

24 April 2019

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Chair
Dame Clare Marx

Chief Executive and Registrar
Charlie Massey

Dear Sir/Madam,

Implementing the NHS Long Term Plan – proposals for possible changes to legislation: GMC response

Summary

- We support any measure that can deliver more effective collaboration and co-ordination between NHS organisations and structures. We believe these proposals should be broadened to enable the GMC, and the NHS as a whole, to provide the maximum possible support to the medical workforce in line with the ambitions of the NHS Long Term Plan.
- The GMC is already supporting many aspects of this plan, but to fully deliver we need to be given the legislative scope to do so. In our view, broadening these proposals beyond 'NHS architecture' would enable that to happen in the most effective and timely way possible.
- Three key measures would greatly assist us. Firstly, reform of how we must register GPs and specialists who qualified outside of EEA member states. The law can require an application of up to 1,000 pages, which can take up to a year to compile, costing the applicant £1,500. Only half of applicants successfully complete it. Against the background of current workforce shortages, this complexity and burden must be reduced to enable the NHS to compete effectively in the global labour market and to ensure that the UK is seen as an attractive destination to senior doctors from overseas.
- Secondly, statutory regulation of Medical Associate Professions (MAPs) must be introduced as soon as possible. Currently, these post-graduate healthcare professionals can't support doctors with tasks such as prescriptions and signing death certificates as they aren't regulated.
- Thirdly, reforming the NHS Performers List to allow a limited scope of practice for GPs. This could help to bring retired GPs (and others) back into the

workforce through allowing far more flexible working conditions for them. It is possible that a significant element of new workforce supply could be opened through a reform of this nature.

Our role

The General Medical Council (GMC) is an independent organisation, accountable to Parliament with a mission to protect patients and improve medical education and practice across the UK. Specifically, we are mandated under the Medical Act (1983) to:

- Decide which doctors are qualified to work in the UK, and oversee UK medical education and training.
- Set the standards that doctors need to follow, and ensure that they continue to meet these standards throughout their careers
- Take action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk.

Scope of the plans

We welcome the opportunity to comment on the legislative proposals in support of implementation of the NHS Long Term Plan. As a body independent of the NHS in England (and its equivalents in the devolved nations), it is not for the GMC to comment on specific changes to 'architecture', but we welcome efforts to increase coordination and collaboration across the wider healthcare landscape.

In parallel, we note that the NHS Long Term Plan also identifies multiple areas where action is to be taken that is clearly within the GMC's remit. A number of the positive steps to support doctors are largely dependent on the GMC being able to fulfil its mandate as effectively as possible, which would require amendments to the Medical Act (1983) and other pieces of legislation. We also see potential for other legislation to be reformed in a way that supports the plan's objectives around workforce.

In our view, any decision about the content of a bill derived from this call for views should be holistic in nature and consider the full range of measures necessary to support delivery of the aspirations that the NHS Long Term Plan includes, and the implications that these might have to the needs of the NHS in Scotland, Wales and Northern Ireland.

With constrained parliamentary time, there is a risk if that if the scope of these proposals is focused on the architecture of the NHS in England, real opportunities to support the wider delivery of the NHS plan, and address similar issues that are dependent on new legislation that could support improved medical workforce flows, will be delayed.

The remainder of this letter sets out some specific proposals that we suggest should be included in any finalised proposals. While it would be possible to deliver many of these without primary legislation, introducing them through these means could make their implementation easier and faster.

Additional areas where new legislation is necessary

Reform of the CESR/CEGPR route to GMC registration to support international recruitment

- 1** The NHS Long Term Plan rightly highlights the significant role of professional regulatory bodies in enabling recruitment of overseas professionals, ensuring the speed of regulatory processes, while upholding high standards.
- 2** Under European Law, the UK automatically recognises the majority of medical qualifications gained in European Economic Area (EEA) Member States and vice versa. This is not (and never has been) the case for doctors who qualified outside of the EEA. We have already made a significant effort to reduce the regulatory burden that non-EEA qualified GPs and specialists, who want to work in the UK, can face.
- 3** But we have now reached the limit of what the law currently allows. As it stands, GPs and specialists who qualified outside the EEA can only register with us, and work in the UK, if they have completed an outdated, prescriptive and expensive process to gain a Certificate of eligibility for specialist registration (CESR) or Certificate of eligibility for GP registration (CEGPR). To apply for one, the law dictates that they have to demonstrate equivalence to the curriculum a UK trainee would follow. This requires them to complete an evidence bundle up to 1,000 pages long, which can take up to a year to compile, as well as pay over £1,500*. The application process can then take a further 6-9 months to process.
- 4** In 2013-2018, only 685 doctors on average per year have applied for specialist or GP registration through this route. In conjunction with the relevant Royal Colleges and in adherence with our legislation, we have only been able to approve and grant registration to 49% of those who apply. Consequentially, only 293 doctors on average are deemed eligible to join our specialist or GP register per year through this route. By way of comparison, every year around 1,100 doctors join those registers through automatic recognition (as outlined above). We are concerned that do not come to the UK as a result.
- 5** Ideally, the law should allow for applicants to demonstrate their knowledge, skills and capabilities in a more flexible manner. This would lead to potentially quicker applications, without lowering standards, so making the UK (in a

* We do not make a profit on the registration process. The figure reflects the cost of the process.

fiercely competitive global workforce market) more attractive to senior doctors from overseas. Increasing the application rate to the GMC by 25% could, by conservative estimates, see an extra 72 specialists/GPs annually coming into the UK each year. Entry onto the Specialist or GP registers is governed by Section 34 of the Medical Act (1983), and secondary legislation derived from it*, which is very inflexible. We would like to see these sections amended to reflect the sections in the Act covering applications for registration from international medical graduates (Section 21) who are not specialists or GPs. In parallel with that, the relevant secondary legislation should be repealed. Section 21 is very broadly drafted and provides that international medical graduates applying for full registration must demonstrate to us that they have the necessary 'knowledge skills and experience' for practice in the UK. There are no regulations sitting beneath this and the GMC has the scope to determine how this can best be evidenced.

Introduce statutory regulation of Medical Associate Professions to support workforce transformation

- 6** In 2017, the Government consulted on the introduction of statutory regulation for Medical Associate Professions (MAPs). This category includes physician associates (PAs), physicians' assistants (anaesthesia) (PA(A)s), surgical care practitioners (SCPs) and advanced critical care practitioners (ACCPs).
- 7** All of these roles are occupied by postgraduate qualified health care professionals who work to the medical model. However, MAPs are currently not covered by the wider professional healthcare regulatory framework so cannot legally perform tasks such as prescribing medication or signing death certificates. There is some evidence that employers are reluctant to use MAPs because of the absence of assurance from statutory regulation.
- 8** In February 2019, the Government announced that they will legislate to regulate physician associates and physicians' assistants (anaesthesia). An alternative approach, which we continue to support, would be to introduce a flexible framework for all four groups of MAPs and any future professions that develop. The relevant legislation should then be flexible and cover all MAPs roles. In order to support the wider aspirations of the workforce implementation plan, the Government should firstly take a decision on which regulator should take on this role, and secondly, look to present relevant legislation to Parliament as soon as possible. We believe the most appropriate legislative vehicle to deliver on these plans is any that arises from these current proposals.
- 9** In our view, there is regulatory coherence in the GMC undertaking the regulation as the roles train and work to a medical or surgical model and have

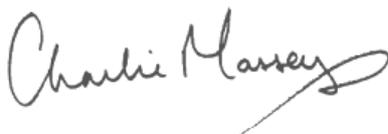
* The General Medical Council (Applications for General Practice and Specialist Registration) Regulations (2010)

a supervisory relationship with doctors. The GMC would therefore, in principle, agree to take on the regulation of MAPs if the UK Government, and those of the devolved nations, asked us to do so subject to agreement of a number of specific practicalities. These include set up costs and the nature of the legislative framework itself, which needs to be both flexible and future proof. We would ensure that there would be no use of existing medical registrants' fees to support costs of bringing MAPs into statutory regulation.

Amend the Performers' List Regulations

- 10** In addition to being a GMC registrant, NHS GPs in England are legally required to be on a 'Performers list' managed by NHS England. Requirements concerning the list are set out in secondary legislation.
- 11** In our view, the Performers List legislation could be broadened to remove potential barriers to mobility of labour. For example, to allow qualified GPs to work with a limited scope of practice. This could encourage retired GPs to return to work in a limited way through, for example, only working certain hours, types of roles, practices and/or treating certain types of patients. It might also be possible to expand the induction and refresher scheme so that doctors who have been practising overseas for a period can come back into the NHS workforce more quickly on return to the UK. Similarly, through greater flexibility in the Performers List, doctors who have been unsuccessful in a CEGPR application could work under supervision in primary care so that they could obtain the knowledge and experience required for them to successfully reapply for the GP register.
- 12** Greater flexibility in the Performers List could lead to the establishment of a staff and associate grade role in primary care. These doctors could plug the ongoing workforce gaps in primary care and support GPs so that they can focus on those areas where they are needed most.
- 13** Finally, enabling trainees in specialities other than general practice to undertake some of their training in primary care would ensure doctors are trained in a way that aligns with the NHS's wider ambition to integrate care across primary and acute sectors.

Yours faithfully



Charlie Massey