, prevent transfer of important information to the affiliate who cannot take appropriate action unless armed with all necessary information.

Recommendation 8

Recommendation 8 applies to general practice, a field which lies outside FIPO's area of expertise.

Recommendation 9

General Medical Council affiliates, together with the complaints management staff of the organisation, should offer to meet with individual complainants (where appropriate) to address their concerns about specific doctors, explaining any actions taken, or the reasons for apparent inaction. Individual doctors may be required to attend such conflict resolution meetings at the discretion of the General Medical Council affiliate.

This recommendation foresees GMC affiliates meeting individual complainants and justifying what has or has not been done as a result.

FIPO believes that complaints management should be separate from the clinical governance role so that judgments made about a doctor's performance, and any requirement for further action is founded on information gleaned from the complaint process to inform those decisions.

To embroil doctors charged with clinical governance functions in day to day complaints handling, places too great a burden upon them and could result in the individual being forced into action that was not appropriate on objective analysis.

Recommendation 10

The General Medical Council should establish rigorous training, accreditation and audit for affiliates, along with comprehensive arrangements for their support in carrying out these functions.

FIPO regards proper training and support of MAC Chairmen as an essential pre-requisite to working effectively in this role, and should the concept of the GMC affiliates be progressed would regard rigorous training, accreditation and audit as a clear necessity. As matters stand through FIPO Nat-MAC, FIPO already offers Guidelines, training and support to MAC chairmen. This role is enhanced by the co-operation of the independent hospital providers.

Recommendation 11

In serious fitness to practise cases, which cannot be dealt with by local regulatory action, investigation and assessment should be carried out by the General Medical Council but formal adjudication should be undertaken by a separate and independent tribunal (with legal, medical and lay representation). Doctors and the General Medical Council should have the right of appeal against the decision of the independent tribunal to the High Court.

More detail is required on this proposal before a full response can be given. It is essential that any tribunal deciding fitness to practise issues has the requisite expertise and access to expert evidence to make valid judgments.

Recommendation 12

The Healthcare Commission and the Parliamentary and Health Service Ombudsman should be able to require the General Medical Council to assess or investigate an individual doctor's performance, health or conduct. These bodies should also be authorised to investigate and bring doctors before the independent tribunal in exceptional circumstances.

If the Healthcare Commission and Parliamentary and Health Service Ombudsman are to be empowered to require the GMC to assess or investigate an individual's performance, we fail to see the need to introduce a separate power for these bodies to bring doctors before the proposed independent tribunal through an alternative route.

Recommendation 13

During its assessment of a practitioner whose fitness to practise has been called into question, the General Medical Council should make full use of the expertise of the National Clinical Assessment Service.

Recommendation 14

The National Clinical Assessment Service should further develop methodologies for the assessment of practitioners with mental health and addiction problems. The NHS should commission a specialised addiction treatment service.

Recommendation 13 refers to the national Clinical Assessment Service which currently deals only with doctors working within the National Health Service and Independent Sector Treatment Centres (ISTCs) treating NHS patients. If NCAS is to be involved in fitness to practice cases via the General Medical Council, then it will be necessary to expand NCAS's remit to include doctors working within the independent sector, and ensure adequate resourcing to avoid delay.

FIPO endorses the recommendation that NCAS should develop further methodologies for assessment of practitioners with mental health and addiction problems and that a specialised addiction treatment service should be commissioned. The service should be open to all doctors whether working in the independent sector or the NHS.

Recommendation 15

In managing cases where fitness to practice has been called into question but which cannot be dealt with locally through a 'recorded concern', the General Medical Council centrally should have the power to specify packages of rehabilitation and conditions on practice, following a comprehensive assessment. Cases should be brought before the independent tribunal only where a practitioner is uncooperative, where such measures have failed to remove serious risk to patients, or where specified serious misconduct has occurred. Arrangements for making interim orders concerning a registrant's practice where urgent action is required should remain in place. The Council for Healthcare Regulatory Excellence should review the handling of such cases, and refer for adjudication before the independent tribunal any for which it is considered that more serious sanctions were appropriate.

In principle, FIPO agrees with the concept of the GMC having the power to specify packages of rehabilitation and conditions on practice without reference to the Independent tribunal.

Recommendation 16

A clear, unambiguous set of standards should be created for generic medical practice, set jointly by the General Medical Council and the (Postgraduate) Medical Education and Training Board, in partnership with patient representatives and the public. These standards should be adopted by the General Medical Council and made widely available. They should incorporate the concept of professionalism and should be placed in the contracts of all doctors.

Recommendation 17

A clear and unambiguous set of standards should be set for each area of specialist medical practice. This work should be undertaken by the medical Royal Colleges and specialist associations, with the input of patient representatives, led by the Academy of Medical Royal Colleges.

Setting unambiguous standards for generic medical practice is something which has already been undertaken by the General Medical Council through the publication of *Good Medical Practice*. Those standards already include a requirement to keep up to

date and where supplemented by further standards set down by the Colleges and specialist associations, and insofar as the independent sector is concerned, FIPO's own guidelines, offer a focussed and comprehensive set of guidelines for Medical Advisory Committee doctors in most areas of practice.

Furthermore, the GMC and other bodies involved in publication of guidance to doctors consult widely on draft text before publication and we do not see that recommendations 16 and 17 would substantially improve the current situation.

Recommendation 18

The process of NHS appraisal should be standardised and regularly audited, and should in the future make explicit judgements about performance against the generic standards, as contained within the doctor's contract.

Like many areas of the report and its recommendations, the reference in this recommendation is specifically on the National Health Service, ignoring the increasingly important part paid by the independent sector in the provision of healthcare for both NHS and privately funded patients. NHS appraisal does need to be standardised and regularly audited but the appraisal also needs to take note of practice outside the NHS.

Where doctors have a mixed NHS and private practice a requirement should be placed upon individual practitioners to provide data on work undertaken in the Independent sector, so that the appraisal can be a whole practice appraisal and not simply based upon the doctor's NHS practice.

For those practitioners operating exclusively in the independent sector, a whole practice appraisal should be undertaken on an annual basis by a medically qualified appraiser with suitable training and experience to conduct that appraisal competently. A certificate of appraisal should then be issued to the appraisee.

Following appraisal, the doctors' certificate of appraisal should be presented to the Chief Executive of all hospitals in the Independent sector where that doctor has admitting privileges as required by the Care Standards Act.

Recommendation 19

The role of the General Medical Council to set the content of the medical undergraduate curriculum and to inspect and approve medical schools should be transferred to the Postgraduate Medical Education and Training Board (whose name should be changed accordingly).

This is not an issue on which directly affects the independent sector although it can be envisaged that more teaching and training will take place in the private sector. FIPO sees no need to alter the present structure and accountability for undergraduate training in medicine.

Recommendation 20

Any organisation contracting with doctors to provide services to NHS patients should ensure that all doctors have successfully completed an accredited assessment of English language proficiency in the context of clinical practice. The content of this examination should be approved by the (Postgraduate) Medical Education and Training Board.

Recommendation 21

A formal opinion should be sought in Europe as to the legality of the introduction of a standardised national examination as a requirement for initial registration with the General Medical Council (in addition to the clinical and other examinations necessary to obtain a university medical school degree within the European Economic Area). This examination would include assessment of both English language proficiency and clinical knowledge, and would be taken by all doctors seeking provisional or full registration, irrespective of their place of primary qualification.

Recommendation 22

Responsibility for the Professional Linguistics Assessment Board (PLAB) examination should pass to the (Postgraduate) Medical Education and Training Board. It is likely that the clinical components of the examination will be commissioned and delivered through United Kingdom medical schools.

FIPO agrees that professional and linguistic proficiency are pre-requisites to good medical care.

Recommendation 23

This refers to student registration, which is not an issue FIPO feels competent to comment upon.

Recommendation 24

All doctors wishing to work in the United Kingdom should be registered with a healthcare organisation that has a General Medical Council affiliate. In addition, all agencies involved in the placement of locum doctors should be registered for this purpose with the Healthcare Commission and be subject to the standards operated by it.

Recommendation 25

At the conclusion of every locum appointment, the contracting organisation should be required to make a brief standardised return to the relevant General Medical Council affiliate, providing feedback on performance and any concerns.

Recommendation 26

The process of revalidation will have two components: first, for all doctors, the renewal of a doctor's licence to practise and therefore their right to remain on the Medical Register ('re-licensure'); secondly, for those doctors on the specialist or GP registers, 're-certification' and the right to remain on these registers. The emphasis in both elements should be a positive affirmation of the doctor's entitlement to practise, not simply the apparent absence of concerns.

FIPO notes the proposal to introduce re-licensure and re-certification to complete the process of revalidation.

As far as we understand it developing re-certification procedures is likely to take the Royal Colleges and Specialist Associations some time, and it may be several years before appropriate procedures are in place.

To avoid further delay in the introduction of revalidation, FIPO suggests that the GMC's current proposals for revalidation are accepted as an interim measure with a longer term aim of introducing re-licensure and re-certification as suggested in the CMO's report.

If re-licensure and re-certification is to go ahead at this stage, we would like to see more detailed proposals on exactly how this will work in practice before providing further comment. The issue here is about practicability and the need to balance patient safety against the administrative burden of collecting data which, in most instances, fails to shed any further light on the doctor's fitness to practice.

The costs for practitioners associated with this proposal also require careful consideration.

Recommendation 27

As doctors approach retirement, they should be invited to a review with their General Medical Council affiliate, where registrant and affiliate should decide together whether a further five-year period of re-licensure is desirable and appropriate. The idea of maintaining a register of retired doctors (to extend beyond such a five-year period) should be considered in more depth: a working group should be established to examine this area and to establish which professional privileges should be permissible for those on such a register. In particular, the safety and desirability of the proposal to allow retired doctors to issue private prescriptions for a limited and defined range of medicines should be considered.

Many doctors will seek to run down their clinical practice over a number of years rather than opting for a specific retirement date, ceasing medical practice altogether. Some may retire from the NHS but continue in private practice. From this standpoint, the concept of a doctor being asked whether a further period of re-licensure is appropriate is one that many doctors will find impossible to determine. Many doctors will wish to keep their options open. Where there are concerns, those responsible for clinical governance should address those concerns at the time. If they are so comprehensive as to warrant a cessation of practice measures must be put in place to achieve this. Short of such concerns being present, it is questionable whether raising the question of retirement in the way envisaged in this recommendation is appropriate or desirable. However, we would support the establishment of a working group to examine this area in more depth.

Recommendation 28

The re-licensing process should be based on the revised system of NHS appraisal and any concerns known to the General Medical Council affiliate. Necessary information should be collated by the local General Medical Council affiliate and presented jointly as a confirmatory statement to a statutory clinical governance and patient safety committee by the chief executive officer of the healthcare organisation and the General Medical Council affiliate. The chairman of this committee should then submit a formal list of recommendations to the General Medical Council centrally.

Again, this recommendation refers to the NHS system and ignores the substantial contribution made by the independent sector to healthcare delivery. What is required here is an integrated approach between those responsible for clinical governance locally, in the NHS and independent sector institutions.

It is suggested that the Chief Executive and GMC affiliate jointly present a statement to the statutory clinical guidance and patient safety committee, which will then furnish the GMC with a list of its recommendations. This is unnecessarily bureaucratic, particularly where doctors work across a number of NHS and independent organisations.

As an alternative, we would suggest the appointment of a lead individual whose responsibility is to liaise with responsible persons in other organisations and then furnish a recommendation direct to the GMC. This is a role that FIPO CGAC could undertake on a regional or national basis.

Recommendation 29

When a practitioner changes employer or contracting organisation between re-licensure cycles, the previous General Medical Council affiliate should provide a standardised record outlining the practitioner's current position in relation to the elements contributing to re-licensure. In addition to any other professional references sought, prospective employers should ensure that such a record is obtained in a timely fashion.

We believe that this would be a useful and relatively simple process to implement.

Recommendation 30

An independent organisation should be commissioned to design and administer the 360-degree feedback exercise required for appraisal and licence renewal.

360 degree appraisal requires skilled and informed interpretation if it is to be effective. We question whether the investment required to introduce 360-degree feedback for all doctors seeking re-licensure and re-certification is necessary when adequate feedback can be gained from trained appraisers with access to data about the doctor at the time of the appraisal.

360 degree appraisal is a very time consuming business for those providing feedback on the individual concerned, and that information must then all be collated and interpreted. The system works best with facilitated feedback and we doubt whether this would be logistically possible for the large number of doctors for whom this would be necessary

FIPO therefore recommends that the concept of 360 feedback is abandoned for medical practitioners and the appraisal system constructed to allow for the introduction of feedback that is available and reliable.

Recommendation 31

Specialist certification should be renewed at regular intervals of no longer than five years. This process should rely upon membership of, or association with, the relevant medical Royal College, and renewal should be based upon a comprehensive assessment against the standards set by that college. Renewal of certification should be contingent upon the submission of a positive statement of assurance by that college. Independent scrutiny will be applied to the processes of specialist re-certification operated, in order to ensure value for money.

FIPO agrees that specialist re-certification should be renewed at intervals of no longer than five years but this recommendation can only be implemented once the Royal College or specialist association has set the required standards which, in many instances, can only be developed after detailed discussion within the relevant body and outside consultation.

Recommendation 32

Where doctors fail to satisfy the requirements of either element of revalidation, they should spend a period in supervised practice or out of practice, prior to assessment, in order that a tailored plan of remediation and rehabilitation may be put in place.

Where doctors fail to revalidate, appropriate remediation and rehabilitation processes must be in place for doctors working in the NHS and the independent sector.

Recommendation 33

A wide and inclusive clinical audit advisory group should be formed nationally to drive the further development of local and national clinical audit programmes, yielding publicly available information to accelerate improvement in practice and service delivery.

Information is key to making any choice but for that choice to be valid, the information on which it is based cannot be open to misinterpretation. FIPO agrees that developing local and national clinical audit programmes is useful, but care must be taken to ensure that any information, to be made available publicly is properly explained to all those having

access to it. FIPO CGAC (Clinical Governance Advisory Committee) exists to develop this role in the independent sector.

Recommendations 34, 35 and 36

These recommendations apply to general practice and therefore FIPO offers no comment.

Recommendation 37

This applies predominantly to the NHS and therefore FIPO offers no comment.

Recommendations 38

The Medical Register should be the key national list of doctors entitled to practise in the United Kingdom and should contain tiers of information (some publicly available, others available with restricted access) about each doctor and their standard of practice. The new Medical Register should be a continuously updated electronic document that would over time subsume a number of other lists and registers currently in place, including primary care performers lists, which should cease to be a statutory requirement.

Recommendation 39

The Medical Register held by the General Medical Council should contain two tiers of information: that which is freely available to the public and that which is secure, with access limited to the individual registrant, General Medical Council affiliates and approved employers and contracting bodies. The following information should be freely available: registration status; date of expiry of licence to practise; specialist certification or inclusion on the GP register and date of expiry of the same; any interim restrictions on practice in force; and any substantive restrictions in force. The secure tier of information should include full demographic information (including electronic contact details), the fact that an investigation by the General Medical Council is in progress if that is the case, and any 'recorded concerns'.

Recommendation 40

Each doctor on the Medical Register should be given a unique and permanent identifier. Those doctors who wish to gain full registration without having previously held student and provisional registration should be required to submit written references from all their previous medical regulators. They may also be required to attend for interview.

We agree that the Medical Register should be the key national list of doctors entitled to practice in the United Kingdom.

If two tiers of information are to be applied, in general we agree with the proposals set out in Recommendation 39. Full access to both tiers should be available to the relevant Executive at private sector hospitals.

FIPO further agrees that each doctor on the Register should have a unique and permanent identifier.

Recommendation 41

Systems should be developed such that when a patient switches registered doctor without changing their address, that patient is offered a confidential interview with a member of staff from the primary care trust, at a place of their choosing.

This applies to general practice and therefore FIPO offers no comment.

Recommendation 42

The primary role of the members of the General Medical Council should be the appropriate corporate governance of the organisation. This role is one of accountability for the quality of services delivered by the organisation in respect of: registration functions; the maintenance of accurate, up-to-date information; the investigation and prosecution of fitness to practice cases; the operation of the devolved system of licensed affiliates; the oversight of revalidation, and the effectiveness of working arrangements with partner organisations.

Recommendation 43

The composition of the General Medical Council should be changed to reflect its new responsibilities. It should become more 'board-like'. Its members should be independently appointed by the Public Appointments Commission, and its President elected from amongst those members.

Recommendation 44

The General Medical Council should be accountable to Parliament, to which it should be required to present a detailed annual report.

If the functions of the General Medical Council are to be radically altered as envisaged within these recommendations, we agree that its composition and constitution will require review. We agree that the GMC should be accountable to parliament.

Further consultation

Representatives of FIPO would be pleased to expand on any of the responses provided within this response or related topics and is keen that the important and increasing role that the independent sector pays in healthcare delivery to both private and NHS patients is fully reflected in the proposals for change in healthcare professional regulation.

Geoffrey Glazer MS FRCS FACS
Chairman of FIPO
8th November 2006