

Health and Social Care Committee's inquiry into the NHS Long-term Plan: legislative proposals

Summary

- We support any measure that can deliver more effective collaboration and co-ordination between NHS organisations and structures. In parallel, 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 on many of its aspects 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 up to an application of up to 1,000 pages, which can take up to a year to compile, costing £1,500*. 49% of applicants don't successfully complete it. This burden must be reduced if current shortages are to be effectively addressed.
- 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

- 1 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.

The scope of these proposals

- 2 In '*Implementing the NHS Long Term Plan: Proposals for possible changes to legislation*' ['the proposals'] NHS England and NHS Improvement state that it would 'would be possible to deliver the NHS Plan without primary legislation' but that it could 'make implementation easier and faster' if this were a possibility.
- 3 The eight areas specified in these proposals are all valid areas to explore in and of themselves. However, they are all primarily focused on the operational structures and processes surrounding the work NHS in England itself. These are commonly referred to as 'architecture'. 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.
- 4 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. These include the creation of a 'workforce implementation plan', which is also being referred to as the 'people plan' and includes commitments to growing the medical workforce, supporting improved international recruitment as well several other key issues that will collectively support the development of sufficient numbers of appropriately skilled doctors across the NHS. These include the content and structure of medical education and training.
- 5 The committee should note that a number of steps that may need to be taken in the context of the NHS plan, particularly those relevant to doctors, are largely dependent on the GMC being able to fulfil its mandate as effectively as possible. We have been closely involved in the development of the interim workforce plan, and we believe that we can support many aspects of it through adaptation of existing policies and processes using our existing powers as afforded by the Medical Act (1983).

- 6** However, there are steps that we would like to take (and would support others in taking) that would require amendments to this Act as well as other associated elements of legislation. We also see potential for other legislation that does not directly shape the work the GMC does, but is linked to it, to be reformed in a way that supports the plan's objectives around workforce.
- 7** We believe these changes would deliver clear and quantifiable contributions to the objectives of the NHS Plan around workforce. As such, the proposals that NHS England are putting forward should be broadened to include changes to the specific powers the GMC has and the processes that we, and others, are required in statute to follow.
- 8** In this context, we note that the Department for Health and Social Care (DHSC) is yet to respond to its 2017 consultation '*Promoting professionalism, reforming regulation*'. The scope of that consultation includes many reforms that could, if delivered, promote our ability to contribute to these objectives outlined in the NHS Plan. But a number that we believe are key are also outside of the scope of the proposals that that consultation included.
- 9** In our view, the primary legislative vehicle for taking forward such proposals forward should therefore be any be any Government bill (or draft bill) that is derived from the 'call for evidence' exercise that NHS England and NHS Improvement have published. Any decision about the content of such a bill 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.
- 10** The committee will be aware that, as matters stand, finding the parliamentary time for new legislation to be laid is a real constraint on reforms in many policy areas, including healthcare. 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. This would have an impact across the UK, given the continued reserved nature of legislation concerning professional healthcare regulation.
- 11** The remainder of this submission sets out some specific proposals that we suggest should be included in any finalised proposals that NHS England and NHS Improvement put forward to Ministers for consideration. We agree with the perspective they express, as outlined in paragraph 2. It would possible to deliver many of these without primary legislation, but introducing them through these means could make their implementation easier and faster. It follows that the benefits derived from them in a workforce context could be felt sooner.
- 12** We are, in parallel, asking NHS England directly to broaden the scope of their aspirations in our response to their call for evidence.

- 13** It has been over 35 years since the Medical Act (1983) was passed and now at least seven years after the large major health related Act of Parliament. If the NHS is to address its medical current workforce shortages, action is needed sooner rather than later. Any legislation in this area must maximise the potential for all organisations to fully contribute to the goals the long-term plan sets out. These proposals could provide a real opportunity for that to happen.

Additional areas where new legislation is necessary

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

- 14** The NHS Plan rightly highlights that 'professional regulatory bodies have a significant role in enabling the recruitment and employment of appropriately trained overseas professionals in the UK. It is critical that individuals looking to register to work in the UK can move through regulatory processes quickly, while upholding the high standards the public expects'.
- 15** Under European Law, the UK automatically recognises the majority of medical qualifications gained in European Economic Area (EEA) Member States and vice versa. Parliament has now passed legislation that ensures that the UK will continue to unilaterally recognise EEA qualifications even if the UK leaves the EU with 'no deal'. It is unclear what recognition will be afforded to UK qualified doctors in parallel in such a situation.
- 16** 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. As part of a review we completed in 2012, we have delivered significantly streamlined processes for bringing them onto our register.
- 17** But it has become clear to us that we have now reached the limit of what the law currently allows in terms of further streamlining this route to registration. 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 that we are obliged by law to follow.
- 18** In order to be able to satisfy the GMC that they are competent to practise, they need apply for and be granted what is known as a CESR/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.

- 19** Over the period 2013-2018, only 685 doctors on average per annum 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.
- 20** Consequentially, only 293 doctors on average are deemed eligible to join our specialist or GP register per year through the 'equivalence routes' currently available. By way of comparison, every year around 1,100 doctors (more than four times as many) join those registers through automatic recognition (as outlined in paragraph 15). Doctors also regularly tell us they want the process to be improved and we are concerned that some avoid or withdraw from coming to the UK as a result. This is clearly undesirable, and actively impedes progress towards the objectives the NHS Plan sets out.
- 21** Ideally, the law should allow for applicants to demonstrate their knowledge, skills and capabilities in a more flexible manner that is at the GMC's discretion. This would give applicants more flexibility in terms of what they need to provide to us leading to potentially quicker applications, but without lowering standards for doctors working in the NHS. 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.
- 22** 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 general registration from international medical graduates (Section 21)- for doctors that are neither GPs or specialist consultants. In parallel with that, the relevant secondary legislation should be repealed.
- 23** 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 provision and the GMC has the scope to determine in policy terms how this can best be evidenced. We believe that a similar, proportionate approach should apply for determining entry to the specialist and GP registers.

* We do not make a profit on the cost of the registration process. The figure reflects the cost of the process that doctors need to go through

[†] The General Medical Council (Applications for General Practice and Specialist Registration) Regulations (2010)

Introduce statutory regulation of Medical Associate Professions to support workforce transformation

- 24** In 2017, the Government consulted on the introduction of statutory regulation for what are known as 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).
- 25** All of these roles are occupied by post-graduate qualified health care professionals who work to the medical model, having been trained in the attitudes, skills and knowledge base to deliver holistic care and treatment under defined levels of supervision. However, MAPs are currently not covered by the wider professional healthcare regulatory framework.
- 26** Because of that, they cannot legally perform tasks such as prescribing medication or signing death certificates. As a result, the potential contribution that they can make to the relieving the workload of an overburdened qualified medical workforce is reduced. There is some evidence that employers are reluctant to utilise the services of MAPs to help relieve the burden on doctors because of the absence of assurance that would be provided by statutory regulation. And where they are being used, patients and the public do not currently have that assurance either.
- 27** We fully support Government's recent decision that PAs and PA(A)s should be subject to professional regulation, especially as they are called upon to perform close examination of patients. Indeed, they perform many of the tasks currently carried out by doctors who are expected to be licensed with the GMC. We also recognise the Government's aim, as expressed in 2015 by the then Secretary of State, to create 1,000 new physician associates posts to work in general practice by 2020 as part of a 'new deal' to alleviate the shortages we see in this field of medicine.
- 28** 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.
- 29** 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 the proposals that NHS England are putting forward in the context of the committee's current inquiry.
- 30** In our view, there is regulatory coherence in the GMC undertaking regulation as the roles train and work to a medical or surgical model and have 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. In parallel, we would undertake to ensure that there would be no cross subsidy on the part of existing medical registrants' fees to support costs of bringing MAPs into statutory regulation.

Amend the Performers' List Regulations

- 31** In addition to being a GMC registrant, GPs providing care in England are legally required to be on a 'Performers' list' managed by NHS England. Requirements concerning admission to the list, alongside mechanisms to impose conditions, suspend and remove practitioners from it, are set out in secondary legislation.
- 32** The Performers' List system is intended to provide an extra reassurance for the public that GPs, Dentists and Ophthalmic Medical Practitioners who practise in the NHS are suitably qualified, have up to date training, have appropriate English language skills and have passed other relevant checks such as with the Disclosure and Barring Service and the NHS Litigation Authority. It does this by giving NHS England powers to maintain the performers list including the admission, suspension and removal of practitioners.
- 33** In our view, the Performers' List legislation could be broadened to remove potential barriers to mobility of labour in terms of supporting entry, exit and return of doctors into primary care and the wider NHS workforce.
- 34** For example, the legislation could be amended to allow qualified GPs to work with a limited scope of practice. This would mean that the NHS would be better placed to 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 types of patients.
- 35** It might also be possible to expand the induction and refresher scheme so that doctors who have been practicing 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 (see paragraphs 18-19) could work under supervision within NHS primary care so that they could obtain the knowledge and experience required for them to successfully reapply for the GP register. Effectively, they could work in UK primary care within limits to gain experience and skills to become a GP.
- 36** Finally, 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.
- 37** Finally, enabling trainees in specialities other than general practice to undertake some of their training in primary care would align with the NHS's wider ambition, which is

shared by its equivalents across the devolved nations, to integrate care across primary and acute sectors and ensure that the medical workforce is trained to support that ambition.