To consider

The Shipman Inquiry: The Fifth Report

Issue

1. Implications for the GMC of the fifth report of the Shipman Inquiry.

Recommendations

2. Council is invited to:

   a. Endorse the approach we should take to the fifth report, as described in this paper (paragraphs 19-22).

   b. Agree that the planned post implementation review and evaluation of the governance reforms should be brought forward and undertaken as soon as possible, in order that the outcome can be taken into account as part of the CMO’s review (paragraphs 26-36).

   c. Agree that, as a matter of principle, there should be a complete separation of governance and caseworking functions within fitness to practise (paragraphs 38-39).

   d. Agree that the Registration Committee should consider the implications for separating completely casework and governance functions within registration (paragraphs 40-42).

   e. Agree that the Fitness to Practise Committee should consider recommendations in the fifth report regarding fitness to practise which have not already been implemented, and identify any further work that we need to undertake in consultation with others (paragraphs 47-64).

   f. Consider the preliminary analysis of the fifth report in this paper (paragraph 65-75).

Further information

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Background

4. The fifth report of the Shipman Inquiry – *Safeguarding Patients: Lessons from the past – Proposals for the Future* – was published on 9 December 2004. The report is in three volumes comprising over 1,250 pages and it contains 109 recommendations. The remit of the Inquiry covered primary care in England only. Nevertheless, as the report makes clear (and the Government have acknowledged) the report has implications for the regulation of all doctors and, in some respects, for the regulation of professional groups in healthcare generally.

5. The recommendations are listed in full at Annex A to this paper in a table which also contains, in respect of each recommendation relevant to the GMC, preliminary observations on the status of the recommendation in the light of any work which has been undertaken, is ongoing, or is envisaged. As will be apparent from the table, the majority of the recommendations that directly impact upon the GMC reflect current GMC policy.

The Government’s response to the fifth report

Statement by the Secretary of State

6. On 9 December 2004, immediately following publication of the report, the Government issued a written statement from the Secretary of State. The statement referred to the work which the Government had recently undertaken in partnership with the profession and others to strengthen medical regulation, the complaints procedures, and to develop clinical governance, and said that the Government was pleased that Dame Janet Smith had recognised the progress that had been made. The statement said that Dame Janet’s recommendations built upon that work, but reflected her concerns that, in some areas, there had been insufficient change to safeguard patients appropriately. The statement said that some of the recommendations made by Dame Janet would have a major impact on service delivery, and would need to be studied carefully with a wide range of stakeholders in a process that would also need to take account of the reports of the Neale and Ayling Inquiries.

7. So far as the recommendations concerning governance and fitness to practise are concerned, the statement noted that significant changes had recently been made to ensure a far greater voice for patient interests, and that new fitness to practise procedures had just been introduced. The Government would consider, with the GMC, the recommendations for further changes to fitness to practise, and the implications of the governance recommendations for other regulatory bodies in health and social care.

8. The statement also said that, overall, the focus should be on the prevention and early identification of problems and ensuring that all reasonable measures are taken to provide the safeguards that are needed.
Announcement by Parliamentary Under Secretary of State (House of Lords)

9. On 17 December 2004, the Government issued a written statement from the Parliamentary Under Secretary of State, Lord Warner. The statement said that, in the light of the fifth report, the Government had requested, and the GMC had agreed to, a delay to the introduction of revalidation planned to begin on 1 April 2005 pending a review to be chaired by the Chief Medical Officer in England, Professor Sir Liam Donaldson. The statement said that the review would build on the recent reforms to the GMC and would involve consultation with the GMC, the medical profession and other interests. It would encompass a review of the role of NHS appraisal in addition to revalidation itself.

10. The President and Chief Executive have since met the Minister and the CMO to discuss the review (see paragraph 78).

The Government’s response to the fourth report

11. A separate paper for this meeting sets out details of the Government’s response to the fourth report of the Inquiry – *The Regulation of Controlled Drugs in the Community* – which was also published on 9 December 2004. The foreword to the document states that, in developing the response to the fourth report, Ministers were mindful of the recommendations in the fifth report and are confident that the action programme set out in response to the fourth report is ‘fully consistent with the broader picture’.

12. Against that background, it is helpful to highlight in this paper some important aspects of the Government’s response to the fourth report since they clearly have more general application. For example, the response makes clear that improvements in the systems for managing the use of controlled drugs should form an integral part of the quality agenda rather than being ‘superimposed as something separate’

13. The response continues:

‘[T]he emphasis should be on supporting healthcare professionals to do things right first time, rather than on catching them out and punishing them when they do things wrong. Better systems will not only help the vast majority of healthcare professionals who want to provide the best possible care for patients, but will also deter the small minority who may be tempted to abuse their professional position.’

14. The Government have decided, as an alternative to creating a new controlled drugs inspectorate, to strengthen and co-ordinate existing arrangements for monitoring and inspection through local networks, and to place a duty upon the Healthcare Commission to ensure that all NHS organisations have satisfactory arrangements in place for the safe use of controlled drugs.

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1 Safer Management of Controlled Drugs Cm 6434
2 Executive Summary, paragraph 5
15. The response argues that:

‘This combination of clear local responsibility for action, and national inspection against the required standards, is in line with current arrangements for improving then quality of clinical care in the NHS more generally. It allows for local flexibility to determine the most appropriate arrangements locally with accountability to a national body. The Government believes that this combination will give the best assurance possible against a future Shipman.’

16. The response also draws attention to the need for better sharing of intelligence on controlled drugs issues and states that the Government will commission a study of the best ways of sharing such information. In doing so, the Government will take into account the Inquiry’s recommendation in the fifth report for a national database of information about healthcare professionals. This issue is discussed in more detail in paper 6b for this meeting.

17. In conclusion, the Government describe their response to the fourth report as ‘proportionate and necessary’ to the issues raised by the Shipman case, and makes clear its determination to ensure that ‘implementation of these necessary safeguards is not at the expense of patient care.’

The fifth report: this paper

18. This paper sets out an overview of the fifth report, so far as its implications for our work are concerned. Other papers for this meeting consider options for making rapid progress in developing medical regulation in a number of strategic areas referred to in the report, and the arrangements for the adjudication of fitness to practise cases (which the report recommends should be completely separated from the GMC). The paper builds on discussions and reflections on the report by Council members and relevant committees which have taken place in the weeks since its publication.

Discussion

Our approach to the fifth report

19. The GMC warmly welcomed the report on the day it was published. Our statement said:

‘We extend our deepest sympathy to the relatives of all Harold Shipman’s victims. We welcomed the opportunity to take part in the Inquiry. We owe it to the victims to find out what went wrong, learn the lessons and change the system where necessary. We find the breadth and the level of detail of Dame Janet’s report impressive and enormously helpful.’

20. We made clear our commitment to continue to work with others to improve patient care.

21. Subsequently, we also warmly welcomed the Government’s decision to ask the CMO to undertake a review in the light of the report. We made clear that if there
were ways that we could improve our revalidation model and other plans, we would want to adopt them.

22. The fifth report represents the most thorough, forensic, and considered analysis of fitness to practise and related regulatory issues that there has been since, at the very least, the Merrison report in 1975, and in many respects that there has ever been, and probably ever will be. It is vitally important that the report, and the terrible and tragic events that made it necessary, are approached in the spirit of learning from the past and as a rich source of proposals for improving the protection of patients in the future. In developing the details of our response over the coming months, and in contributing to the CMO’s review, it may be helpful for us to make clear the principles that will inform our approach, and to underline the seriousness with which we regard the issues raised. Our response to the report will

- a. Flow from our statutory purpose ‘to protect, promote and maintain the health and safety of the public’.
- b. Be informed by principles of good regulation.
- c. Demonstrate our determination to learn from the past.
- d. Take into account, so far as is possible, wider developments including the lessons of the Neale and Ayling Inquiries and the emerging conclusions of the Kerr and Haslam Inquiry.
- e. Recognise that the GMC is part of a wider network of organisations with responsibility to assure the quality of care and that, as the Secretary of State has recently emphasised, regulation at every level should primarily be focused on the prevention and early detection of problems.
- f. Identify opportunities to make progress as quickly as possible so that desirable changes are not delayed pending the CMO’s review.
- g. Build upon the reforms that we, the Government and other stakeholders have developed in recent years while seeking further opportunities to improve the regulatory machinery such that it continues to command public and professional confidence.

**Recommendation:** To endorse the approach we should take to the fifth report, as described in this paper.

*The Inquiry’s findings about the GMC’s handling of Shipman’s case in 1976*

23. In 1976, Shipman was convicted of various offences involving controlled drugs. The convictions were referred to the GMC. The outcome was that Shipman received a warning about his future conduct. Dame Janet, while critical of aspects of what the GMC did and did not do, notes that this reflected the rehabilitative approach followed at the time and subsequently (and which Parliament implicitly endorsed in 1978 in legislating to introduce the health procedures). Dame Janet states in her letter to the Secretary of State covering the report that the policy of allowing drug-abusing doctors to continue in practice while subject to conditions has never
been called into question. While she has not made a specific recommendation about the policy, she has said that if it gives rise to public concern there should be an open debate about how such doctors should be treated. And Recommendation 99 is that the GMC should commission research into drug abusing doctors following supervision under the health procedures. The Health Review Group will consider these points, amongst others, as part of its ongoing programme of work.

24. Dame Janet concluded emphatically, however, that from the information available in 1976, the GMC could not have suspected Shipman’s true nature as a serial murderer and that, from then until his arrest in 1998, the GMC cannot be held responsible for the fact that Shipman remained free to practise.

The recommendations

25. Of the 109 recommendations in the report, almost half - the first 48 – relate mainly to the NHS (although a number also have implications for the GMC). The following sections of this paper discuss recommendations that are directly relevant to the GMC.

Culture, Constitution & Governance

26. Recommendation 106 provides that the GMC’s constitution should be changed such that elected medical members would not have an overall majority. Lay members and those medical members who were appointed rather than elected should be selected by the Public Appointments Commission on the basis of open competition. For both lay and appointed medical members there would be a strong emphasis on members’ duty to safeguard the public interest.

27. Currently, Council has 35 members of whom 19 are elected medical members, 2 appointed medical members and 14 appointed lay members.

28. Dame Janet has concluded that the GMC should continue to have a majority of medical members. Contrary to a number of reports in the media, she has not recommended that there should be a majority of lay members, and indeed says:

‘[The GMC] should certainly be dominated by medical members’ 3

29. The fundamental features of the model of regulation advocated by the GMC – involving professional ownership of standards alongside strong public involvement, accountability and transparency – have therefore been endorsed by the Inquiry. However, Dame Janet has concluded that the GMC has had a culture within the organisation that puts being fair to doctors ahead of protecting patients. For example, the report states:

‘I would like to believe that the GMC’s culture would continue to change in the right direction by virtue of its own momentum. However, I do not feel confident that it will do so. I am sure that there are many people within the GMC, both members and staff, who want to see the regulation of the medical profession based on the principles of ‘patient-centered’ medicine and public protection.

3 Para 27.310
Indeed, I think it is likely that all members are theoretically in favour of those principles. The problem seems to be that, when specific issues arise, opposing views are taken and, as in the past, the balance sometimes tips in favour of the interests of doctors.  

30. While Dame Janet concedes that there has been significant cultural change over the past five years, she believes that further change is required in order to demonstrate that patient protection is at the forefront of our collective mind. Dame Janet has concluded that this will not be possible so long as the majority of members of Council are elected by doctors. She believes that it is difficult for a doctor who depends for his or her position on an electorate of doctors always to put the public interest first (although she is sure that some manage to do so). And she considers that many doctors believe they are electing ‘representatives’ to Council rather than electing those who regulate them.

31. In many ways the recommendation is surprising. The Inquiry did not have the powers, and did not attempt, to conduct a general inquiry into medical regulation (of the kind undertaken by the Merrison Committee in the 1970s). The Inquiry did not take evidence about the GMC’s role in medical education, or in standards (except in relation to fitness to practise) or in registration (except in relation to revalidation). The picture the Inquiry gained from its analysis of our work was, inevitably, heavily skewed towards fitness to practise. To say that is not to express criticism of the Inquiry: the fact that a partial picture only was considered flowed inevitably from its terms of reference.

32. The recommendation, and the conclusions that underlie it, also seem surprising when the scale of change within the GMC is considered since the mid-1990s, and especially in the past three years. Inevitably the Inquiry focused on the GMC. But had there been more scope for bench-marking the GMC’s current performance against that of other regulatory bodies in the UK and abroad, different conclusions might have been reached.

33. In so far as the Inquiry had concerns during the hearings in 2003 about the composition of Council, the focus of those concerns (which reflected views expressed on behalf of the relatives of Shipman’s victims) was on whether lay members of the GMC are truly ‘lay’. So far as that issue is concerned, Dame Janet has come down firmly in favour of our position that it is desirable that lay members should come from a wide variety of backgrounds, including health care, although she observes that:

'It may be that, in the past, the mix has been rather too heavily weighted towards the NHS professionals'.

34. The Inquiry never explored with GMC witnesses the assertion, on which such reliance is placed in the report, that the elected medical majority provided for in the GMC’s constitution leads inevitably and ineluctably to a culture which places the protection of patients second rather than first and foremost. Dame Janet has not

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4 Para 27.308
5 And Dame Janet draws attention to the independent approach taken by Arun Midha (who gave oral evidence) and other lay members, notwithstanding their healthcare background – para 15.25
found any primary evidence on which to found her conclusion and recommendation. Rather, she has drawn inferences from the findings she has reached in relation to the GMC’s operation of the fitness to practise procedures over many years, and from what she sees as failures of will in carrying through the fitness to practise reforms and revalidation.

35. One of those examples (the supposed reversal of a decision to send performance assessment reports to employers) – and on which reliance is placed in this section of the report – is factually incorrect (see paragraphs 53-56). A second – the assertion that the Government forced upon a reluctant GMC a statutory duty to disclose information to employers – appears to disregard specific evidence that it was the GMC that requested the Government to make this change. And, elsewhere, the report contains an apparently small, but, in the light of the recommendation, material error. The Chief Executive is reported as having told the Inquiry in oral evidence that a policy decision not to implement in full a recommendation of the Policy Studies Institute (concerning the treatment of criminal convictions) had not been for him but for ‘elected members’. In fact, as the relevant transcript made by the Inquiry records, the Chief Executive made no mention of ‘elected members’ although he did discuss the role of Council members more generally. We have informed the Inquiry that we will be writing formally in due course to draw their attention to a number of such points.

36. Nevertheless, regardless of how it came about, the recommendation deserves serious consideration and public debate. As the Government have made clear, it has implications for all the health and social care regulatory bodies, and will be amongst the issues to be considered by the CMO’s review. Council was already committed to undertaking later in 2005 a post implementation review and evaluation (PIRE) of the governance changes introduced in 2003. As a contribution to the CMO’s review, it would be helpful to bring forward this review so that the results are available to the CMO as soon as possible. We therefore suggest that work in preparation for the review should begin at once. If the recommendation is agreed we would propose to circulate all members with details of a draft remit, process and timescale for this review.

**Recommendation:** To agree that the planned post implementation review and evaluation of the governance reforms should be brought forward and undertaken as soon as possible, in order that the outcome can be taken into account as part of the CMO’s review.

37. In the meantime, as part of the routine audit programme, our independent auditors – Mazars – will be undertaking an audit of our governance arrangements. They will report to the Audit Committee in February 2005, and their report will be taken into account during the PIRE.

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6 Para 27.301
7 Para 27.289
8 Letter from GMC to Secretary of State 1 March 2000 (submitted to the Inquiry - HP 02 04688)
9 Para 20.186
10 Transcript for day 212, 11 December 2003, page 90
Separation of casework and governance functions

38. Recommendation 50, which applies to the investigation stage of the fitness to practise procedures, provides that there must be complete separation of the GMC’s casework and governance functions. The report points out that although the operational intention is that Council members should not sit on panels of the Investigation Committee, there has not so far been a Council decision to this effect.\(^\text{11}\)

39. Dame Janet’s point is well made in relation to the investigation stage of the fitness to practise procedures. Council has increasingly recognised that the role of the governing body and its members in casework is to ensure that appropriate decision-making frameworks are in place, together with arrangements for auditing decisions and ensuring that the outcomes inform policy development. This is an opportunity, building upon Dame Janet’s recommendation, to establish that, as a matter of principle, there should be a complete separation of governance and casework functions within fitness to practise.

**Recommendation:** To agree that, as a matter of principle, there should be a complete separation of governance and case working functions within fitness to practise.

40. Dame Janet’s recommendation clearly has potential implications for all GMC work including registration casework. In May 2002 Council considered models for the future delivery of our registration functions within the re-structured Council of 35 members. It concluded that controlling entry to and maintaining the registers were core functions of the GMC and should remain the direct responsibility of the Council. It was acknowledged, however, that this did not mean that Council members were the only people who could carry out those functions.\(^\text{12}\) Council agreed that both members and non-members would need to be involved.

41. In April 2004 the Registration Committee concluded that, given the Committee’s knowledge of the technical aspects of the current registration work, it would be prudent ‘at the start of the new procedures’ for casework to be undertaken by members of the Registration Committee.\(^\text{13}\) In reaching this decision, members were aided by the knowledge that the abolition of limited registration was likely to reduce the volume of casework significantly, thus making it much less important to involve non-GMC members in the work. They accepted, however, that it would be desirable to have the ability to co-opt non-GMC members so that they could gain experience of casework, or in the event of the volume of casework increasing.

42. Clearly, therefore, there has long been an acceptance that non-GMC members could and should be involved in registration casework decision making. The only issue is whether this should be to the exclusion of Council members. There is an argument to be made for the involvement of members on the grounds that it

\(^{11}\) Para 25.90
\(^{12}\) Separation of Registration Functions and Registration Appeals, GMC Council paper, item 13C, 21-22 May 2002
\(^{13}\) Registration Committee minutes, 21 April 2004.
helps to ensure that policy making is properly informed by knowledge and experience. But this is not dependent upon members undertaking casework. These considerations might be addressed by creating feedback links with the decision makers, audit of procedures and effective quality assurance. Before Council is invited to consider a recommendation that governance and casework functions should be separated within registration, it would be helpful for the Registration Committee to analyse the operational implications which would flow from such a decision, and what arrangements for quality assurance and policy development would need to be put in place.

**Recommendation:** To agree that the Registration Committee should consider the implications for separating completely casework and governance functions within registration.

**Patient and Public Involvement**

43. We should continue to promote, and give priority to, the principle of wider patient and public involvement in the GMC’s work which Council endorsed on 30 November 2004. This issue is explored in greater depth in a separate paper for this meeting.

**Public Accountability**

44. Recommendation 107 provides that the GMC should be directly accountable to Parliament and should publish an annual report for scrutiny by a Select Committee.

45. We consulted on a similar proposal during the development of the governance reforms in 2000-2001, but it was rejected by the Department of Health. We are currently accountable to the Privy Council, and CHRE has oversight of aspects of our work.

46. We made a number of submissions to Dane Janet on this point, and she has accepted them. We therefore warmly welcome this recommendation. This model of accountability has the potential to increase public understanding of the GMC and, through promoting a more informed debate about our role and performance, to increase public confidence in the GMC and in medical regulation.

**Fitness to Practise**

47. Dame Janet has welcomed many of the reforms to the FTP procedures which were introduced on 1 November 2004, stating that these are ‘capable of providing a much improved method of protecting patients from doctors who might harm them’\(^\text{14}\) and recognising that the GMC has made improvements in response to the Inquiry. However, whilst she has said that in some areas the new procedures will be a significant improvement, resulting in ‘greater consistency and openness, and will provide improved patient protection’\(^\text{15}\) in others ‘the reverse appears to me to be

\(^{14}\) Paragraph 139

\(^{15}\) Paragraph 25.4
48. The report has made 55 recommendations with direct implications for the reformed procedures. Dame Janet has stated that these recommendations ‘will, if implemented, further improve the consistency, fairness and transparency of the GMC’s decisions’ and have been made ‘in a constructive spirit in the hope that they will be given serious consideration by the GMC’.

49. The FTP recommendations that impact on the operation of the reformed fitness to practise procedures can broadly be divided into two subcategories as follows:

a. Recommendations which accord with current practice or policy.

b. Recommendations that require further consideration.

50. Recommendation 51 – that the adjudication stage should be undertaken by a body independent of the GMC – is considered in paper 6c for this meeting. Recommendations 45, 46 and 47 concern information about a doctor’s fitness to practise that should be made available to patients and the public. Our proposed response to these recommendations is covered in more detail in paper 6b for this meeting.

Recommendations which accord with current practice or policy

51. The majority of the report’s FTP recommendations are in line with the GMC’s policy model for the operation of the reformed FTP procedures. Many accord with current practice. However, the report proposes in many cases that, for reasons of clarification and/or transparency, the relevant provisions should be enshrined in the Medical Act or the Rules. Recommendation 100 suggests that every aspect of the procedures in which doctors or complainants have an interest should be set out in rules.

52. This is contrary to the general direction of travel in regulation where increasingly the emphasis is on keeping legislation simple and flexible, and on reserving detailed operational matters within published guidance. This approach is endorsed by the Department of Health. However, the Fitness to Practise Committee should review all of these recommendations and consider whether some or all of the operational detail of our procedures should be specifically covered in the Medical Act or in the rules. This will require further discussion with the Department of Health.

53. We are unclear as to why one particular recommendation has been included in the report. Recommendation 66 is that:

‘The November 2004 Rules should be amended to include a provision whereby reports of performance assessments should be disclosed by the

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16 Paragraph 25.349
17 In her press statement published on 9 December 2004
18 Paragraph 25.5
GMC to doctors’ employers or PCOs as soon as possible after receipt.’

54. Dame Janet criticises the GMC for reneging on a previous decision to share performance assessment reports with employers. She suggests that this provision was not included in the final draft of the rules and she describes this as ‘extremely disappointing’.

55. However, the duty to share the performance assessment report with a doctor’s employer or Primary Care organisation is indeed included in the new rules (which were provided by us to the Inquiry in draft on 30 September 2004). Rule 7(5) of the rules provides:

‘ 7(5) Where an assessment has been carried out in accordance with Schedule 1 the Registrar shall send a copy of the assessment report to any person by whom the practitioner is employed to provide medical services or with whom he has an arrangement to do so.’

56. We will be drawing the Inquiry’s attention to the fact that this section of the report, and the supporting recommendation, may be based on a mis-reading of the draft rules.

Recommendations that require further consideration

57. The report includes several recommendations that, if implemented, would reflect a change in Council’s policy in relation to the operation of the reformed FTP procedures. These recommendations will require careful consideration by the Fitness to Practise Committee and discussion with other interested parties, including the Department of Health and CHRE. These recommendations include the following key areas:

The tests to be applied by decision-makers

58. Dame Janet proposes that new, clear and objective tests for the investigation and adjudication stages of the procedures be adopted and codified in the legislative framework. She believes that the tests she proposes would alleviate the problems of construction and circularity which she suggests are inherent in the current tests, and provide a more objective and transparent measure of the category of case that ought to proceed to adjudication.

Standard of proof

59. The report recommends that the GMC reopen its debate about the standard of proof to be applied by FTP Panels. The GMC’s current guidance states that where there are disputed facts, these will be decided to the criminal standard. However, Dame Janet suggests that ‘there should be a full recognition that the GMC’s primary function is to exercise a protective jurisdiction and not a punitive one’, and so the civil standard of proof would ‘usually be appropriate’, but that the

19 Recommendation 53, new tests proposed at paragraphs 25.63 and 25.67
20 Recommendation 81
21 Paragraph 27.256
criminal standard may be appropriate where allegations of misconduct amount to a serious criminal offence.

Warnings

60. The report makes two recommendations relating to the issuing of warnings.\(^{22}\) Firstly, Dame Janet recommends that the GMC reconsider its proposals for the issuing of warnings at the investigation stage. She suggests that (in line with the investigation stage test proposed by her) all cases that might warrant a warning should be referred to a FTP Panel and handled at the adjudication stage. She also recommends that the Medical Act 1983 should be amended to permit a FTP Panel to issue a warning in a case where it has been found that a doctor’s fitness to practise is impaired but not to a degree justifying action on registration. This is not currently permissible under the Medical Act 1983.

Review of investigation stage decisions

61. Dame Janet comments on the new provisions allowing the President to review decisions not to refer cases forward for adjudication. She recognises that this represents a ‘definite improvement’\(^ {23}\). However, she suggests that this review should be carried out by an independent external commissioner, in order to allay public concern that the GMC is a ‘closed shop’ and to avoid overburdening the President or leading him to delegate the task to others.\(^ {24}\)

Consensual Disposal

62. The GMC has requested an amendment to the Medical Act 1983 to provide it with the power to extend its ability to agree undertakings with the doctor at the conclusion of an investigation in cases other than those raising health or performance issues. Relevant provisions have been drafted by the Department of Health lawyers, for inclusion in a Section 60 Order proposed for consultation in 2005.

63. The report recommends, however, that any such consensual disposal in cases, other than those relating to performance or health issues, should take place in public at the adjudication stage of the procedures.\(^ {25}\) This model for consensual disposal is, in effect, provided for by the introduction in the reformed FTP procedures by the use of formal undertakings before a FTP Panel. However, the additional power to dispose of such cases by way of undertakings at the investigation stage would enable the GMC to resolve issues without the need for a full panel hearing, where to do so would be proportionate and sufficient to protect patients or otherwise in the public interest.

64. The Fitness to Practise Committee will need to go through each of the recommendations in some detail at its meetings in February and April 2005, looking specifically at those recommendations that would require some change in direction. This would enable the Committee to undertake a full analysis of the position as it

\(^{22}\) Recommendations 68 and 86
\(^{23}\) Paragraph 25.263
\(^{24}\) Recommendation 73
\(^{25}\) Recommendation 71
currently stands, and to consider the policy position in relation to the key issues identified in paragraphs 9 to 16. It is likely that this review, which will contribute to the CMO’s review, will involve an external consultation exercise with interested parties. FPC would then bring its recommendations back to Council for agreement in due course.

**Recommendation:** To agree that the Fitness to Practise Committee should analyse recommendations in the fifth report regarding fitness to practise which have not already been implemented, and identify any further work that we need to undertake in consultation with others.

**Revalidation**

65. Recommendations 103 and 104 provide that revalidation should comprise, as required by Section 29a of the Medical Act 1983, an evaluation of an individual doctor’s fitness to practise; and the GMC’s annual report on fitness to practise should include clear statistical information the year’s revalidation activities. These recommendations need to be considered alongside recommendations 25 and 26 which state that it must be made clear (by the NHS) whether appraisal is to be purely formative, or part formative and part summative; and, if the latter, it must be made more robust through, for example, the definition of standards against which a doctor would either pass or fail the appraisal. It is important to bear in mind that these recommendations, like others in the report, are concerned with GPs (and GPs in England specifically) although they clearly have implications for all doctors.

66. Dame Janet has not called into question the fundamental proposition, on which revalidation has been based since development work first began in 1998, that, for most doctors, revalidation must be based on information derived from clinical governance. Far from proposing breaking the link the clinical governance (as some have advocated) Dame Janet considers that it should be made more robust.

67. The principles on which we have developed revalidation remain valid: the purpose of requiring every doctor, through revalidation, to reflect meaningfully on their practice was not for its own sake, but as a means to an end. Reflective practice, undertaken properly and based on audit and other evidence, should enable doctors to improve their practice and the care they provide for patients, and to identify any emerging problems and seek appropriate peer and other support before patients are put at risk. If the main purpose of revalidation had ever been to provide an external mechanism to detect ‘bad doctors’ we would not have developed it as we did. Revalidation evolved so that it worked with the grain of the Government’s developing quality agenda in which the emphasis has always been, and remains, on the prevention of harm rather than the detection of dysfunction after the event.

68. Dame Janet has rejected evidence from the CMO that local certification would provide an explicit assurance to the GMC about the doctor’s fitness to practise. Thus, she has concluded that the proposed arrangements would not, unless strengthened, provide an evaluation of doctors’ fitness to practise.

69. Dame Janet has called for some of the evidence for revalidation to be included in doctors’ folders to be specified and compulsory, and has made extensive
recommendations about what the specified evidence must include. These proposals will need to be considered by the CMO’s review, together with her recommendations about appraisal. It is worth drawing a distinction between Dame Janet’s observations about clinical governance – which at this point in time she does not believe is sufficiently embedded in primary care (but which given more time could become more sensitive and robust) - and her observations about appraisal, which as currently conceived she does not consider will ever be robust.

70. Proposals for local certification (and the infrastructure underpinning it) under development by the National Clinical Governance Support Team (NCGST) would almost certainly have gone some way towards meeting Dame Janet’s concerns, but the CMO’s review now provides the opportunity for a thorough examination of what may remain to be done in order to ensure that revalidation will command the confidence of patients, the public and the profession. We would not want revalidation to proceed while that confidence was in doubt. For that reason, the President welcomed the review when the proposals for it emerged.

71. In the meantime, the postponement will enable us to undertake useful development work, including more thorough and rigorous pre-piloting, than would have been possible under the original timescale of 1 April 2005. In addition, we have been in discussion with the Academy of Medical Royal Colleges about how best to take forward work on developing specialty-specific criteria, standards and evidence to underpin revalidation. The decision to postpone revalidation will enable this work to progress over the coming months. We have agreed in principle to provide financial support to the Academy in undertaking this important project. We will inform members when more detailed proposals have been developed.

72. In Recommendation 104, Dame Janet helpfully proposed that we should prepare an annual report. We welcome this recommendation as it is complementary to our intention to undertake ongoing analysis of management information arising from the applications for revalidation and their outcomes. Such ongoing analysis is an important part of the evolution of revalidation and is good management practice, since it will allow us to review and evaluate the implementation of revalidation from the outset and to identify improvements, and additions to our proposed system.

Some strategic opportunities to develop medical regulation

73. The report contains a number of very helpful recommendations which have the potential to bring greater coherence to medical regulation through a more effective interface between the GMC and NHS and other organisations with relevant responsibilities. These are:

a. Recommendation 17 (the need for a single portal for directing complaints or concerns to the appropriate body).

b. Recommendations 40-43 (the need for a central database which would contain information about every doctor working in the UK).

c. Recommendations 45-47 (information that should be available to the public and patients).
74. There are opportunities to make rapid progress with all three groups of recommendations. Paper 6b for this meeting explores the issues in greater depth.

*The role of CHRE*

75. Dame Janet has made two recommendations concerning the role of CHRE. The first – number 108 – is that Section 29 of the NHS Reform and Health Care Professionals Act 2002 should be amended to reflect now-established case law that CHRE’s powers include the right to appeal against acquittals and findings of ‘no impairment’. Recommendation 109 is that there should in the future be a review of CHRE’s powers to see whether any extension of them is necessary. We welcome both recommendations.

**Recommendation:** To consider a preliminary analysis of the fifth report in this paper.

*Next steps*

The Tameside Families Support Group

76. Before the fifth report was published the President, Chief Executive and two lay members had a very constructive meeting in Hyde with the Tameside Families Support Group. It was agreed that it would be useful to have a further such meeting once the report was published, and before Christmas we wrote to the Group’s legal representatives to put the arrangements for this in hand. The purpose will be to review with the Support Group the recommendations in the fifth report relevant to the GMC, and to discuss how these will be taken forward.

Talk to Council members by Dame Janet Smith

77. Dame Janet kindly accepted an invitation from the President to speak to members about the fifth report after the Council dinner on 24 January 2005.

*The CMO’s review*

78. The details of the review were still being finalised at the time this paper was prepared. We understand that the scope of the review will be broadly-based, reflecting the fact that the Shipman Inquiry, together with the Neale and Ayling Inquiries, have raised a wide range of important issues about medical regulation both locally and nationally. The review will cover the more significant of these issues including the governance of the GMC, the adjudication function and the role of the GMC, revalidation and NHS appraisal. We will circulate members as soon as more details become known.

*Resource implications*

79. The recommendations in the fifth report range from measures that could be implemented with almost no impact on resources, to those which (such as the removal of adjudication) have massive, but as yet unquantifiable, implications for us.
Much more detailed analysis will be required as part of our contribution to the CMO’s review.

**Equality**

80. This paper has not been the subject of a full equality impact assessment. Such an assessment will be required in taking forward the separate initiatives referred to in the paper.