General Medical Council

Agenda item:	**M3**
Report title:	**Chief Executive's Report**
Report by:	**Charlie Massey**, Chief Executive, chiefexecutive@gmc-uk.org, 020 7189 5037
Action:	**To consider**

Executive summary

This report outlines developments in our external environment and progress on our strategy since Council last met.

Key points to note:

- Looking ahead to the negotiations on exiting the European Union, we believe there is a very strong patient safety case in taking a different approach in healthcare towards the automatic mutual recognition of professional qualifications. We will make this case strongly to the next UK Government.

- The appalling case of Ian Paterson, who was convicted of 17 counts of wounding with intent in April 2017, is a reminder of the importance of the enhanced system of clinical governance introduced through revalidation since 2012. We are ensuring the learning from the Paterson case informs our work as we take forward the recommendations of Sir Keith Pearson on revalidation.

Recommendation

Council is asked to consider the Chief Executive's report.

Developments in our external environment

Mutual Recognition of Professional Qualifications Directive

1 Doctors from the European Economic Area (EEA) are essential to the provision of high quality healthcare services across the UK. However, we have long been concerned that the Recognition of Professional Qualifications (RPQ) directive is not fit for purpose and, in its current form, represents a risk to patient safety.

2 The directive severely limits our ability to check that EEA qualified doctors joining the medical register meet the same threshold as UK doctors and are safe and fit to practise. The directive also limits our ability to deliver greater flexibility in postgraduate medical education by restricting the ability of UK trainees in one speciality that is covered by the autonomic recognition of professional qualifications to transfer into another specialty. To realise fully the ambitions we set out in our report to the four UK Governments in March 2017 on promoting greater flexibility in training, we need changes to be made to the directive's application in the UK.

3 Following the general election on 8 June 2017, the new UK Government will begin negotiations on exiting the European Union. As the Government prepares for these negotiations, we will make clear our patient safety concerns about the RPQ directive and argue strongly that future arrangements must ensure we are able to check that doctors from the EEA meet the same tests of clinical competency as UK-trained doctors. We have recently consulted on plans to establish a Medical Licensing Assessment (MLA), which we believe would be the simplest and fairest way to assure the quality and safety of all doctors practising in the UK irrespective of where they trained.

4 In April 2017, the House of Commons Health Select Committee published its report into Brexit and health and social care. The report welcomed the opportunity for the UK to negotiate a more pragmatic approach to the RPQ directive within the British regulatory model, and expressed support for the principle that all clinicians working in the UK should be asked to demonstrate relevant language, skills and knowledge competence.

Party manifestos 2017

5 The three main UK parties (Conservatives, Labour and the Liberal Democrats) have all published their general election manifestos. Shortly after the general election was called in April, we wrote to each of the three party leaders to ask whether they would consider including a commitment to legislative reform in their election manifestos so that the current outdated system of professional regulation of healthcare professionals can be modernised and rationalised. The Conservative Party manifesto includes a commitment to reform.

Ian Paterson case

6 Ian Paterson, a breast surgeon in the West Midlands, was referred to the GMC in 2010, whereupon we launched an investigation, suspended him from all medical practice, and referred him to the police. In April 2017 he was convicted of several counts of wounding patients.

7 This appalling case has raised understandable questions about whether there are other doctors like Ian Paterson who have gone undetected in the health system.

8 Of course, all doctors have a duty under GMC guidance to take prompt action where they have concerns about patient safety, including reporting concerns about a colleague's fitness to practise to their employer or to the GMC. In addition to this professional responsibility on individual doctors, an enhanced system of clinical governance has been in operation since December 2012.

9 Revalidation means that doctors are now checked regularly to ensure they are up to date and remain fit to practise. The system also places responsibility on employers to share information about the performance of doctors, not to wait for others to raise those issues.

10 A doctor with a working pattern like Ian Paterson would now have a Responsible Officer – a senior doctor (bound by our professional standards like any other, as well as a statutory duty since 2011) who is responsible for overseeing and evaluating the practice of all doctors working in their organisations. That Responsible Officer would make sure that doctor had an annual appraisal (focused on our professional standards) covering both their NHS and private work that took into account feedback from patients and colleagues, an analysis of any complaints, and an evaluation of the quality of their work.

11 Successful completion of annual appraisals is a requirement of revalidation. However a Responsible Officer will only recommend a doctor for revalidation if they are satisfied there are no outstanding concerns about their practice.

12 While we are confident that the system is far more robust now and that another doctor like Ian Paterson should not be able to practice, we must be vigilant and we believe further steps can be taken to further reinforce the regulatory framework.

13 As we take forward the recommendations of Sir Keith Pearson's independent review of revalidation, which was published in January 2017, we intend to give more guidance to doctors on the types of colleagues they need to get feedback from for their appraisals, explore how random colleague feedback could be introduced to prevent doctors 'cherry picking', strengthen patient feedback and establish a clear protocol on whole practice appraisal (where a doctor works in both the NHS and the independent sector).

East Kent Hospitals University NHS Foundation Trust

14 We have serious concerns about the quality and safety of core medical training at Kent and Canterbury Hospital, within East Kent Hospitals University NHS Foundation Trust.

15 The decision to move approximately 40 doctors in training from their posts to other sites across the Trust was taken on 8 March 2017 following an urgent visit by Health Education England (HEE) and us. The visit highlighted serious concerns including inadequate clinical supervision, particularly in the Urgent Care Centre, high workload and poor access to educational opportunities.

16 To accommodate concerns about the safe delivery of patient care and training in the intervening period, the date for withdrawal has been extended to 19 June 2017. This will have given the Trust and system partners, including NHS Improvement, just over three months to prepare for the withdrawal of trainees since the initial decision was made. We continue to discuss the situation with the service and system partners and are clear that without a sustainable solution to the challenges faced at the site then withdrawal of trainees will go ahead as planned on the 19 June 2017.

17 On 26 April 2017 we wrote to interested parties, including HEE, attaching formal conditions to the approval of the Foundation, Core Medical, General Practice and Higher Medical Training Programmes at Kent and Canterbury Hospital. These form a clear basis on which we will take further action if needed.

Gosport Independent Panel

18 We have been supporting the Gosport War Memorial Hospital investigation into unexpected deaths and failures of care for elderly patients through the disclosure of materials which we hold which may assist the Panel's investigation. Following the submission of a business case, the Panel have provided a contribution to our costs which reflects the extensive searches and redactions we have been asked to undertake.

19 We are determined to do all we can to support the work of the investigation. Work on the redaction of sensitive personal data from the material already disclosed to the Panel is continuing and is on track to be completed by July 2017. The Panel is scheduled to publish its findings in spring 2018.

Progress on our strategy

Flexibility of training review

20 Our report *Adapting for the future: A plan for improving the flexibility of UK postgraduate medical training* was sent to the four health ministers of the UK at the end of March 2017. It identifies five core problems that create barriers to more

flexible training arrangements, and sets out how each of these problems could be addressed. The report has been well received by our key stakeholders, particularly so among doctors in training, and we are pleased it has been seen as a significant step forward to addressing the long standing issues around flexibility.

21 Included in the commitments and published in May 2017 are our package of educational reform which will help support greater flexibility. These include our new standards for curricula, *Excellence by Design*, the framework for Generic professional capabilities and associated guidance. A wider programme of work with stakeholders will take place over the coming months to ensure we meet the other commitments in the flexibility review, such as the review of the Academy of Medical Royal Colleges transferable competencies framework.

Collaboration with regulators and system partners

22 In addition to joining NHS Improvement and the Care Quality Commission's regular oversight meetings about providers and sites that are in difficulty – the first of which Paul Buckley and Colin Melville attended at the end of May 2017 – we have also reached agreement with the National Quality Board (NQB) to attend the NQB on an ad-hoc basis to strengthen links between our work and the work of the Board in providing coordinated leadership for quality as the Five Year Forward View is implemented. These developments in the English regulatory system will enable us to extend our influence as a national partner in the wider regulatory system.

Changes to our executive governance and directorate structures

23 We have streamlined our internal executive governance arrangements by establishing a new single Executive Board which takes the place of the Strategy and Policy Board and Performance and Resources Board. The Board will meet monthly and will be chaired by the Chief Executive. It will focus on significant decisions and oversight in relation to policy, strategy, finance, performance, operational delivery and resources. We will continue to sight Council on the decisions taken by the Board via this report and the Chief Operating Officer's report. These changes will help make GMC decision-making more rapid and agile and, along with other changes internally, will ensure the GMC continues to be a high performing regulator that understands its registrants, stakeholders and the healthcare systems across the UK.

24 Further to my update to Council in April, we are currently recruiting a director to lead a new Strategic Communications and Engagement Directorate. The recruitment for this post is currently live and we hope to have the successful candidate in post by the autumn.