General Medical Council

Agenda item:	**M6**
Report title:	**Developing the UK medical register**
Report by:	**Jo Nicholas**, Policy Manager - Regulation Policy, Strategy and Communication, jo.nicholas@gmc-uk.org, 020 7189 5376
Action:	**To consider**

Executive summary

This paper sets out the results of our consultation on the List of Registered Medical Practitioners (LRMP), along with our conclusions and next steps. Our full consultation report, including a detailed question by question analysis, is attached at Annex A.

We committed to undertake a review of the LRMP in our corporate strategy (2014 – 2017). A significant amount of preliminary work was undertaken prior to the decision to consult. In March 2015 independent research found that LRMP offers limited information compared with some other jurisdictions and that it has not kept pace with the recent expansion of the GMC's functions. The research found significant appetite for the development of the LRMP.

On the 5 July 2016 we launched a formal public consultation on our proposals to develop the LRMP. We received 7,741 responses to the consultation – the largest response rate to any consultation the organisation has ever run. The majority of respondents did not support the options set out for developing the register.

Recommendations

Council is asked to:

- **a** Consider the report of the LRMP consultation *Developing the UK medical register* at Annex A.
- **b** Agree that in the light of the consultation feedback, to limit further development of the register at the present time to:
  (i) Enhancing its functionality in relation to the information it already contains.
  (ii) Exploring with the Academy of Medical Royal Colleges the desirability and feasibility of collecting and recording information about doctors' scope of practice.

Introduction

1 In our Corporate Strategy (2014 – 2017) we committed to 'Undertake a review of the List of Registered Medical Practitioners (the online medical register) to explore ways of making it more accessible and more useful for patients, employers, and doctors'. This commitment was part of our wider programme of work to be a modern and proportionate regulator, and sought to make the register more open, relevant and useful to our key interest groups in their work and interaction with doctors.

2 As part of our preliminary scoping work, we commissioned independent research. In March 2015 the research reported that the List of Registered Medical Practitioners (LRMP) offers limited information compared with some other jurisdictions and that it has not kept pace with the recent expansion of the GMC's functions. The vast majority of stakeholders involved in the research agreed that more information should be available on the register, but there was a wide range of views and much less consensus about what that additional information would be. We made some limited additions to the LRMP at the start of 2016 (including identifying on the register which doctors are in approved training programmes).

3 Council considered draft proposals for developing a public consultation on how to further improve the online medical register in February 2016, and agreed to go out to consultation as proposed and report back at the end of 2016. We launched a formal public consultation on our proposals to develop the LRMP on 5 July 2016. We received 7,741 responses to the consultation, the largest response rate to any consultation the organisation has ever run.

4 The vast majority of responses were from doctors and medical students, with a small number representing organisations, members of the public and other individuals. However, we engaged directly with a number of stakeholders including employers and patient organisations via numerous Regional Liaison Service sessions, and presented our proposals directly to audiences including medical royal colleges, NHS Workforce Forum and the GMC's Responsible Officer Reference Group. We also commissioned a survey of public opinion through the online polling agency Populus.

5 We have now completed the full analysis of all responses to the consultation. This paper sets out the main themes, conclusions and next steps. The full consultation report is at Annex A.

Key issues raised in the consultation feedback

The purpose of the register

6 There was a recurrent view that the extension of the register constituted '*over-regulation*' and '*grotesque…mission creep*' beyond our proper remit. The majority of

respondents said that the purpose of the register should simply be to provide assurance that those on the register are appropriately qualified and fit to practise medicine in the UK. They felt that the register serves this purpose well currently, and did not think there was a need for change. The Medical Defence Union commented *'The information the GMC publishes about registered doctors must be consistent with its primary purpose as a regulator of protecting patients and no more than is required to comply with that duty'*.

7 One of the main concerns highlighted by respondents was that providing additional information on the register would create an advertising and marketing tool for doctors, allowing patients to '*shop around*' leading to increased privatisation of healthcare. Respondents were concerned that the additional information would turn the register into an '*online CV*' or a kind of '*Facebook for doctors*'.

Safety and privacy

8 The most common concern about the options put forward related to the risk to doctors' safety and privacy if additional information is provided on the register. Many of these concerns were based on a misunderstanding that the GMC was proposing to publish personal data, such as home addresses. There was no proposal to require doctors to put their sensitive personal data into the public domain, nor would we contemplate doing so. Nevertheless, there was anxiety around potential harassment and stalking, as well as discrimination, fraud and identity theft, with particular roles or specialties more vulnerable. One doctor commented *'Doctors have the same rights to privacy as any other member of the public. This must be balanced against the GMC's remit to protect the public. Little of this additional information offers protection to the public but much of it severely effects of the privacy of doctors'*.

Additional information on the register

9 The consensus was that no additional information should be provided on the register, even if that information was to be provided on a voluntary basis. One consultant felt there is '*simply no compelling safety argument'* for providing additional information on the register and most felt that adding the categories described to the register would not be of value to the public.

10 We asked respondents to select from a list of options the categories of information that they thought would be helpful to include on the register. The majority of respondents did not think that any of the categories of information were helpful to include on the register. The most popular category selected was credentials (14% support) followed by scope of practice (12% support). The least popular categories were a link to recognised feedback websites (2% support), registrant's photo (3% support) and a link to the website of the place a doctor works (4% support).

11 A significant number of respondents raised the potential for some of the information to be used to discriminate or disadvantage certain groups of doctors, and advantage others. In particular, languages spoken and a photo could encourage discrimination on the basis of ethnicity, religion and age. For example, a doctor in training said *'given recent events such as an increase in racist attacks and the recent decision to reduce the number of doctors by the current health secretary, by defining and classifying a doctor by what they look like, you could be opening up the doors to even more judgment by the colour of someone's skin or where they are from - neither of which should matter at all'.*

12 One GP said *'…gaps for travel or maternity sickness could all appear as though [the] doctor had just taken time out or been unemployable'*. Some worried that doctors would be tarnished from working in troubled hospitals, with one respondent saying *'Junior doctors who have been sent to hospitals that have been rubbished in the press will be forever linked with that hospital'.*

A tiered approach to the register

13 The tiered approach to the register reflected the limitations to our current legal framework. We suggested a voluntary approach to potential new information on the register.

14 One of the main concerns expressed by all respondents was that over time doctors will feel under pressure to add voluntary information to the register and that there will be an expectation to do so as standard practice, so as not to be 'adversely judged by the public'. A doctor in training said '*Some may feel that their doctor is 'less trust worthy' when they just chose to protect their private life.'* Another doctor said *'Patients and the public may associate a 'more full' entry on the register with greater experience or clinical ability which may not necessarily be true'.*

15 Many were concerned that the voluntary information could be misinterpreted by members of the public. One respondent said '*The fact that doctor A can speak 7 languages or has 20 letters after their name bears no link to them being a better/more caring/ more trusting doctor than doctor B who speaks one language with their sole medical degree.'* A GP commented '*excessive amounts of information may be complex and confusing and may make the register less accessible'*.

Accuracy and validity

16 Most respondents felt that all information provided on the register should be verified in order to preserve the integrity of the register - if we cannot verify the accuracy of information provided, it shouldn't be on the register at all. Respondents said that there is a public expectation that all information on the GMC register is accurate. There were concerns that voluntary information provided on the GMC register would

give false assurances to members of the public that the information is verified by the GMC. A member of the public said '*no information should be included without direct verification, sampling is completely unsatisfactory and risks consequential errors in published information'.*

Cost and burden

17 A significant number of respondents referred to what they saw as the cost implications of the proposals and the resources required to maintain and verify any additional information. They assumed a '*likely increase in annual fees to maintain this Tier 2 [voluntary] information'*. A doctor in training said '*Increasing the data held on the register will increase costs at a time when the profession has already experienced many years of pay freeze.'* In fact none of the options presented would have impacted on the Annual Retention Fee (ARF).

18 Doctors also highlighted the burden of providing any additional information, and keeping that information up to date. This would be particularly challenging for those who moved roles, such as doctors in training.

Enhancing the functionality of the register

19 We asked how we can improve the register and make it more user friendly and we received many helpful suggestions. Many respondents recommended an improved search function including the ability to search by specialty and location as well as what the person is 'known as' and what the person's name 'sounds like'. We received recommendations to clarify and simplify the language used on the register, making sure that lay terms are used wherever possible, with abbreviations clearly explained. Respondents also recommended improvements to the layout and navigation of the site, such as reducing the number of clicks required to access relevant material, reducing the number of 'pop-up windows', and giving the register given a more prominent location on the GMC home page.

Conclusions and next steps

20 There was a difference between the feedback we received during the scoping and research phase of this project, and the responses we received through the consultation. We moved forward with this consultation on the basis of the support we received in the early phases of this project.

21 There was a clear lack of support at the time of the consultation for the options we had put forward to develop the online medical register. This was despite the independent research in 2015 having indicated a consensus for at least some changes, and feedback through other engagement demonstrating an appetite for improvement. Nearly all respondents objected to adding further information to the

Agenda Item 6 - Developing the UK medical register

Feedback about our proposals

Question 1: Do you agree with the purpose of the medical register described in this section of the consultation?

	Yes	No	Not sure	Blank[1]
All respondents[2]	1979	3619	947	1196
Organisations	34	16	10	21
Doctors	1126	1895	580	441
Members of the public	42	13	12	13
All other individuals[3]	73	41	18	707

Question 2: Do you think the register should serve any additional purpose? If so, what should that be?

	Yes	No	Not sure	Blank
All respondents	301	5866	365	1209
Organisations	15	39	7	20
Doctors	139	3249	206	448
Members of the public	24	28	13	15
All other individuals	15	89	26	709

Responses to question 1 and question 2 were very similar. In many cases responses were simply copied over from question 1, or were a summarised version of the response to question 1. We have combined the analysis of questions 1 and 2 to avoid duplication.

[1] In this table, and the following tables, 'blank' refers to the number of respondents who did not select either 'yes', 'no' or 'not sure'. However, they may have provided comments in relation to the question, which were taken into account in our analysis.

[2] In this table, and the following tables, 'All respondents' refers to organisational responses, doctors, members of the public, other individuals, as well as those who did not tell us whether they were an organisation or an individual.

[3] In this table, and the following tables, 'All other individuals' refers to those respondents who told us they were individuals, but are not doctors or members of the public. For example, it includes medical educators, medical students and other healthcare professionals. It does not include those respondents who did not tell us whether they were organisations or individuals.

20 The consultation document explained the historical use of the register to *'help patients and the public distinguish between qualified and unqualified doctors'*. It then went on to discuss the changing context of medical practice and patient expectations and said that '*If the medical register is to remain relevant and useful, it must evolve to meet the changing needs of those who use it'* and '*we believe we need to make more information available to meet today's expectations'.*

21 In question 1, 26% of respondents said that they agreed with the purpose of the register as stated in the consultation document, which included the need to evolve to meet changing needs. Organisations and members of the public appeared to support our stated purpose of the register more than individual doctors. In question 2, only 4% of respondents said that they thought the register should serve an additional purpose.

22 2814 (36%) respondents provided additional comments to support their response to question 1, and 1416 (19%) respondents provided additional comments to support their response to question 2.

Recognising the need to improve

23 A small number of respondents recognised the need to adapt to changing needs and expectations and agreed that the register should better reflect modern practice and in particular include any conflicts of interests.

24 In particular, members of the public said it would be helpful to include on the register more information about what doctors are able to do within specialties, qualifications, training and experience, conflicts of interests, fitness to practice concerns and complaints and in particular whether a doctor works in both the NHS and private sector. One member of the public commented '*The register needs to have info on specialisms, training and continued professional development, and list of employment if it is to be of any use to patients'.*

25 Interestingly the Omnibus Survey of 2000 members of the public found that only a quarter of respondents had ever searched online for information about a doctor and only a third of respondents were aware of the GMC's register. The most common reasons for searching online for information about a doctor was to check what area(s) of practice the doctor specialised in (24%) and searching for a new GP upon moving to a new area (22%).

26 Very few doctors recognised the need to develop the register to remain relevant for users. One consultant said '*I agree and I also agree that the register in its current form has insufficient information to allow patients and organisations to form a reliable opinion as to a doctors credentials and capabilities'* A doctor in training expressed support for the register serving an additional purpose, commenting *'Should provide*

tiered approach wrote *'As an example I would not be able to provide practice details, since I am occasionally subject to threats of serious harm or death in my area of practice!'* Similarly one GP wrote *'I do not want my photo and specific work place freely available online, as a woman it makes me feel vulnerable'.*

Links to external feedback sites

88 A small number of respondents also took the opportunity to disagree with any linking of the register to external feedback sites. One consultant wrote it would be *'trial by social media'.* A GP wrote *'The very presence of links to feedback sites will legitimise these sites, despite a dearth of evidence that such feedback on such sites are related to quality of practice or doctor'.*

Question 6: Do you agree that making provision of some categories of registration information voluntary would help mitigate some of the possible disadvantages of our proposed two-tier model?

	Yes	No	Not sure	Blank
All respondents	1193	3075	749	2724
Organisations	21	26	7	27
Doctors	716	1652	439	1235
Members of the public	17	25	13	25
All other individuals	27	49	10	753

89 Overall, 1193 (15%) respondents said that making the provision of some information voluntary would help to mitigate some of the disadvantages of the proposed two-tier model. 2245 (29%) respondents provided additional comments to support their response.

Qualified agreement

90 A small number of respondents agreed that making provision of some categories of registration information voluntary would help mitigate some of the possible disadvantages of our proposed two-tier model. However, their agreement was qualified.

91 For example, a number suggested that we would need to make patients aware that the voluntary information was not verified, and a disclaimer should be included on the register. Others said it was necessary to be clear that a lack of information did not imply a doctor has something to hide, and that some doctors are unable to provide additional information due to the sensitivity of their work. One respondent suggested

that to better mitigate against the disadvantages identified, tier 2 information could form a document completely separate from the register. This would make it clear to members of the public that doctors are not *'withholding information from the register'*.

92 Some members of the public said that disclosing additional information about a doctor's practice should be mandatory. They did not see any risks in introducing a two-tiered approach to the register, particularly where additional information is already published elsewhere. One noted that currently people search the internet for information which may be misleading. Yet if doctors provided additional information on the register, there would be less incentive for people to look elsewhere to 'fill in the gaps'. Some members of the public felt that the GMC should require more information from doctors, but it should be a doctor's decision as to whether or not they want that information published.

Disagreement with a two-tier approach to the register

93 The vast majority of respondents took the opportunity to explain again why they did not agree with a two-tier approach to the register. These reasons mirror the comments provided in response to question 5: inaccurate and inconsistent information on the register; expectations on doctors to provide this information and disadvantage to those who do not; potential to mislead patients; there are other more appropriate forums to publish this information; impact on privacy and safety and a potential for the additional information to cause discrimination.

94 A small number of respondents said that the two tier approach was simply a means for any negative consequences to be blamed on the doctor for providing the information in the first place, rather than GMC.

Question 7: Are there particular groups who would be helped or disadvantaged by our approach to providing more information on the register? If so, which groups and why?

	Yes	No	Not sure	Blank
All respondents	2672	865	1399	2805
Organisations	34	4	12	31
Doctors	1496	487	786	1273
Members of the public	18	9	27	26
All other individuals	40	15	28	756

95 2674 (35%) respondents agreed that there were groups of doctors who would be helped or disadvantaged by our approach to providing more information on the register. Doctors and organisations agreed more strongly than members of the public. 2595 (34%) respondents provided additional comments to support their response.

Those who will benefit from the approach

96 Respondents identified that those working in private practice would benefit from being able to provide more information on the register. One GP said *'The private sector docs who are trying to sell themselves will love this'.* Similarly, many felt that commercial or private companies would also benefit from the availability of the information as the register would become a 'marketing' or 'advertising tool'. One doctor in training said '*I think private companies will be helped by having this 'linked in' style profile of each doctor to help them with recruitment. The same goes for international recruitment agencies'.*

97 Other people whom the approach might benefit included: patients (discussed below); Responsible Officers and Medical Directors for recruitment purposes; those doctors who are tech savvy; doctors overseas wishing to account for their absence; recruitment agencies. The Patients Association survey also said there might be benefits for those for whom English is not their first language, and those with mental health problems.

Benefits and disadvantages to patients

98 There were mixed views about whether the approach would benefit patients. Some respondents, particularly members of the public, identified that patients will be helped by the additional information by better facilitating patient choice.

99 However, respondents also cautioned that the additional information may confuse patients or lead them to making incorrect judgements. One doctor in training said '*patients will be given information that can be freely misinterpreted and add nothing to their care'.* Some highlighted the complex nature of healthcare and one consultant said *'Information judged by general public without a true comprehension of healthcare system and facilities offered where an individual doctor works'.*

100 The Patients Association acknowledged the benefits of more information being made available to the public but warned that adequate explanations should also be included. '*We welcome the GMC's commitment to recognising changing needs of patients and believe that public has a right to be informed about their healthcare. New information must be adequately explained and how it can be effectively used'.*

Groups that might be disadvantaged

101 Many respondents raised concerns that the safety of groups of doctors working in certain fields would be at risk. For example, one GP said '*Docs working in child*

protection, family planning, abortion, prisons, reproductive health and forensic psychiatry may be endangered by this'. Some raised the concern that the freely available information would encourage stalkers and increase the risk posed to their victims. A similar concern was expressed for the victims of abusive relationships. This would disproportionally disadvantage women. One GP said '*Any doctor who has had a stalker or similar would be hesitant to make information about their place of work known to the general public'.*

102 A large number of respondents expressed concerns that the additional information on the register would give opportunity for certain groups to be discriminated against and thus inadvertently have a negative impact on patient care. One doctor in training said '*This could lead to all sorts of discrimination e.g. employment depending on appearance, gender, what your hobbies are, where you went to medical school etc. Patients may decide not to see an appropriate specialist based on their interpretation of trivial personal information, delaying or preventing their own care'*. Respondents referred to the '*current anti-immigration context'* in the '*post-Brexit Britain'*.

103 Respondents identified that those who did not provide additional information on the register could be viewed with suspicion or perceived to have less experience or skills than colleagues with a full profile. One consultant said *'It may look if you provide less information you are less qualified when you are only trying to protect yourself'.*

104 The Royal College of Radiologists raised concerns about how the public may interpret information relating to qualifications. 'Doctors who do not have, for example, additional, non-mandatory qualifications might be perceived as being of lesser value. Public perception may be that quantity equals quality and the very variable nature of consultant employment (which can only increase) may lead to confusion about value'.

105 A small number of respondents, including the Patients Association, highlighted that groups who are not '*technologically savvy'* may be disadvantaged, as well as those with learning difficulties or English not being their first language. '*Based on the Office of National Statistics data those without internet for households with one adult aged 65 or over, only 49% had internet access. In 2015, of the 14% of households in Great Britain with no internet access, 31% reported that this was due to a lack of skills'.*

106 A small number of respondents suggested that having more information available on the register would increase the risk of doctors being victims of identity theft and fraud.

Question 8: Are there other disadvantages associated with the two tier model which we have not considered here? If so, how might they be mitigated?

	Yes	No	Not sure	Blank
All respondents	2341	481	1962	2957
Organisations	26	8	17	30
Doctors	1251	269	1161	1361
Members of the public	12	8	31	29
All other individuals	28	13	42	756

107 2341 (30%) respondents agreed that there were other disadvantages associated with the two tier model that we had not considered in the consultation document. 481 (6%) respondents said there were no additional disadvantages.

108 2075 (28%) respondents provided additional comments to support their response. Overall, respondents said that the disadvantages of a two tiered model significantly outweighed the benefits. The additional information was not seen as necessary, particularly given that much of it is already available to the public through another source. Respondents indicated that their preference would be not to include the proposed information on the register, or not to amend the function of LRMP.

109 A number of the disadvantages raised by respondents are not specifically related to the two-tier model, but relate to including additional information on the register more generally.

Voluntary nature of the information

110 The voluntary nature of the information in tier two was considered a disadvantage by many (although the vast majority of respondents did not think that it should be mandatory to provide the information). Many respondents said that those who chose not to provide tier two information would be perceived as having something to hide or being less skilled or experienced than their colleagues. One consultant said "*There will be a perception amongst searchers of the register that doctors who do not provide complete Tier 2 information have something to hide or lack specialist skills/abilities."* A doctor in training said '*Some may feel that their doctor is 'less trust worthy' when they just chose to protect their private life'.* Another doctor said *'Patients and the public may associate a 'more full' entry on the register with greater experience or clinical ability which may not necessarily be true'.*

111 Respondents said that this would put pressure on doctors to share information that they did not want to share. There was a risk that '*people may feel compelled by their*

employer or colleagues to include information they may not feel comfortable having in the public domain' (GP). Furthermore employers or others could put pressure on doctors to share tier two information. There was a worry that tier two information would, in effect, become mandatory. One doctor in training said '*Trainees may come under pressure from Annual Review of Competency Progression (ARCP) panels and examination boards to publicise information about their success or process in training, no legislation exists to protect juniors who are vulnerable to exploitation through ARCP panels'.*

Discrimination and inequality

112 Some comments specifically highlighted the possibility of information leading to discrimination, particularly the publication of photographs or information about languages spoken – '*Language or place of qualification being used a proxy for race'* (consultant).

113 One consultant said that 'By including photographs of doctors their families could also become targets of discrimination'. And a sessional or locum doctor said that *'Doctors are at risk of being prejudiced against for either race, education, ethnicity etc'*. Some also highlighted a *'Public prejudice against those with less experience in the uk or trained abroad, or in failing hospitals/practices'*.

114 Some mentioned that the 'very concept introduces inequality'. One doctor in training said '*In the current system with minimal published information, everybody is on even-footing...introducing additional elements of choice and more fields of enquiry will self-evidently uproot this more even playing field*. *Some worried about the creation of a hierarchy amongst doctors. A GP commented, 'it must be clear that [a] 2 tier register doesn't mean 2 tier doctors'.*

115 Some respondents thought that a two tier model would advantage those in private practise as it gives them an advertising platform. One doctor in training commented '*Those doctors heavily involved in private medical work are likely to invest considerable time and money in making their websites and feedback sites (which the register will link to) look as professional and polished as possible regardless of their actual reputation or skills'.*

Cost and burden

116 A significant number of respondents referred to the cost implications of these amendments to the LRMP and the resources required to implement and maintain the additional information. They felt a disadvantage of the tier two model was a '*likely increase in annual fees to maintain this Tier 2 information'* (consultant). A doctor in training said '*Increasing the data held on the register will increase costs at a time when the profession has already experienced many years of pay freeze'.* Some respondents suggested that those who want the information should pay for it, or that only those who upload tier two information should pay for it.

Accuracy and verification of information

117 Another commonly perceived disadvantage of the two tier model was felt to be the difficulties with ensuring the accuracy of the information in tier two. There were concerns about the administrative burden that keeping this information up to date would place on doctors, particularly given how quickly this information could go out of date, and the consequences that doctors might face if the information is not kept accurate. A considerable number of respondents felt that the GMC would have to take responsibility for keeping this information up to date.

118 Some also questioned whether there might '*be a tendency for some doctors to exaggerate certain areas of skill / competency'* (consultant).

119 Respondents also highlighted that the subjectivity of the data could be a disadvantage if there were not clear explanations and controls in place. They raised a potential to mislead rather than aid the public if it is not fully understood. For example, what some define as language proficiency may be a basic qualification, and for others might indicate that the individual is bilingual. Information *"would need to be offered to the public with great caution in order not to mislead but to make best use of the valuable resource which is NHS staff diversity"* (doctor in training). Another doctor in training said '*People will get confused when they see differing amounts of information about different doctors'.*

120 In relation to linking to feedback sites, the risk to doctor's reputations was a disadvantage highlighted by many respondents. Responses highlighted that this is one sided data, with no right of reply for doctors if there is no way to take this information down or dispute the comments. Concerns were also expressed by many respondents that linking to these sites from the LRMP, indicates GMC endorsement of the information, and encourages subjectivity.

Suggestions for mitigations

121 Suggestions for mitigations mainly focussed on not putting additional information on the register, particularly tier-two information. Suggestions to mitigate these risks included the availability of options to quickly and easily take down, or hide, information; to include significantly less personal information; keeping private practice information separate from other information; clear explanatory information about the voluntary nature of tier two.

Disadvantages based on the types of information that could be published on tier two

122 Many respondents raised a risk to the safety and privacy of themselves and their families, as well as the risk of identity theft, fraud, junk mail providers and cold-callers. These comments have been taken into account as part of other questions in the consultation.

Purpose of LRMP and the GMC

123 A number of respondents said that the two tier model was unnecessary because the information is already available in other formats, it turns the register into an advertising platform and the provision of the information was outside the remit of the GMC. These comments have been taken into account as part of other questions in the consultation.

Question 9: Which of the following categories of information do you think would be useful to include on the register? Please indicate whether this should be Tier 1 information, Tier 2 information, or if neither please leave blank.

124 Respondents were asked to select from a list of options the categories of information that they thought would be helpful to include on the register. They were then asked to indicate whether the information should be Tier 1 or Tier 2 information.

125 The majority of respondents did not think that any of the categories of information were helpful to include on the register. The most popular category selected was credentials (14% support) followed by scope of practice (12% support). The least popular categories were a link to recognised feedback websites (2% support), registrant's photo (3% support) and a link to the website of the place a doctor works (4% support). Responses from patients and the public reflected the overall responses.

Employment History

	Useful to include	Not useful or left blank
All respondents	514	7227
Organisations	24	57
Doctors	284	3758
Members of the public	26	60
All other individuals	22	824

Languages spoken

	Useful to include	Not useful or left blank
All respondents	712	7029
Organisations	20	61
Doctors	404	3638
Members of the public	27	53
Other individuals	28	811

Agenda Item 6 - Developing the UK medical register

Conflicts of interest/competing professional interests

	Useful to include	Not useful or left blank
All respondents	720	7021
Organisations	24	57
Doctors	428	3614
Members of the public	23	57
Other individuals	22	817

Scope of practice

	Useful to include	Not useful or left blank
All respondents	950	6791
Organisations	27	54
Doctors	579	3463
Members of the public	29	51
Other individuals	25	814

Practice location

	Useful to include	Not useful or left blank
All respondents	507	7234
Organisations	25	56
Doctors	290	3752
Members of the public	29	51
Other individuals	23	816

Credentials

	Useful to include	Not useful or left blank
All respondents	1057	6684
Organisations	32	49
Doctors	608	3434
Members of the public	32	47
Other individuals	31	809

Links to data held and verified by other recognised bodies, such as medical royal colleges

	Useful to include	Not useful or left blank
All respondents	681	7060
Organisations	26	55
Doctors	399	3643
Members of the public	23	56
Other individuals	25	815

Registrant's photo

	Useful to include	Not useful or left blank
All respondents	213	7528
Organisations	14	67
Doctors	101	3941
Members of the public	18	61
Other individuals	17	823

A link to the website of the place a doctor works

	Useful to include	Not useful or left blank
All respondents	327	7414
Organisations	18	63
Doctors	175	3867
Members of the public	24	55
Other individuals	15	825

A link to recognised feedback websites

	Useful to include	Not useful or left blank
All respondents	144	7597
Organisations	11	70
Doctors	75	3967
Members of the public	17	62
Other individuals	9	831

126 However, both the Patients Association survey and the independent Omnibus survey demonstrated a much higher level of support for the inclusion of additional information on the register.

127 The survey conducted by the Patients Association asked respondents whether they thought the register should contain additional information. The majority of respondents said that it should, and the most popular categories selected were employment history and scope of practice.

128 The majority of respondents to the Omnibus survey said they would find it helpful for doctors to provide additional information on the type of work they usually conduct (86%) and whether they have any specialist qualifications or professional interests (85%). Having a photograph of a doctor was considered the least helpful of all the types of information tested (49%).

129 As part of their engagement with stakeholders, our Regional Liaison Service found that the categories of information to include on the register which received the most support were: scope of practice; credentials; languages spoken; employment history; declarations of interest. They found that some patients were supportive of adding further information on qualifications, experience and scope of practice, as well as practice location. Yet patients noted that they will often use google or practice website to search for information, commenting that a large amount of tier two information is available elsewhere. Patients highlighted the difficult in searching for doctors on the register but were against the idea of publishing photographs. They felt this would not be necessary and would impact on doctors' personal safety.

Question 10: If there are categories of information listed above that we shouldn't attempt to collect, please explain why.

130 This question gave respondents the opportunity to explain the reasons why they don't think that the additional information should be included on the register. 3276 (42%) respondents provided a response to this question.

131 Respondents said the additional categories were unpopular for a range of reasons. Of all of the categories of information that were suggested could be added to the register, the inclusion of photographs and links to feedback websites were by far the categories most frequently commented on. This was reflected across all categories of respondent, including patients. The Patients Association said '*from the supporters surveyed for this consultation response, photographs were the main category identified as 'shouldn't attempt to collect', this was followed by a link to recognised feedback*'.

Unnecessary, burdensome and costly

132 Respondents said that the additional categories were unnecessary, burdensome and costly to introduce and maintain. Many doctors said they would be angered if their fees were spent this way. Many said the benefits were not adequately described to warrant the cost and burden of the inclusion of new categories. The PSA commented that the…*'benefits of [the] two tiered register and other benefits to public protection in providing other categories of information [are] not demonstrated'.* Some highlighted the fact that patients cannot choose their own doctor in the NHS, therefore the information had little benefit. One consultant said '…*patients in the NHS do not ever have any say in which surgeon they are referred to. The NHS does not provide this choice to patients'.*

Changing the purpose of the register

133 Many respondents said that publishing this kind of information was not in keeping with the purpose of the register, to define whether a doctor is registered to practice. A number also thought we were supporting privatisation of healthcare. They felt we should limit the information we publish on the register to information required to be published by the Medical Act. One doctor said *'If I wanted to advertise my private services then let me pay for that. This is not the remit of the GMC'.* Another said '*All you are attempting to do is create a catalogue of doctors and drive towards a style of healthcare more similar to private healthcare'.*

134 Respondents were concerned that the additional information would turn the register into an *'online CV'* or a kind of *'Facebook for doctors'*. Linked to this was the view that this information was already available elsewhere. It was frequently noted that many doctors already share this kind of information on other websites and that they do so at their discretion. This would mean duplication of information on practice websites and NHS Choices.

Rights to privacy

135 Many respondents said that publication of this information was intrusive and a breach of privacy - '*it violates my right to privacy'*. There was a very strong view that doctors did not want their personal data published online. Publishing some of the information will create safety risks for doctors and their families, as well as increase to risk of identity theft. This was particularly true in relation to employment history, location of practice and photographs. Many doctors mentioned risks of stalking and harassment and one GP said this was '*more likely to occur to females with photos I should think'*. The British Army in particular highlighted that inclusion of practice location would be a big difficulty for military doctors. One doctor said '*Practice location and a link to place of work allow easy cold calling for advertising to individuals, or worse, facilitate impersonating a doctor to intrude into sensitive systems as they make stories more plausible'.*

Potential to discriminate or disadvantage groups of doctors

136 A significant number of respondents raised the potential for some of the information to be used to discriminate or disadvantage certain groups of doctors, and advantage others. In particular, languages spoken and a photo could encourage discrimination on the basis of ethnicity, religion and age. For example, a doctor in training said *'given recent events such as an increase in racist attacks and the recent decision to reduce the number of doctors by the current health secretary, by defining and classifying a doctor by what they look like, you could be opening up the doors to even more judgment by the colour of someone's skin or where they are from - neither of which should matter at all'.*

137 Doctors could be disadvantaged by publishing practice history that demonstrates they have changed roles frequently or taken breaks in practice such as maternity leave. The Medical Defence Union said '*There is also a concern that inappropriate inferences may be drawn by some from employment history – for example that of a doctor who has moved around and undertaken many posts, or even of a doctor who has held the same post for many years, or a doctor who has unexplained gaps in employment or worked abroad for a period of time'.*

138 Some respondents also highlighted that some doctors could gain advantage by putting this information on the register. One consultant thought that doctors with commercial interests and individuals engaged in private practice could be advantaged by the inclusion of the above categories, as well as… '*photogenic, white, self-promoting, non-EU (post Brexit), non Black and Minority Ethnic (BME) doctors, particularly if well-connected/privileged (because the nature of each professionals' social and professional milieu will be indicated by the level of detail in the social media and review site level detail you seem to propose)'.* The Royal College of Psychiatrists highlighted that additional information *'…could end up being a tool for promotion of services and sway patients more toward choosing the doctor with the most complete profile, rather than the doctor who is most appropriate'.*

Accuracy of the information

139 Many respondents said that it would be too difficult to ensure the accuracy of the information or to keep the information up to date on an ongoing basis. Therefore it would diminish the registers reliability and reputation as an up-to-date, robust data source. In relation to employment history, some said it would be disproportionately difficult for doctors in training and locum doctors to upload and keep up to date with frequently changing posts, which could also be negatively misinterpreted by patients. Language proficiency was another area highlighted as difficult to verify. The MPS said '*Inclusion of additional categories complicates matters and [it would] lose [the] status of [the] register as robust and reliable, up to date reference source'.*

140 A small number were concerned that a failure to upload accurate information by the doctor would lead to fitness to practise investigations being carried out against them for dishonesty, even if done by honest mistake.

141 Links to recognised feedback sites was one of the main categories respondents commented on. They felt that including this invalidated information on the register would inappropriately legitimise the feedback on the sites or will be seen as endorsements by the GMC. Respondents felt strongly about the subjective nature of the feedback, with many highlighting that patients only gave feedback when they weren't happy with the outcome of the consultation, for example being refused antibiotics or sleeping pills. One GP suggested that *'If you propose to include this sort of review surely you should also provide peer review/360 MSF/Patient satisfaction questionnaires, which are more likely to be balanced accounts of a doctor's practice?'*

Vague or too confusing

142 Some respondents raised the risk that the additional information could confuse or mislead the public. For example, one GP said `*Languages: I speak 3 others conversationally but would not want patients to visit me expecting medical level of communication in said language'.* Many also said that the additional information would not be of any benefit to patients. One respondent said `*The fact that doctor A can speak 7 languages or has 20 letters after their name bears no link to them being a better/more caring/ more trusting doctor than doctor B who speaks one language with their sole medical degree'.*

143 Some categories of information were considered too vague and required additional definition. In particular, scope pf practice and credentialing were not well understood by the few people who commented on them. One respondent said *'Scope of practice' is too vague and is almost certain to over-generalise to an extent which could be misleading for patients.* Scope of practice was seen to be something *'dynamic'* and *'highly individual'.* However some did provide comments in favour of scope of practice information such as *'Special knowledge regarding autism and disabilities pelvic radiation disease training completed in the above areas'.*

Question 11: What other categories of information would you find useful to include on the register?

144 1652 (21%) respondents provided comments in response to question 11. The significant majority of respondents did not suggest any additional information (beyond those already suggested in the consultation document) to be included in the LRMP.

Comments against additional categories of information to include on the register

145 The vast majority of comments received cautioned against including other categories of information on the register. *'The MDU generally uses the GMC register only for the purposes of identifying individual doctors. When seeking any other information about*

doctors, staff members asked said they use a search engine which usually provides links to relevant information through the doctor's employing organisation(s) or practice(s) and/or academic institution'.

146 A large number of comments stated that the register should be kept to an absolute minimum, and questioned the purpose of expanding the register. One consultant said *'It is a GMC register. Therefore the only data relevant is GMC stuff. When did you get registered, what is your registration status, is there a specialist registration? Most of the rest of the data you want has nothing to do with the GMC'.*

147 A number of respondents said we could improve the current register. For example, one consultant said *'What you have now is sufficient and perhaps you could simply improve it with for example plain English explanations of what qualification abbreviations mean, and perhaps links to Royal College websites and support resources…'*

Additional categories of information that might be useful to include on the register

148 A very small number of respondents made suggestions about other categories they might find useful to include on the register.

149 12 organisations proposed additional categories of information. Their most common requests were for further information on special interests or sub-specialties, including recognition of trainer status (when legislation allows), teaching status and membership of advisory boards, faculties or health charities. A small number of also requested additional details on revalidation, notably revalidation dates and completed annual appraisals.

150 13 members of the public made suggestions focused on three areas more detail on historical fitness to practise cases, additional details on the location and nature of the registrants' employment (including involvement in private practice, out of hours practice and charitable activities) and additional details on scope of practice (clarification on the scope of an individual's responsibilities and their areas of specific expertise). One member of the public said *'It is essential to include information about criminal convictions, cases of malpractice and negligence, and any disciplinary procedures against them. This should be included whether in the private sector or the NHS, and whether in the UK or abroad. It should also be noted whether the disciplinary procedures were properly concluded or not…..It must be easily accessible and readily available to help them if they had to bring a case against the wrongful practitioner*.

151 Suggestions were made by a small number of doctors, doctors in training and medical students. These included: more detail on qualifications and stages of training; revalidation; employment and work location; scope of practice; areas of special interest, research publications and prizes/awards received.

152 One doctor in training said *'…I do think that current area(s) of specialism would be more accurate and less misleading in the case of doctors who have made a clear career change and could no longer safely practice in a formerly recognised specialty'.*

153 The three quotes below are example of suggestions received from consultants.

'There should be details of any specialist areas that do not fit the current areas of registration - for example spinal surgery. Currently spinal surgeons do not have any specialist field on the register yet we do have the ability to be employed in the NHS as a pure spinal surgeon from either an Orthopaedic or Neurosurgical training background'.

'Place of training actually - it is important for patients to know whether a doctor has trained in the UK or not. Being registered with the GMC does not mean one has obtained their qualifications in the UK and training, as we know very well, is extremely variable across Europe and the world and impacts on how we practise'.

'where extra income is obtained for professional services, e.g. pharma, immunisation companies, consultation fees etc'.

In addition, we received one comment recommending closer integration between the GMC register and NHS Choices website

'…The Patients Association recommends that staff listed under a practice on the NHS Choices website are better connected to the GMC's medical register as currently just a doctors' GMC number is listed and this requires patients to understand how to search and use the register. By better integrating the GMC register and the NHS Choices website, the Patients Association believes that the public would have greater awareness of the register and the register would better promote and maintain confidence in the medical profession'.

154 A number of respondents suggested the inclusion of information already present on the register, or information already suggested in the consultation document.

Agenda Item 6 - Developing the UK medical register

Question 12. Do you agree it is sufficient for Tier 2 information to be subject to verification through sample audit, provided the status of the information is made clear to those consulting the register?

	Yes	No	Not sure	Blank
All respondents	952	2574	913	3302
Organisations	17	25	7	32
Doctors	554	1404	523	1561
Members of the public	22	17	13	28
All other individuals	35	32	13	759

155 952 (12%) agreed that it was sufficient to verify a sample of tier 2 information, provided the status of the information was made clear to those consulting the register. 3302 (43%) respondents did not answer the question. 1934 (25%) respondents provided comments in their response to this question.

A sample audit is not sufficient

156 The majority of respondents across all groups said a sample audit was insufficient verification. Most comments can be summed up by the following statement by a doctor in training - '*All of it should be 100% accurate and verified'.* Another doctor said *'If one of your overarching principles is to be able to validate this information, a sample audit is insufficient'.*

157 The main concern was that the information on the register would not be accurate if all of the information was not verified. The GMC register is relied upon as a trustworthy source of information. For example, one consultant said '*I don't think audit is enough as the GMC is a trusted brand'* and a doctor in training said *'Sample audit is not good enough. It has to be every detail posted on the website. The GMC is the only body trusted fully by patients, too trusted for you to leave things to chance that you may catch out falsifications through sample audits'.* A member of the public said '*no information should be included without direct verification, sampling is completely unsatisfactory and risks consequential errors in published information'.* Respondents noted that the GMC is a highly regarded regulatory body and there is public expectation that information provided on the GMC website is accurate and validated. It would be unrealistic to expect the public to understand the implications of information only being checked by sample audit.

158 Respondents were concerned that a sample audit would provide false assurances to members of the public that all information is verified by the GMC. One medical student said *'I believe that when the public are looking for information on the GMC medical*

register they should be assured it is accurate and verified and there is limited value of additional information that the public have to judge whether it is accurate or not' .

159 A number of respondents highlighted the potential risk to patients if inaccurate information is on the register. One doctor in training said *'If only one mistake is found and leads to patient harm the press will have a field day with the story!!'* A member of the public said *'No, everything must be checked and verified for every member listed. There cannot be any room for error when patient safety is at risk'.*

160 Respondents commented that sample audits do not guarantee the accuracy of the information, which may result in some doctors who provide false information never being identified. If tier two information is voluntary it is likely that only a small number of doctors will contribute information, in which case auditing a sample of the information is of limited value.

161 Some respondents questioned the value of auditing voluntary information. One GP said '*If it is voluntary then why does it need auditing?'* A doctor in training said '*Since it is voluntary information, the process of verification should not cost anything (in time, opportunity costs or monetary costs) for the doctor concerned'.*

Cost and burden

162 A significant number of respondents said that a sample audit would create additional burden for doctors and increase their workloads. Doctors in particular questioned an increase in their fees to cover the cost of this exercise and felt it was unfair for doctors to *'shoulder the burden'* of a sample audit. One doctor in training said '*Doctors already have enough form filling and bureaucracy to content [sic] with without this'.* A number of responses from members of the public also questioned the additional burden on doctors *'This all just sounds like unnecessary burden on doctors'.*

General opposition to having additional information on the register or a two tier approach

163 Many respondents re-iterated that they do not agree with putting additional information on the register. Their reasons are set out in response to earlier questions in this report, but include the cost, the purpose of the register and privacy and safety issues. Many respondents also voiced their opposition to a two-tiered structure for the register. Again, the reasons provided have been set out earlier in this report.

Those who agreed it could be useful

164 A small number of respondents did agree that a sample audit would be useful; although not all were convinced it would be sufficient to ensure accuracy. Some organisations said it might be helpful in assessing the functioning of a two tiered system, but will not identify those who may misuse the system. One consultant said '*It would be idiotic of a doctor to present incorrect/inaccurate information on a GMC audited website'.*

165 A number of respondents also highlighted the need for a process for someone to question the accuracy of the information. One GP said *There should be a function for the public to alert the GMC if they believe any tier 2 information given is misleading or untrue.* Another GP said there should be a whistleblowing option if they spot a colleague's inaccurate entry. A member of the public said '*There should be an easy way for anyone searching the register to log a query concerning information found to be inaccurate or out-of-date'.* Some also asked how we would distinguish between mistakes or intentional provision of misleading information.

Suggestions to better verify the information

166 Some respondents suggested additional ways to verify the information. These included: declarations; annual returns; independent validation; email prompts; clear sanctions for false information; a statement of when the entry was last updated or verified.

Question 13: If you've used the online register, do you have any thoughts on how we can improve it and make it more user friendly?

167 2002 (26%) respondents provided comments in response to this question. The significant majority of respondents either chose not to comment or declared that the register was acceptable as it was and should not be changed.

168 Many felt that the online register was already user friendly, that the proposed 'benefits' of the changes were disputed (with questions raised over the credibility of the research), and that the changes could represent a risk to privacy and individual safety. One consultant said '*Patients who want to search for certain specialists in a certain locality can quite easily search the directories of their local NHS or private institutions. There is no need for the GMC to add this information as it is already in the public domain. Furthermore, as doctors frequently move practice/hospital then this information may not be up to date'.*

169 Most of the recommendations provided in response to this question were about information that could be displayed on the register (echoing responses to the other questions in the consultation), as well as the usability of the entire GMC website rather than the register.

170 Recommendations to improve the register tended to fall into three main themes – improving the search function, simplifying language and improving the layout and navigation.

171 The most popular response was related to access to the register. Respondents stressed that the information should be easily accessible and understandable, and that patients should be made aware that they are able to access this information.

Improve the search function

172 Recommendations to improve the search function included introducing the ability to search by specialty and location, as well as what the person is 'known as' and what the person's name 'sounds like'.

173 One doctor in training said '*It would be useful to be able to specify specialty. I occasionally need to find GMC numbers for colleagues and having to root through 200 entries for John Smith is infuriating when I know they work in a small specialty'.* Another doctor in training said it would be helpful to search for a maiden name. *'I previously worked under my maiden name and anyone searching for me under that would find no record of me currently online'.*

174 The Medical and Dental Defence Union of Scotland (MDDUS) said *'…some doctors practice under colloquial names - either by first name (e.g. 'Dr Sam') or by a contraction or abbreviation of a long surname. It is difficult to search the LRMP unless the full registered surname is known. This can be made difficult again where the surname may be such that there [are] a variety of spellings. The 'sounds like' option currently available is helpful, but only of limited use. Perhaps this facility could be enhanced'.*

175 One member of the public said *'It would help to have a wider variety of search parameters, e.g. hospital name and department, as an alternative to only the doctor's name or GMC reference. When a patient does not know the doctor's full name or its correct spelling, there has to be an easier way to find the correct profile on the register'.*

176 However, a number of respondents also expressed concern at proposals to amend the search function. In particular, there was a concern that this may facilitate the identification of potentially vulnerable doctors – including those working in high risk specialties (forensic psychiatry) and those working within the military.

177 RAF Medical Services said 'Allowing people to search for a doctor by local area and qualifications will compromise the security and safety of doctors if the person searching wishes to do them harm e.g. doctors who are GPs with a specific set of diplomas (such as Dip Av Med and DMCC) are likely to be from a military background'.

178 A doctor in training said *'…But if a doctor has been the target of a crime and legitimately needs to move away, they are either penalised for not listing their location, or they are immediately findable… Extreme care needs to be taken when designing the search engine to avoid disadvantaging doctors from vulnerable minorities / making them the easy target of hate-crime'*.

179 A number also felt any attempt to improve the search functionality of the website would not be compatible with the GMC's remit, particularly when this information is already held in the public domain or available elsewhere. For example, one doctor in

training said *'Why is it important for users to have their expectations met? Why is this more valid than a doctors right to privacy?*

Clarify and simplify language

180 Recommendations to clarify and simplify the language used on the register included making sure that lay terms are used wherever possible, with abbreviations (and doctor's grades if introduced) clearly explained.

181 The Christian Medical Fellowship said *'Making it clear what 'registered without a licence to practise' means would help both patients and organisations using the register. Doctors working overseas usually have to relinquish their licence. Although the licence only relates to practice in UK, some users may think that a doctor without a licence is not fit to practise, whereas they are actually in good standing but have temporarily relinquished their licence while working outside the UK. This confusion may prevent doctors from getting registered in other countries, or may reduce the confidence patients have in them. Two small changes would help: 1. Adding 'in UK' to the label 'registered without a licence to practise'. 2. Adding an explanatory note: 'Registration without a licence to practise means that the doctor is in good standing with the GMC but not currently licensed to practise in the UK'.*

182 Members of the public in particular requested additional detail about the areas of practice doctors are legally and professionally competent to practice in, providing details of qualifications, explanations of abbreviations and explaining why doctors might be suspended.

183 One member of the public said *'Just to make the whole thing transparent to all and any information to be made easy to access this, together with a breakdown of what a Doctor, Consultant is legally, professionally and qualified to carry out'.*

184 A medical student said *'…Perhaps it would be useful to have a small blurb or pop up to explain what the different grades of doctor are. Or perhaps you could click on the doctors position (e.g. - ST3) and it would explain exactly what this means so that the public can be in no doubt'.*

185 Respondents to the Patients Association survey stressed that the information should be easily accessible and understandable, and that patients should be made aware that they are able to access this information.

Improve layout and navigation

186 Recommendations to improve the layout and navigation of the site included reducing the number of clicks required to access relevant material, reducing the number of 'pop-up windows', and giving the register given a more prominent location on the GMC home page. Consideration of the amount of text and font size was also suggested. Some also suggested tailoring the availability of the information towards the audience,

with different levels of information available depending on whether someone is a member of the public, an employer or a doctor.

187 On consultant said *'The register should include options to change the text size/contrast etc and include dyslexia friendly fonts. The pages and entries should zoom in properly and also the colours should be clear with well defined borders. Finally it should include the option to change languages of the buttons perhaps?'*

Conclusion

188 Respondents to the consultation demonstrated a clear lack of support for to the options put forward for developing the online medical register, and nearly all respondents objected to adding further information to the register. This was despite the independent research in 2015 having indicated a consensus for at least some changes, and feedback through other engagement demonstrating an appetite for improvement.

189 Most respondents wanted to limit the purpose of the register to providing assurance to the public that a doctor is registered and licenced to practise medicine in the UK. They did not see the GMC as having a role in providing the public with additional information.

190 There were clear concerns raised by respondents. The main concern was related to doctors' privacy and safety. While some of these comments were based on a misunderstanding that we were proposing to publish sensitive personal data, they demonstrate the strength of feeling among respondents.

191 We recognise the importance of balancing openness against the individual privacy of doctors and understand the concerns raised by a large majority of respondents about additional information potentially having a severe impact on their safety and privacy. For the avoidance of doubt, however, we have not proposed to publish any private or sensitive personal data and the options presented related only to doctors being able, voluntarily, to include information relevant to their professional roles.

192 Respondents also raised concerns about the potential for additional information to disadvantage some groups of doctors or promote discrimination, as well as mislead members of the public.

193 Challenges around the practicality of the proposals were another cause for concern. In particular any cost of amending the register, the difficulty of keeping the information up to date, and the risks of information not being accurate. It's worth clarifying that none of the options presented would have impacted on the annual retention fee.

194 These views, coupled with the volume of responses received, demonstrate the need to exercise caution before deciding to introduce any further changes to the register. At this time, we will not take forward these options to enhance the register.

Agenda Item 6 - Developing the UK medical register

195 We will continue to develop our plans for credentialing following the positive outcome of our consultation in 2015. We will also work with the Academy of Medical Royal Colleges to explore the desirability and practicalities of collecting and possibly recording information about doctors' scope of practice. However, we would take on board feedback from this consultation before making any decision to proceed further.

196 As part of phase one of our digital media strategy, we are intending to do work to improve the look and functionality of the LRMP. The helpful suggestions provided in response to the consultation will help to inform this work.