



House of Commons
Health Committee

The use of overseas doctors in providing out-of-hours services

Fifth Report of Session 2009–10

*Report, together with formal minutes, oral and
written evidence*

*Ordered by the House of Commons
to be printed 25 March 2010*

HC 441
Published on 8 April 2010
by authority of the House of Commons
London: The Stationery Office Limited
£14.50

The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at www.parliament.uk/healthcom

Committee staff

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Footnotes

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1 Introduction

1. In 2004 new arrangements for out-of-hours general practice were introduced as part of a new General Practitioner (GP) contract with the aim of addressing inadequate standards and difficulties in retaining doctors in general practice. Many consider the new system an improvement on its predecessor, but it has some serious weaknesses, in particular in the use of EEA¹ doctors and the failure to check their language skills and clinical competence, which led to killing of a patient, Mr Gray, by Dr Ubani, a German locum. As a result of the failings this incident revealed we decided to undertake a short inquiry. We took oral evidence from representatives of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs), a medical director of a GP out-of-hours service, the Chief Executive of the General Medical Council (GMC) and his deputy, the Chairman of the Council of the Royal College of GPs, and the Minister of State at the Department of Health, Mike O'Brien MP. We received 7 memoranda.

2 The Reform of Out-of-Hours GP Services in 2004

2. The reforms gave GPs the right either to continue providing out-of-hours care services, or to opt out and pass the responsibility to their Primary Care Trust (PCT). After the reforms, the majority of practices (90%) transferred their out-of-hours responsibility to their PCT.² This was unsurprising. GPs had found the previous arrangements onerous and a report by the National Audit Office (NAO) found that, on average, each GP gave up a mere £6,000 per annum when they opted out.³

3. Under the new system, apart from the small minority of GPs who continue to provide out-of-hour services, PCTs commission services either from commercial providers or from local not-for-profit GP co-operatives. The cost to the NHS seems much greater than before.⁴ According to the NAO:

Our survey found that the actual costs of providing out-of-hours for 2005–06, the first full year of the new arrangements, were £392 million, 22 per cent more than the £322 million allocated by the Department and an average of £13,000 per whole-time equivalent GP to provide.⁵

The Minister told us that GPs had “got the best deal they ever had from that 2004 contract and since then we have, in a sense, been recovering.”⁶

1 In this report we use “EEA doctors” as a shorthand to cover doctors from the EEA (EU countries plus Iceland, Norway, Liechtenstein and Switzerland) as well as other doctors with EC rights, excluding UK nationals, who graduated at EEA or Swiss medical schools.

2 Ev 29

3 National Audit Office, *The Provision of Out-of-Hours Care in England*, HC (2005–06) 1041, Summary, para 3.

4 *Ibid.*, Part Four.

5 *Ibid.*, Summary, para 13.

6 Q 109

4. The Department of Health showed little regard to securing value for money for taxpayers when they negotiated the out-of-hours GP service reforms in 2004. GPs gave up a mere £6,000 per annum to rid themselves of their out-of-hours obligations; the cost to the taxpayer in the first year of the new system was an average of £13,000 per whole-time equivalent GP.

5. Despite the increased cost of providing out-of-hours services, and while the new system may be an improvement on the old, there is considerable dissatisfaction with it. The British Medical Association claimed that out-of-hours care was “unacceptably patchy around the country” and that some services fell “shockingly short” with respect to the quality of care.⁷ We were informed that patient surveys found that only two-thirds of patients were satisfied with the services,⁸ but it is unclear whether this rating relates to access to services rather than the quality of care received. The Minister acknowledged that out-of-hours care was “not good enough” and must be improved.⁹

6. While there are other problems with the new system, in this inquiry we focus on the most prominent weakness, namely commercial providers of out-of-hours services’ employment of EEA locums who have inadequate English and/or general practice expertise. This has led to poor care and the deaths of patients. Mr David Gray died in 2008 as a direct result of negligent care and gross incompetence due to inadequate training and inexperience by Dr Daniel Ubani, a German locum, on his first shift working for the Cambridgeshire PCT.¹⁰

7. Following the inquest into Mr Gray’s death, the Cambridgeshire Coroner made recommendations for improving the out-of-hours system. Reviews of out-of-hours services were carried out by the Department of Health and the Care Quality Commission. These highlighted shortcomings in regulation and the failure of some out-of-hours companies and PCTs to vet EEA doctors, as they are legally obliged to, and of SHAs to adequately monitor PCTs’ performance.

3 Assessing the competence of doctors from the European Economic Area working in the UK

8. In respect of the employment of doctors from the EEA who wish to work here, responsibility for ensuring that they are competent in general practice and have the necessary English language skills to communicate effectively with patients, their families and other health professionals rests with the GMC, SHAs and PCTs and other organisations which employ doctors, such as commercial out-of-hours providers and locum agencies. The Minister of State for Health summed up the responsibilities as follows:

7 Ev 50-51

8 Q 2

9 Q 107

10 Inquest into the Deaths of David Gray and Iris Edwards: Coroner’s Summing Up, Decisions and Announcements

There are three checks essentially on any GP who comes in from an EEA State. The first is the qualification: is this person a doctor? It is the job of the GMC to register them if they are a doctor. The GMC, under the 1983 Act, is not able, [...] to carry out language checks on EEA nationals. However, we were aware of that and that is why the 2004 regulations are the way they are, because we knew that was the case. The second check, therefore, is for the PCT. They have to have a performers list and everyone who wants to act as a GP and do any out-of-hours would need to be on that performers list. There is a legal obligation on the PCT to check that they have language competence and also to check that there is nothing known about their behaviour which means they are not a competent GP to carry out out-of-hours. The third check, and in many ways the most important one and where we have to tighten up a lot, is on the employer because the employer, either a co-operative or a private company, needs to ensure that the competence in terms of the skill and also the language skills are adequate to do GP services.¹¹

9. EEA doctors must be registered with the UK's independent regulator of medical professionals, the GMC, in accordance with European legislation and national law (the Medical Act 1983).¹² Obtaining registration depends on the country where the doctor obtained their primary medical qualification, their nationality and the nature and extent of their postgraduate experience.¹³ Whereas International Medical Graduates¹⁴ from non-EEA countries must undergo a rigorous assessment of their clinical and language skills by the GMC before they can be registered, the GMC is "obliged to accept certificates issued by European authorities at face value, and cannot go behind them to investigate further".¹⁵ Thus, in practice, it can do nothing to vet the clinical competence or language skills of EEA qualified doctors.

10. The GMC has insufficient powers in this area so the task of vetting EEA doctors falls on employers and PCTs. Contractors employing doctors to provide NHS primary medical services, including commercial bodies or GP co-operatives providing out-of-hours care, are responsible for ensuring that a doctor is suitably qualified and competent to undertake the specific role in question. This includes conducting pre-employment checks with the GMC on a doctor's registration and their licence-to-practise status. For a doctor wishing to work as a GP, these checks must ascertain whether a doctor has the necessary language skills, training, clinical knowledge and experience in the speciality to undertake the role.

11. Each PCT maintains a medical Performers List and in order to practise in NHS primary care, a doctor must have been admitted onto one of these lists. PCTs have a legal responsibility to undertake various checks on applicants, including an assessment of a doctor's English language and general practice skills.

11 Q 114

12 Ev 48–49

13 *Ibid.*

14 International Medical Graduates (IMGs) are doctors who, regardless of where they may have obtained their primary qualification, do not have right of indefinite residence or are not settled in the United Kingdom (as determined by immigration and nationality law).

15 Ev 50

12. In addition, PCTs which commission out-of-hours GP services are obliged to be clear about the standards which must be met, to ensure that adequate monitoring of these standards takes place and that action is taken immediately where problems arise. PCTs need to assure themselves that employers are carrying out the necessary checks.

13. Finally, SHAs should be monitoring PCTs to ensure that they are undertaking their duties effectively.

4 Proposed changes

14. In response to the death of Mr Gray in February 2008, the Department carried out a review of Performers Lists which was published in March 2009.¹⁶ Subsequently, in June 2009 the Care Quality Commission published an interim statement on the services provided by “Take Care Now”, the commercial healthcare provider involved in the Ubani case, and announced an inquiry.¹⁷ At the request of the Department of Health, Dr David Colin-Thomé, Director of Primary Care at the Department of Health, and Professor Steve Field, the Chairman of the Royal College of General Practitioners, undertook a more general review of commissioning and the provision of out-of-hours services.¹⁸ Finally, the Cambridgeshire coroner published the finding of the inquest into the death of Mr Gray and made recommendations to prevent a similar tragedy happening again. The coroner found that Dr Ubani had been “grossly negligent” in administering an overdose of diamorphine and that Mr Gray had been unlawfully killed.¹⁹

15. These investigations have made numerous recommendations to strengthen out-of-hours GP services. We took evidence about these proposed changes from a number of the authors of the reports and other witnesses, who also proposed reforms. We discuss these below.

The role of the GMC in the assessment of language and clinical skills

16. Witnesses were critical of the legislation which prevented the GMC from assessing either the clinical or language skills of EEA doctors. It cannot be taken for granted that EEA doctors have appropriate clinical skills since the standards expected of general practice in the UK do not necessarily correspond with those of other European countries.²⁰ Niall Dickson, Chief Executive and Registrar of the GMC, told us:

The problem in relation to Europe is that [...] the definition “general practitioner”, which is happily used and we have to accept, does not really apply so that in Germany they do not have general practitioners as they do here. Dr Ubani was

16 Department of Health, *Tackling Concerns Locally: The Performers Lists System: A Review of Current Arrangements and Recommendations for the Future*, March 2009.

17 Update on Enquiry into Take Care Now and Out-of-Hours Services, Care Quality Commission, June 2009, www.cqc.org.uk.

18 Department of Health, *Current arrangements for the local commissioning and provision of out-of-hours primary care services*, January 2010.

19 Inquest into the Deaths of David Gray and Iris Edwards: Coroner’s Summing Up, Decisions and Announcements

20 Q 71

supposedly a qualified general practitioner according to the rules of the European Union and we had to register him on the GP register, which simply goes to show that system absolutely does not work.²¹

17. The GMC is frustrated by the restrictions placed on it. EU law clearly forbids the GMC from testing for clinical competence, but the GMC told us that it only forbids the systematic testing of language skills; i.e. the Council could test in individual cases where it was thought necessary. Mr Dickson claimed that DH civil servants had ‘gold-plated’ the EU Directive when drafting the Medical Act 1983 so as to prevent it from undertaking any language testing. Mr Dickson contrasted this with the approach in France:

If you come from a non-French speaking country the [French] regulator will ask to have a chat with you and if they think your French is not up to much on an individual basis they might ask you to take a test or to go away and learn French and then come back again. The 1983 Medical Act actually prohibits us from doing that.²²

18. Mr Dickson argued that: “Free movement of labour is fine but in our view patient safety trumps the free movement of labour.”²³ Legislative change is required, he argued:

We would like a change in the law both in this country to the 1983 Medical Act which in our view goldplates the European Directive and actually makes it even more difficult in relation to language and we would like a change to the European Directive which would enable us to check competency of doctors coming from the European Union.²⁴

19. The Minister disagreed about the possibility of amending the 1983 Act. The GMC and the Department have apparently received conflicting legal advice as to whether the Medical Act 1983 could be amended without contravening the European Law.²⁵

20. In any case, the relevant European Directive will be revised in 2012. The Minister told us that he supported European legislative change to enable the GMC to test the linguistic competence of EEA doctors who wish to work in England:

If we were able to change it in 2012 so that the GMC were able to carry out some language tests, I would welcome that and I am certainly happy to press for that.²⁶

21. EU legislation prevents the GMC both from testing the clinical competence of EEA-qualified doctors who wish to work in the UK and from systematically testing their language skills. The GMC believes that the Medical Act 1983 “gold-plated” EU Law and forbade the GMC from giving any language tests to EEA doctors. The GMC informed us that the situation in France was different: there, the regulator undertook language tests within the remit of the relevant EU Directive. If the GMC had been able to check

21 Q 69

22 Q 87

23 Q 64

24 *Ibid.*

25 Q 115

26 *Ibid.*

the language skills and clinical competence of EEA doctors wishing to practise as GPs, lives might have been saved.

22. There is a difference of legal opinion between the Department of Health and the GMC. We recommend that, without delay, the Department and the Council share their legal advice about the legality of amending the Medical Act 1983.

23. We further recommend that, as a matter of extreme urgency, the Government seek to make the necessary changes to the Directive 2005/36/EC before it is due to be revised in 2012, to enable the GMC to test the clinical competence of doctors and undertake systematic testing of language skills so that everything possible is done to lessen, as soon as possible, the risks of employing another unsuitably trained or inexperienced doctor in out-of-hours services.

Performers Lists, PCTs and SHAs

24. Given the GMC's lack of powers, it is vital that PCTs carry out thorough checks on the clinical and language skills of EEA doctors. This must be done because it cannot be assumed that these skills are always what they should be where a doctor has an overseas qualification. The Royal College of GPs informed us:

There is a lack of competence—clinical and linguistic—of some of the GPs entering the UK to work in the NHS. I have consistently raised this issue with senior officials and politicians at the Department of Health.²⁷

25. Unfortunately, some PCTs have not done their job. Professor Field stressed that problems had occurred despite systems being in place to prevent them: “if everybody did what they should have been doing properly the quality of care would have been good”.²⁸

26. Dr Ubani was refused access to West Yorkshire PCT's Performers List following a failed language test. However, the Cornwall and Isles of Scilly PCT failed to check Dr Ubani's language skills and also neglected to check whether he had applied for inclusion on any other PCT's Performers List. We were told by Professor Field that:

Clearly Dr Ubani got in through the performers list in Cornwall and the Scilly Islands. He was rejected in Leeds I understand because of his language. Cambridge PCT took him on and there were no checks. Now you have three PCTs there all meant to be doing similar checks with different outcomes.²⁹

This happened in spite of the Department of Health's and the GMC's repeated reminders to PCTs of their responsibilities.³⁰

27. Surprisingly, some PCTs do not even appear to know that the GMC is not permitted to undertake language tests, as a recent review commissioned by the Department of Health indicated.³¹

27 Ev 46

28 Q 58

29 Q 72

30 Q 104

28. The Minister stressed that the failure to carry out the requisite checks was illegal. He told us:

I am making absolutely clear that PCTs should have been, by law, since 2004 looking at language skills. They had no discretion on this; it was a legal obligation. They should be doing it now. If they have not been doing it, and we know Cornwall was not doing it, then they were in breach of the law.³²

29. We asked the Minister what actions had been taken against those PCTs which had broken the law in this way. We were informed:

We confirm that the Department's understanding is that no disciplinary action has been taken by the PCT. The South West Strategic Health Authority, which is responsible for performance managing local NHS bodies, is aware of and is monitoring the situation. We understand that the PCT has since reviewed its procedures and has introduced a number of new safeguards, including arrangements for assuring itself that GPs it admits to its performers list have necessary knowledge of English language.³³

30. There has also been a failure on the part of SHAs, which are supposed to performance manage PCTs. Professor Field told us:

The SHAs frankly also need to take this seriously and make sure that the PCTs are doing their job properly. All SHAs should do that in England. There are enough checks and balances to make sure there is a safe system but it is not taken seriously and consistently from PCTs all the way through the system.³⁴

31. The Minister stressed that because it would take time before either the Medical Act 1983 could be amended (even if it were permissible) or the EU Directive could be revised, it was essential that in the meantime PCTs and SHAs were doing their jobs properly.³⁵

32. The Coroner in Mr Gray's case recommended that the DH "institute a national database of doctors from abroad who apply for inclusion on any performers list", containing data held on them by PCTs relevant to their fitness to practise.³⁶ This would enable PCTs to check on the status of would be GPs, in particular whether a doctor had been rejected by another PCT.

33. The Minister considered that there was a strong case for such a database:

Q110 Sandra Gidley: You have mentioned about the performers list that you have put extra guidance out and you have tried to get everything up to standard, but was that the right system in the first place? Do you agree with the coroner's recommendation that there should really be a national database of doctors?

31 Department of Health, *Current arrangements for the local commissioning and provision of out-of-hours primary care services*, January 2010.

32 Q 113

33 Ev 55

34 Q 71

35 Q 114

36 Inquest into the Deaths of David Gray and Iris Edwards: Coroner's Summing Up, Decisions and Announcements

Mr O'Brien: Yes, I do agree with that and we want to consult with the medical profession on how we do this. Is a PCT performers list approach the best one? There was a review that completed in March of last year which recommended 62 recommendations for reform and improvement of the performers list and that did not recommend that we move to a national database, but I do think there is a strong argument for that and what we want to do is work out how we should do that, so the straight answer to your question is yes, we do think we need to move to that, and the question is quite how we do it and what the next steps are.

34. We agree with the Minister that it is essential to ensure that the system of vetting EEA doctors begins to work at once without waiting for the necessary national and EU legislative changes.

35. In the interim, SHAs and the healthcare regulator, the Care Quality Commission, must ensure that all PCTs are carrying out language tests on EEA doctors and assessing their fitness to practise before they are admitted to Performers Lists.

36. The Department must implement the recommendations of the 2009 Performers List review without delay. We also recommend that the Department of Health review the merits of a national database for doctors working in general practice.

37. The Minister told us that Cornwall and Isles of Scilly PCT had acted illegally in admitting Dr Ubani to their Performers List³⁷ but subsequently the Department informed us that no disciplinary action had been taken by the PCT although the SHA was monitoring the situation and the PCT had reviewed its procedures. Moreover, no action has been taken against the PCT.

Commercial providers

38. There are good out-of-hours services. Two of the GPs we took evidence from suggested these were more likely to be provided by not-for-profit GP co-operatives than commercial providers since the former were more likely to have local GP engagement and involvement. Professor Field told us:

I do [...] feel that co-operatives offer an advantage over private providers in that it does mean that you are more likely to have local GP engagement and local GP provision therefore out-of-hours as well as in-hours, and the communication is better.³⁸

39. Commercial providers must meet clinical governance and other standards set by PCTs who commission their services, but there is a danger that, in a drive to cut costs, quality of clinical care is squeezed. Fay Wilson, a GP working for an out-of-hours GPs co-operative, informed us of her concerns:

I really am fundamentally anxious about the fact that this is a purely marketised privatised bit of the health service. I am personally uncomfortable with it but here we

37 Q 113

38 Q 57

are and we have to make the best of it. I talk to GPs and people who have been in my position who say, “I will not work in the new system because I have had to drop my standards too much and I cannot reconcile myself with it”.³⁹

40. Monitoring the standards achieved by care providers who have been commissioned by PCTs, whether commercial or non-profit, requires constant vigilance. Mr Bates, Chief Executive of NHS Worcestershire, told us:

I think one of the lessons that I would offer up to the Committee today is that if you think you can procure a service, sign a contract and say that we have everything pinned down in a contract and we can now turn our backs and work on some other problem, you are wrong.⁴⁰

41. Unfortunately, it is apparent from the Department’s own review that some PCTs are failing in their responsibility to monitor the standards of providers who have been commissioned to provide out-of-hours care.⁴¹

42. The Department must ensure that all PCTs’ contracts with out-of-hours service providers detail the standards for quality of care, clinical governance and risk management in out-of-hours services. SHAs should play a stronger role in examining how PCTs are meeting these requirements. In addition, we recommend that the Care Quality Commission address PCTs’ competence in this area under the new regulatory system. The Care Quality Commission must also use its powers under the new registration system to deal with commercial providers that endanger patient safety by failing in their obligation to check the clinical and language skills of overseas locums.

Induction, Training and Revalidation

43. Overseas GPs who come to work in the UK and who may be completely unfamiliar with the NHS and its systems can begin to see and treat patients without a thorough induction, training and mentoring process. The coroner in Mr Gray’s case found that:

It is clear to me that Dr Ubani in his dealings with patients over that fateful weekend was incompetent—not of acceptable standard. I consider the familiarisation process and induction process provided to Dr Ubani to have been for him insufficient. Indeed I think it was inadequate.⁴²

This view was echoed by Professor Field who told us “I do not believe that our training for out-of-hours is adequate at the moment”.⁴³

44. It is imperative that PCTs ensure that contracts with out-of-hours providers detail rigorous standards in respect of the recruitment, induction and training that doctors

39 Q 7

40 Q 4

41 Department of Health, *Current arrangements for the local commissioning and provision of out-of-hours primary care services*, January 2010.

42 Inquest into the Deaths of David Gray and Iris Edwards: Coroner’s Summing Up, Decisions and Announcements

43 Q 75

should receive. Furthermore, PCTs must be satisfied that these are delivered by any sub-contractor or agency which providers may use.

Formal Minutes

Thursday 25 March 2010

Members present:

Mr Kevin Barron, in the Chair

Mr Peter Bone
Sandra Gidley
Stephen Hesford
Dr Doug Naysmith

Mr Lee Scott
Dr Howard Stoate
Dr Richard Taylor

Draft Report (*The use of overseas doctors in providing out-of-hours services*), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 44 read and agreed to.

Resolved, That the Report be the Fifth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[The Committee adjourned.]

Witnesses

Thursday 11 March 2010

Page

Mr Paul Bates, Chief Executive, NHS Worcestershire, **Mr Mike Farrar**, Chief Executive, NHS North West, **Mr Antek Lejk**, Director of Partnership Commissioning and Primary Care, NHS Cornwall and the Isles of Scilly, and **Dr Fay Wilson**, Medical Director, BADGER Out-of-Hours Co-operative Ev 1

Mr Niall Dickson, Chief Executive and Registrar, **Mr Paul Philip**, Deputy Chief Executive and Director of Standards and Fitness to Practise, General Medical Council, and **Professor Steve Field**, Chairman of Council, Royal College of General Practitioners Ev 11

Rt Hon Mike O'Brien QC MP, Minister of State for Health, **Dr David Colin Thomé**, National Director for Primary Care and Medical Adviser, and **Mr Gavin Larnar**, Director, Professional Standards, Department of Health Ev 19

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3	General Medical Council (OHS 03)	Ev 48
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5	Medical Defence Union (OHS 05)	Ev 51
6	Mike Farrar, NHS North West (OHS 06)	Ev 53
7	Patients Association and Stuart and Rory Gray (OHS 07)	Ev 53
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9	General Medical Council (OHS 03A)	Ev 57

List of Reports from the Committee during the current Parliament

The following reports have been produced by the Committee in this Parliament. The reference number of the Government's response to the Report is printed in brackets after the HC printing number.

Session 2009–10

First Report	Alcohol	HC 151 (Cm 7832)
Second Report	Work of the Committee 2008–09	HC 152
Third Report	Social Care	HC 22
Fourth Report	Commissioning	HC 268

Session 2008–09

First Report	NHS Next Stage Review	HC 53 (Cm 7558)
Second Report	Work of the Committee 2007–08	HC 193
Third Report	Health Inequalities	HC 286 (Cm 7621)
Fourth Report	Top-up fees	HC 194 (Cm 7649)
Fifth Report	The use of management consultants by the NHS and the Department of Health	HC 28 (Cm 7683)
Sixth Report	Patient Safety	HC 151 (Cm 7709)
First Special Report	Patient Safety: Care Quality Commission, Monitor, and Professor Sir Ian Kennedy's Responses to the Committee's Sixth Report of Session 2008–09	HC 1019

Session 2007–08

First Report	National Institute for Health and Clinical Excellence	HC 27 (Cm 7331)
Second Report	Work of the Committee 2007	HC 337
Third Report	Modernising Medical Careers	HC 25 (Cm 7338)
Fourth Report	Appointment of the Chair of the Care Quality Commission	HC 545
Fifth Report	Dental Services	HC 289 (Cm 7470)
Sixth Report	Foundation trusts and Monitor	HC 833 (Cm 7528)
First Special Report	National Institute for Health and Clinical Excellence: NICE Response to the Committee's First Report	HC 550

Session 2006–07

First Report	NHS Deficits	HC 73 (Cm 7028)
Second Report	Work of the Committee 2005–06	HC 297
Third Report	Patient and Public Involvement in the NHS	HC 278 (Cm 7128)
Fourth Report	Workforce Planning	HC 171 (Cm 7085)
Fifth Report	Audiology Services	HC 392 (Cm 7140)
Sixth Report	The Electronic Patient Record	HC 422 (Cm 7264)

Session 2005–06

First Report	Smoking in Public Places	HC 436 (Cm 6769)
Second Report	Changes to Primary Care Trusts	HC 646 (Cm 6760)
Third Report	NHS Charges	HC 815 (Cm 6922)
Fourth Report	Independent Sector Treatment Centres	HC 934 (Cm 6930)

Oral evidence

Taken before the Health Committee

on Thursday 11 March 2010

Members present

Mr Kevin Barron, in the Chair

Charlotte Atkins
Sandra Gidley
Stephen Hesford
Dr Doug Naysmith

Mr Lee Scott
Dr Howard Stoate
Mr Robert Syms
Dr Richard Taylor

Witnesses: **Mr Paul Bates**, Chief Executive, NHS Worcestershire, **Mr Mike Farrar**, Chief Executive, NHS North West, **Mr Antek Lejk**, Director of Partnership Commissioning and Primary Care, NHS Cornwall and the Isles of Scilly and **Dr Fay Wilson**, Medical Director, BADGER Out-of-Hours Co-operative, gave evidence.

Q1 Chairman: Good morning and welcome to this one-off evidence session in relation to the use of overseas doctors in providing out-of-hours services. I wonder if, for the record, I could ask you individually to introduce yourselves and the current position you hold.

Dr Wilson: My name is Fay Wilson; I am a GP in Birmingham. I am the Medical Director of BADGER which is a GP out-of-hours service based on a cooperative, mostly of doctors who have not opted-out of the responsibility.

Mr Lejk: I am Antek Lejk; I am Director of Partnership Commissioning and Primary Care of Cornwall and Isles of Scilly Primary Care Trust.

Mr Farrar: Mike Farrar, Chief Executive of NHS North West Strategic Health Authority.

Mr Bates: Good morning. I am Paul Bates, Chief Executive of NHS Worcestershire.

Q2 Chairman: Once again welcome and thank you for coming along. The first question I have is to all of you. The death of David Gray in 2008 has caused great public concern about the quality of out-of-hours GP care. How much confidence should the public have in these services? Is patient safety at risk? I do not know who would like to start. Antek?

Mr Lejk: I can only speak on behalf of our area actually and I think it is probably dependent on the systems in place to assure and performance manage those services. From our point of view we had a new provider about three or four years ago and we had some initial teething problems with that so in response we set up a really quite tight performance management regime which includes GPs, LMC, public as well as our contract management type people on a monthly basis going through all the performance stuff. We were concerned about performance so we constantly challenge and check that, including the clinical aspects. I think because of what happened in terms of a new contract we took a fairly rigorous approach to that performance management role but that was a result of that initial set of problems and I suspect it is variable across the country to be honest.

Mr Bates: Public confidence and GP confidence in out-of-hours is absolutely critical and without that public confidence the public behaves in a different way and accesses services in an inappropriate way which causes us problems. Do they have confidence? I think the patient surveys show probably across the country something like a 66% to 70% satisfaction rate with out-of-hours services which, given the nature of the services, is reasonably high. However, I suspect that is satisfaction about the access to the service rather more than it is about the quality of care that perhaps professionals have to judge. I think public confidence is absolutely critical and this may be something we return to during this morning.

Dr Wilson: These services tend to have been commissioned on the basis of “never mind the quality, feel the width”. That is not say that people are not interested in quality and safety, it is just that those were taken for granted or taken as read. The performance management has historically tended to be about access, how long it takes for something to be done rather than really anything to do with quality and there is a presumption there. The extent to which you can impose quality by performance management is something that would be interesting to debate. I think part of what we are looking at is about the culture within organisations. I am a believer—as you would expect me to be—in a doctor-led service because I think in general if you have doctors leading the service and being responsible for it they will take a responsibility for those quality aspects. However, where commissioning has been done—I do not say it still is because I think we are learning—on the basis of how fast is it and how low can we get the cost, then quality is something that gets squeezed. I am sure you know somebody-or-other’s law that you can have any two out of three of cheap, quick and reliable and I suspect on out-of-hours, because of the way the market has worked, reliable has been taken for granted and there has been a focus on cheap and quick. I hope we are moving in the direction of reliable.

Mr Farrar: My sense is that the public should have a generally high level of assurance about the quality of out-of-hours care but because you have multiple

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providers and because you have variability in some of the commissioning arrangements, it is inevitable that the quality of service will be variable across the country. There were tragic circumstances leading to the event that provoked this inquiry and I think the public should be very assured that is an unlikely occurrence; we would not expect that to be something that would be present in many of our systems. My sense is that they should have generally high assurances, as they should in the whole of the National Health Service. I think out-of-hours care is getting much better; I think it is improving. There are a lot of steps being proposed now as a consequence of this incident that should give people a lot more assurance, but I think it is inevitable there will be variability in the quality that is provided as there is in the health service across the whole in-hours service as well.

Q3 Chairman: Since the out-of-hours services were reformed in 2004 how well do you think that Primary Care Trusts have done in terms of meeting their responsibilities? Mike, obviously you will have an overview but I put the question to all three of you really.

Mr Farrar: One of the reasons why out-of-hours care has always come in for some attention when we have been looking at the reform of the system is that probably since the early 1990s when individual GPs stopped doing their own out-of-hours—which was the big real sea change in this—and were allowed to use third parties to deputise for them, we moved away from the kind of model that people had that their family doctor would always be available to them. It was the right thing to do because constantly in surveys people were saying, “We don’t want to work in the profession because of the out-of-hours commitments”. We did have a high level of complaints compared with in-hours services about out-of-hours and I think we have still seen that situation. In 2004 one of the key changes that we wanted to make was by moving to commissioners—PCTs commissioning GP out-of-hours who also commissioned A&E departments, walk-in-centres, NHS Direct, minor injuries, et cetera, et cetera—we were able to try to get a framework where PCTs could commission a coherent out-of-hours service. I still think we have a long way to go. My sense is that we still have a variety of entry points to the system and we have not quite navigated the public. If you say to me, “Has this been a sensible change?” I think it is a sensible change. We have yet to get the benefits of that sensible change, and Paul might want to talk about it from a PCT who have thought hard about commissioning that range of services and how they have gone about it. The technical aspects of whether they have contractually made sure that all the key quality elements are in place, I think when we have looked at our patch we have 15 Primary Care Trusts that we are very assured on, seven where we have some questions we are pursuing, and a couple that really need to do an awful lot better. That is the kind of scale of things, but we were trying to get that coordinated out-of-hours service and I think PCTs still have some way to go.

Q4 Chairman: Paul, would you agree with that? Obviously you sit in one.

Mr Bates: Absolutely. The journey in Worcestershire has been an interesting one. I came into Worcestershire in 2005 and was the Chief Executive from 2006 of the pan-Worcestershire PCT. Worcestershire was providing its own out-of-hours services through the PCT as a direct provider. I was uncomfortable with that; I did not think it was our core business, the daily operation of an urgent care service. We were getting a significant number of complaints and therefore as a good commissioner we decided we were not the right people to be providing that service and we embarked upon an incredibly extensive commissioning and procurement process. In preparing for today we have looked at this again and we think it is probably the best procurement we have ever done. We have put in more expertise, more time and more resource; we have brought independent experts in, including independent GPs and patient representatives to help us do it. The Care Quality Commission is looking at that currently so I think they will be the judges of what I have said but, having gone through all that process, we entered into a contract with Take Care Now and we therefore return to the issue I said beforehand that if public confidence in the service dips, because of something that is happening hundreds of miles away from your own patch, it can actually have an impact back on your home territory. Despite the fact that we think it was one of our best procurements, clearly there are still lessons to be learnt, there is still a sophistication to that which needs to be applied. I think one of the lessons that I would offer up to the Committee today is that if you think you can procure a service, sign a contract and say that we have everything pinned down in a contract and we can now turn our backs and work on some other problem, you are wrong. Experience shows that you need to put somebody quite senior—a senior clinician—to work alongside your out-of-hours provider for many, many months when they first take on that contract.

Q5 Chairman: Antek, do you agree with that?

Mr Lejk: In 2004 when we went through our tendering for a provider what we had before, which was the GP co-op, we did not really know what the quality of that service was like and we were having complaints and there were issues that were not at the high end of quality, so what we now have in place is something which is much more aware of what the issues are and gives us a chance to really drive into those. I agree very much with what Paul was saying, it is one thing to secure a new provider but actually you then have to work with that provider, as you would with any other provider, on a really, really regular, rigorous basis and in terms of our performance we are interested in quality, we do look at things like complaints, we look at what is happening with our health service and we look at patient information as well and play that back to try and make sure they are working on that. Appraisal and those kinds of things are all part of what we expect. One of the things we have done recently is to really try to embed that provider in our health

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system so they are an integral part of our pandemic flu planning, they are an integral part of our emergency care network and that kind of thing. What you cannot do is just see them as a bolt-on, a bit of a contract, you do a bit of performance management just to make sure the numbers are okay; actually they are an integral part of that health community. By being drawn into it I think they feel better; they feel more engaged and they can tell us the problems they have with the rest of the system and we can use that to re-align our commissioning elsewhere. It is not helpful if you just see them as a kind of separate contract and treat them in isolation.

Q6 Chairman: Fay, what is your view on this?

Dr Wilson: I suppose I come from a different angle. Our co-op has been in existence since 1996 so when it came to 2004 we were completely unsuccessful in securing any contracts. It was just as well that the majority of our GPs had not opted-out because otherwise we would not have existed from then. The reason really was that we were too expensive and we had a set of quality standards which were too expensive to run for people to buy. That was at a time when there was not much sophistication around commissioning. By 2006 we had learned that we had to be competitive so we had to modify our standards and stop trying to sell people diamonds when they did not want to buy them. We also realise by now that you do have to have more or less an industry in bidding and doing all this sort of thing. One of the difficulties we have as a small GP co-op type provider is that we do not have the resources in order to keep up with the processes which PCTs use, which are increasingly the sort of processes they would use for contract managing, say, an acute trust or a large NHS provider. The paradox, I guess, is that we might want to see more local involvement of GPs and less what you might call industrial process, but if you are not a very, very large provider the difficulty is keeping up with the processes involved. We are continually trying to get ourselves large enough so that we do have a back office team which can cope with the sort of contract monitoring requirements for everything really from meetings to turning out reports and so on, while at the same time not losing our connection with our local frontline. I suppose part of the trick of this is it is primary medical services but it is being managed in the same sort of way as the hospital sector or the ambulance service but with a different sort of basis.

Q7 Chairman: It seems from what you are saying that two years into the change you were a lot more comfortable with where you should have been and presumably with what the PCT were asking.

Dr Wilson: No, we were not comfortable at all, it is just that we felt that we were not big enough to carry on and we had to make a decision that either we modify our offering so that it was cheap and cheerful, if you like, or we would go out of business. We had to make a decision whether to give it up and say that we were eccentric and enthusiastic but not a saleable product, or we had to say, "Let's find out what people want and sell it to them". I really am

fundamentally anxious about the fact that this is a purely marketised privatised bit of the health service. I am personally uncomfortable with it but here we are and we have to make the best of it. I talk to GPs and people who have been in my position who say, "I will not work in the new system because I have had to drop my standards too much and I cannot reconcile myself with it".

Q8 Chairman: The implication in my first question to all of you was this issue about patient safety. How can you reconcile that you have to drop standards and reconcile the events of the last couple of years? What standards did your co-op drop?

Dr Wilson: For instance, if we look at how fast we visit people, the national policy requirement is that a routine home visit or routine face-to-face consultation will happen within six hours of the decision being made; our previous internally imposed standard was within three hours. That is a simple example. Obviously if you are going to do things faster you are going to have to have more doctors on duty and that is more expensive. If you are going to produce an offering which is competitive with the market it has to be less expensive. It is simple as that.

Q9 Chairman: In terms of economics I accept that, but what I am trying to tease out here is what it means to patients in the end?

Mr Bates: Chairman, can I just help complete the picture, as it were? Because otherwise there is a danger we believe that the PCTs' approach to commissioning here has been about cheap and cheerful. I do understand what Fay is saying about being in a competitive position tendering for these services it may well feel as though you are having to look back all the time at what you are going to be able to say in comparison with your competitors. In Worcestershire where we undertook our procurement we did not accept the lowest price tendered. Our conviction was that the best proposal being put to us was one which was actually not the lowest price and that was the contractor we should go with to get the service that we wanted. Amongst the lessons that we have learned in the last year or two is that sadly the national standards can be used in a way that says, for instance around the six hours that Fay has referred to, that is the norm. Clearly our expectation was much more in line with Fay's that actually visiting should be done within the hour or two hours as the norm, not "Oh, we are only required to do this within six hours". I am not criticising our contractor because I think that is a phrase that many of the contractors around the country might well use because of this interpretation of standards. So that is a lesson learned. It cannot be that those standards become the average and the norm; they have to be the exception.

Mr Farrar: I have been in front of this Committee before looking at the costs of the overall contracts and if I remember rightly one of the significant additional costs post-contract was the amount of money spent on out-of-hours services, which I think went up by something like £300 million across the

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country after the contract. Part of the reason that happened was because the unit costs of the labour went up so when GPs were not obliged to provide care, and therefore it was on a contracted basis, the actual individual costs of GP input went up. When we were doing the contracts we assumed that you would be able to offset some of that and in fact the maths suggested that. Another constant concern with out-of-hours which the profession put forward is being called out for things that do not require a doctor's input and therefore call triaging was an important element of this. The view was that call triaging would offset some increase in the price of GP input. That is why the business about the standards is quite tricky to compare because some of the call times, if we had very good call triaging in place, would actually take away the need for the face-to-face contact therefore you could get those standards up, at least maintain the standards as they were before and potentially improved in terms of the time it would take. I think the comparison of saying, "We used to do it in one to two hours before and now there's a minimum standard which is six hours", it is actually a more complex picture than that because what you would hope is that you got people there as fast as possible for those people who need a response as fast as possible and, for those people who did not, they might not even get a response in the way they previously had because they had been dealt with properly on the phone. I just think we need to bear that in mind, but particularly the fact that post-contract there has been a lot more money spent on out-of-hours than there was previously.

Q10 Chairman: It is a bit of a confusing picture. Mike, as you hinted there you were involved in the actual negotiations. I think you held a position with the NHS Confed in the 2003 negotiations. The simple question I would like to ask is do you now regret allowing GPs to give up providing this service for something like £6,000 a year which is not a very high sum in terms of cost, is it?

Mr Farrar: No. The work we did at the time benchmarked the cost of out-of-hours care across the country and it ranged from about £4,000 per GP to about £13,000 per GP. The mandate that I had leading the negotiation was that there was a £3,000 element of new resource to put into PCTs baseline to buy out-of-hours care and the negotiation landed on a figure of £6,000 from the GP's pocket and £3,000 new, coming to £9,000 which sat pretty much in the middle of the range of out-of-hours care. Effectively it was more than £6,000 that went into PCTs; they had £9,000 per GP to buy that service. Our view—and I still come back to it—was that PCTs commissioning rather than GPs commissioning, effectively providing their own services, should have given you a much, much better opportunity to get a coherent urgent care response. £9,000 alongside the way that PCTs were working with their A&E departments, their walk-ins and NHS Direct as part of an overall offer in my view should have led to standards improving not deteriorating. I would still defend that decision but I think we have to fully

exploit this business about coherence of the service offered. I think we still have to get some of that benefit back.

Q11 Chairman: You suggested yourself that of the PCTs you currently oversee in this position some of them are not as good as others and so we are still years down the line and do not have that coherence you thought we should have had.

Mr Farrar: There has been a rise in demand for urgent care and there are a lot of very, very clever people trying to explain why that rise in demand has arisen, but what I know now—particularly over the last year and maybe with necessity being the mother of invention, as the money starts to look tough for the NHS we start to address this—is that you have a much more coherent front-end of A&E with GP input, the out-of-hours service is better linked in and in my view, if you were asking me about where is the most danger around out-of-hours care, it is where it has always been: it is the handover between out-of-hours services and in-hours services. The systematic approach to transfer of information that we have now, in my view, is much better than it was in previous out-of-hours arrangements.

Q12 Dr Stoute: If you had £9,000 per GP and you thought that was about right, why did it cost £300 million a year more to run the service?

Mr Farrar: I think it was because in the first year a lot of Primary Care Trusts rolled over previous contracts and the previous contract price went up. When we were looking at the range that we had in place to base the £9,000 on—it was £4,000 to £13,000—what we had was a number of Primary Care Trusts who simply contracted with their existing supplier, but the price had gone up and they did not really have an alternative offer at that time. Over time my sense is that that price has probably been absorbed up as PCTs have been more rigorous about their cost for out-of-hours care. The initial problem was that we simply paid more for what we had before because of the price of labour going up.

Q13 Dr Stoute: If I have done my sums right that £300 million is something like £100,000 per GP. There are approximately 30,000 GPs; £300 million. I am just trying to do the sums. That is an awful lot of money per GP. It makes your £9,000 so far out of left field that it does not make any sense.

Mr Farrar: I am not certain I am right but I was trying to remember what the National Audit Office said in their Report into the contracts that tried to attribute where some of the over-spend on the contract came. I am sorry I cannot vouch for that figure.

Mr Lejk: Just to reinforce that point about working in different ways after the change in contract, Cornwall is a very rural and dispersed county so we have particular issues about access and we tend to need more capacity in place than you would normally have in a city, for instance. We also have a network of minor injury units across 14 community hospitals as well. Before we contracted we had the situation of out-of-hours services sitting alongside

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minor injuries services not talking to each other and not working together. Through the contracting arrangements we have been able to force a more integrated and shared approach to the delivery of care. We have further to go so there is more we need to do around mental health services and so on to make sure we do have an integrated service out-of-hours. I think, as commissioners of all of that, we do take it more seriously and we can see the opportunities to make the system more effective.

Dr Wilson: Part of the difficulty was that the costing of out-of-hours prior to the contract changing did not really take account of paying the doctors to do the work. In areas where people had to pay someone else to do the work or continue to pay the doctors to do the work, my perception is that certainly around my part of the country there were some quite big changes. For instance, there was an enthusiasm for NHS Direct to be the front end so the costs were different and I think that changing of systems partly cost more money. I think PCTs will legitimately say, "Let's see if we can do it a different way and see if the ambulance service can provide or if NHS Direct can provide" and in my view there had not been a full costing in the contract of the value as opposed to the price of the work that GPs were doing. I think we have not realised the potential benefits in terms of coherence and integration. I do not think that can all be laid at the feet of PCTs not commissioning imaginatively; it is partly the way the contracts are set up, partly the types of contracts they are in that they do not easily integrate, and partly the NHS in itself in its contracting mechanisms does not easily move across sectors and integrate them, and partly because in out-of-hours the contracts are fairly short term (generally speaking they are three-year contracts, three years plus one, plus one) and it is actually quite difficult if you are a provider to think about an investment in a long term either in relationships or services and, having put something new together, by the time you get it working it is time for the next tender. I think there is something here about length of contracts and some of the actual practicalities from the PCT's point of view of development as opposed to monitoring existing contracts. The PCT cannot just write down and say, "We want you to do this, this and this" and it happens the next day and keeps happening.

Chairman: Thank you for opening this up. We are going to put ourselves under a bit of pressure in terms of time, but we now have a series of specific questions about this aimed at individuals. If you could all be quite brief in responses and questions as well we should be able to stick somewhere near the timetable.

Q14 Dr Naysmith: You will all be familiar with the report by Dr Colin-Thomé and Professor Field about the out-of-hours service following Mr Gray's death. I just want to ask you, do you think PCTs are doing enough to improve monitoring of the out-of-hours services they commission in the light of this report? Are they moving in the right direction?

Mr Bates: I think the report sets a standard higher than most PCTs have been working to of late. Because of the attention my PCT has put into out-of-hours over the last year I had expected that when I read that report I would feel very, very comfortable that we were doing everything it suggested. I think it sets out for us that there is still more we need to do. However, I think it also raises some questions about how far do commissioners go and how much ought we to be relying on the providers themselves to take this responsibility. It gives me an opportunity to say that however we move forward in the coming months and years, whatever we do we must not take away the primary responsibility for the quality from the provider itself.

Q15 Dr Naysmith: You have just said something very interesting, at least I think it is interesting. In this Committee we looked at dental services not that long ago and one of the things we found was that if the PCTs really took commissioning good general dental services properly then there were good services in the area and there was not this hysteria about not being able to find a dentist. You have said you thought that your commissioning of this particular out-of-hours service was the best you had ever done. Does this not suggest that it is not possible for PCTs to do everything the best they have ever done, that there is too big a job to commission all the different complicated things that PCTs have to commission? How do you feel about that?

Mr Bates: I think we are capable of commissioning and ensuring that we have good out-of-hours services. I think any PCT that is not open-minded and constantly looks to see how it can improve that commissioning is going to have a problem. Having said I thought we have done it well, you can always do it better. I think there is an issue that PCTs cannot be undertaking lots of major commissioning exercises at one time or in one year. You have to be very selective.

Q16 Dr Naysmith: Are some of the PCTs too small to do the job properly?

Mr Bates: Some PCTs would have struggled to undertake the number of commissioning tasks that we have undertaken over the last 12 months and therefore working together and collaboratively across PCTs is something that PCTs are increasingly doing now. We have arrangements at regional level and we have local collaborative commissioning arrangements so there is a lot of that joint work going on. I think the essential point that I would want to make is that the idea that in our case in a portfolio of services beginning to approach a billion pounds you can be constantly embarking on a dozen or 20 major commissioning exercises in a year; you cannot. You need to be selective, you need to get it right and you need to have long term contracts as Fay has referred to. The range and complexity of services we provide is just far too great for any PCT to be doing a massive turnover in that commissioning every year.

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Q17 Dr Naysmith: Antek, can we go back to the monitoring arising from the report that I mentioned?

Mr Lejk: I think we probably put more effort into our performance management of out-of-hours in the last 24 months than we would have done if everything was hunky-dory. What we tend to do in terms of highlighting areas where we need to put more effort is to look at the data, look at the experience that patients are receiving and if there is a problem we go in and spend more time on it. That has led to benefits. I think the one thing that comes out for me from this having recently got involved in it is that we do tend to rely on assurances and I think we now have to double-check some of those assurance. There are things that we think are all right because a process has been adopted. I am sure there will be a question about performers lists later on but in terms of that I think what we relied on too heavily was that just because the right form had been filled in and a doctor is passed by the GMC, does not mean you do not have to assure yourself of their competence.

Q18 Dr Naysmith: Are you saying your monitoring was just asking whether they were doing what they said they were doing?

Mr Lejk: To some extent what we were doing was just thinking that the quality element was covered off by somebody having got into a system and not probing deeply enough to actually gain assurance for ourselves that that is the case and, going back to Paul's point, also then requiring providers to do the same. The danger is that each part of the process thinks that somebody else has covered off that assurance and therefore not enough checking is done to make sure that when you employ somebody to do a piece of work they are competent, fit for purpose and able to communicate. I think for me that is what has come out of this, that we are applying a much more rigorous review of that and re-reviewing it on a regular basis to make sure it is not just about getting into the system but staying in the system because you cannot just rely on the things that we were relying on.

Q19 Dr Naysmith: Fay, both Antek and Paul are throwing it back to you and saying that it is partly your responsibility as well.

Dr Wilson: Yes. Perhaps I am more optimistic, which surprises me slightly. You asked about the response to these recommendations and my perception is that it has put things up a gear, that PCTs are interested. My aim as a provider is to help them deliver this and to make it easier for them. We deal with six PCTs and I have a great interest in not having six separate local suites of KPIs, for instance, so that there is some logic across them but also I realise that the people who do the commissioning, for the reasons that you heard, have loads of things to do so I can help by saying here is an easy way to deal with the West Midlands Regional Check List, for instance, here is all the information we have and sharing it between them. I think they have geared up and I see

movement here which I would say from the PCTs I have been dealing with, I would be positive about the fact they are taking this on.

Q20 Dr Naysmith: This is probably not an appropriate question for you really, but do you encourage out-of-hours doctors to report on the performance of other out-of-hours doctors? I have become quite familiar with two or three different out-of-hours services and some of them rigorously check doctors who come in and some of them do not. Is there any system whereby if somebody new appears who has never been on the job before and somebody who is part of the system notices that, is there a way of indicating that to the people who are organising the services? I know we are going to have questions about this later on, but just in terms of your responsibilities.

Dr Wilson: Yes, not just doctors but all staff and we do it by enabling them not to be named as the person who made the report and also to have a no-blame approach to it which I know is always said but not very often done. In terms of the number of reports coming in, it is a very intensive way of dealing with them but it works for us because of the way we deal with it. It means that a level of responsibility has to be taken within the organisation. If we had to report that information elsewhere I think the participation rate would be lower. Of course this is an issue for other organisations like the GMC and so on who have similar sorts of questions.

Q21 Dr Naysmith: It is a question of picking things up early, is it?

Dr Wilson: Yes.

Q22 Dr Naysmith: Mike, what is the role of Strategic Health Authorities in this? Are they beginning to monitor what is going on?

Mr Farrar: Clearly we would be looking at PCTs commissioning overall and ensuring they were getting good quality services. That would be picked up generally. We had a great focus on urgent care in terms of access and you have to see some of those key national targets as whole system ones which include the GP out-of-hours service so I think there has been scrutiny. In terms of the detail, looking at whether or not they will assess, we have done periodic reviews and questions, and obviously the last incident has provoked quite a flurry of activity as these things do, and when we have gone to another layer of detail about the assurance, as I said, when we looked at our PCTs we had 15 that we thought were well on top of this, seven that we thought had some questions to ask and a couple that we have gone back to and said, "You probably need a bit more help and you need to understand how important this is". That would be quite a normal distribution. If you looked at all kinds of areas, that kind of thing is not unusual in the health service performance management process really.

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Q23 Dr Naysmith: We have had quite a lot of evidence indicating that clinical governance has not really been very high on the agenda. Is that the case in your PCT?

Mr Bates: Not at all. I think we have shovelled loads of clinical governance into the system.

Q24 Dr Naysmith: There are lots of good clinical governance policies agreed with the providers and yourselves.

Mr Bates: Absolutely. In preparing for today I have been looking through the clinical governance arrangements of previous providers, current providers and potential providers and it is clear it is all there in policies and it is all there in processes. However, linking it back to the previous question, no amount of process and no amount of assurance systems replaces the value you get from people exercising their own professional responsibilities and saying, "This is not good enough; I have to speak out about this". The most likely source of immediate alert to the fact you have a problem doctor, problem nurse or problem call handler will come from the staff working alongside them. That is more important than any of the processes that we can put in place.

Q25 Dr Naysmith: Fay, what is your view on clinical governance?

Dr Wilson: My experience of this is that it is more the provider offering up rather than a creative, iterative sharing process, but that does not surprise me in a sense because if we look at the big picture for a PCT the amount of time and resource they could devote to this is not huge. I think it is greater following this report because there is more in the spotlight, so to speak, so I am optimistic about that being more of a creative process.

Q26 Dr Taylor: Paul, you will not be surprised if I want to focus on Worcestershire just for a little while.

Mr Bates: Not surprised at all.

Q27 Dr Taylor: Talking about monitoring, the Care Quality Commission's interim report and I am quoting from Cynthia Bower: "Our visits to the five trusts that commission Take Care Now's services showed they are only scratching the surface in terms of how they are routinely monitoring the quality of out-of-hours services". I always remember coming to you with a string of complaints, comments from GPs and some crucial things from whistleblowers. You have made the point of it being the professionals' own responsibilities; these were whistleblowers who were frightened to come other than through me to protect their anonymity. I was amazed that the Overview and Scrutiny Committee had no clue that the service was not absolutely perfect and again criticisms had not actually come through to you until I brought these. I am absolutely with the Care Quality Commission because they actually detail the sorts of complaints that I was getting—the efficiency and quality of call handling

and triage, the number of unfilled shifts, the quality of decisions made by clinical staff. I do not really want to go back into the past, I want to go into the future. We know that you have a new contractor coming in because Take Care Now are opting out and selling their contract before the Care Quality Commission reports on them. What steps are you taking to make sure that you can monitor the service that the new huge provider really gives us? I do not see how you can embed it, as I think Antek said, in the health community.

Mr Bates: I will not go back over the past as you have asked me not to, except to say of course that the CQC report is about the five PCTs operating in their area. As Dr Taylor knows, once we had had his information and that from our local medical committee we commenced our own independent investigation of the quality of our service long before CQC were asked to become involved. In terms of what we will do, that will be essentially different from what we do now if TCN is taken over by a different company, we are actually in discussions which relate back to the most recent guidance that says you must get greater GP involvement in influencing the quality of the service. I think we have to be careful what we mean about GP involvement because some GPs are just GPs, but some GPs are shareholders in private companies that want to be the alternative provider of a service. I just want to flag up that there are issues of interest here. However, we have made it clear we would not allow our contract to pass to any company that was not able to demonstrate to us how GPs are going to have a bigger influence on the quality of the service. The current conversation we are having is about the establishment of a GP advisory body on which there will be nominees of the local medical committee and the PCT and practice based commissioners. Within its first month of life it will agree with any new contractor the ways in which you would, first of all, measure the GP influence and GP involvement. One of those measures might be the percentage of local GPs that actually work for the service. That GP management body will have direct access to the PCT as a corporate body and to me, and it will review in its own way the quality of the service that has been provided which of course will largely be based on the intelligence their own patients are giving them when they see them in surgery during in-hours. I think we have tried to work up a proposal that puts in something completely new than we have had hitherto. It should mean the sorts of issues you brought to my attention are brought to my attention earlier. I do need to flag up that having a conversation with your local GPs about their influence on the out-of-hours service has to take account of the fact that some GPs have more than one level of interest in the out-of-hours service.

Q28 Dr Taylor: The system you are setting up is entirely different; it did not exist with Take Care Now?

Mr Bates: No, it did not exist with Take Care Now.

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Q29 Dr Taylor: There was no local GP monitoring of that?

Mr Bates: Not in the way that we are proposing now. On an ad hoc basis we have actually had our own GPs going in and doing unannounced visits to the service so we have had other arrangements, but this would be a more permanent and more powerful central body of GPs working with the new provider's medical director to continually spotlight what was the quality of service.

Q30 Dr Taylor: Do you have any teeth if you have worries about quality?

Mr Bates: Absolutely. Forget any GP management body. The contract terms are voluminous, to such an extent, I have to say, that when I look at some of the contracts that PCTs are placing now, they are so voluminous that breaches of contract every day are almost inevitable. We are making it too difficult and putting in too much detail for some of providers. However, we have the teeth, if necessary, to cancel contracts. In our particular case, because of our peculiar circumstances, we are putting in place arrangements which would allow us to review the on-going nature of the contract after six months, so we put in a special clause.

Q31 Charlotte Atkins: Dr Wilson, what would you say the arguments are for commissioning out-of-hours services from GP co-ops as opposed to commercial, profit-making providers?

Dr Wilson: If we say these are primary medical services, which is what they mostly are (there are other things which are added to them) those are services which are normally provided by GPs. If we look at what is the product, the product is a consultation with a GP or another primary healthcare worker. That product is the same thing which is normally delivered during the day because GPs do urgent and unscheduled care during the day. At its basic level, if you like, I think there is a reason there for commissioning the service from GPs. The GP co-op is a collective group of GPs and should have at its heart the interest we have heard about in Worcestershire and the professional interest in delivering a good service in the same way they do during the daytime. Putting it together into a co-op simply means it is large enough to be able to do some of the other things that you cannot do on a practice basis like running a call centre or being able to deliver proper reporting to the PCT on a contract basis as well. On an efficiency basis—I would extend this to any other not for profit arrangement—in our co-op all the money that comes in is spent on running the service. There are no shareholders to pay; the money is within the NHS. It is an irksome matter to me that my organisation is classified as not being part of the NHS because it feels like part of the NHS, it operates as part of the NHS but I accept why it is classified that way. I think with a commercial company its priorities may not be the same. If you are commercial company of course—and we are a company too—there are things that you have to do.

You cannot trade at a deficit. If you are a company with shareholders I presume your shareholders would not be happy if you were not turning in a profit and producing dividends or producing some assets for the company or, for instance, perhaps your scheme is that you grow big enough and then you can sell yourself to some other organisation and make a profit that way. A GP co-op is inhibited and cannot sell the goodwill in the organisation whereas if you are a commercial you can buy and sell goodwill in these services. There is much more of a commercial market which to me produces less stability. The fact is that we are a co-op in Birmingham and as long as the GPs are still there and opted-in we will still be there so there is some stability there for the NHS. I talked about whether we would take a risk if we just had a three-year contract, if we were a commercial company which had a three-year contract which might come to an end, we would be looking at where else we could have contracts, we would be managing our risk, we perhaps would not have invested as heavily in the local health economy as we are, also interested in it. Would we have taken the risk that we took with the flu pandemic when it hit us with a big explosion last year; probably not, and we were providing services into areas and to patients whose contracted provider is actually a commercial organisation. I think there is something about embedding in the local health community. I do not know whether that answers your question.

Q32 Charlotte Atkins: Do you cover the whole of Birmingham?

Dr Wilson: No, we cover most of Birmingham; we are not the main provider to one of the PCTs. We provide a small part of the service but we are not the main provider in one of the PCTs. Only about a third of our GPs have actually opted-out so the city is a patchwork in a way but we cover most of the patients in Birmingham either with our opted-in co-op or through our contracts with two of the PCTs in Birmingham. We are the contractor for Solihull where half of the doctors are opted-in and half are opted-out.

Q33 Charlotte Atkins: Would you say that profit providers are trying to cut corners and compromise safety? You were talking earlier about having to compromise on your diamond service, as it were. What is your view? Do you think profit providers do tend to cut corners?

Dr Wilson: I do not think anyone sets out to cut corners. If you are aiming to be any sort of a provider you want to be providing a good service because your ability to go and sell your product somewhere else depends on your reputation. If you were making clothes and they fell to bits on the first wearing people would not buy them again and they would not buy them somewhere else. I do not think anyone sets out to cut corners. I think people do set out to provide an attractive offering and if the offering depends on certain things then that is what

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people will produce. My own organisation has quite low cost contracts—the benchmarking exercise pointed that out—so we cannot do things in the way we would like to do them. I cannot have as many doctors on duty as I would like to have because there simply is not enough money to pay more. We all have to cut corners. Frankly, if I had to find X amount out of the budget every year to pay the shareholders that would mean I would have to cut corners unacceptably. Where do you move from economies to cutting corners?

Q34 Charlotte Atkins: Do you think that profit providers provide a less good service than perhaps co-operatives?

Dr Wilson: I could not say that I have evidence for that at all, but I think there are factors which would lead them in that direction. A private provider is not necessarily going to provide a worse service than an NHS body which would perhaps put those to one side or a GP co-operative. I think there is something about a GP co-operative in that you have the professional leadership, you have the financial efficiency and you have the local interest and embedding into the local health economy. I think those are advantages but you might say that I would say that.

Q35 Dr Stoate: I want to ask Mr Lejk a specific question about Dr Daniel Ubani. The current rules are that if a doctor is registered anywhere in the EEA they are entitled to go onto the GMC's Register. No question. However, in order to be a GP in this country they have to be on a performers list and, as we have heard before, that is the responsibility of Primary Care Trusts. In order to get on a performers list the PCT must be satisfied of the clinical skills of that doctor and their performance in the language. What checks did your PCT make in putting Dr Ubani on the performers list?

Mr Lejk: I think what we acknowledge is that at that time we were not as rigorous as we are now because we were making assumptions around the assurances that come from GMC registration and also, being an EU national, there was the whole debate about how you could apply the language test. We have now changed our system so that anyone who does not have a qualification from an English speaking country will automatically have to provide evidence of a language test.

Q36 Dr Stoate: My question is not about what you do now. My question was what checks did you make because you were responsible to ensure his clinical standards and language skills were up to speed. What checks did you make?

Mr Lejk: At the time we had no reason to feel that he was not competent.

Q37 Dr Stoate: You had no reason to think that he was competent, either.

Mr Lejk: Yes and we acknowledge that our systems were not as tight as they should have been so we have had to tighten them up since.

Q38 Dr Stoate: Did you know at that time he had already been refused from another performers list?

Mr Lejk: No, we did not.

Q39 Dr Stoate: You made no checks about that at all.

Mr Lejk: No, we did not.

Q40 Dr Stoate: I suppose you have already answered this in a way, but what are you going to do to make sure it never happens again?

Mr Lejk: Like I say, not only are we tightening up our arrangements around language competency, we are also not assuming that just because somebody is a qualified doctor that they are going to be fit to practise and have the skill level. We have set up a new panel with a medical director and myself who review all the cases including every 12 months reviewing those who are already on the list.

Q41 Dr Stoate: What are you doing to ensure that they are qualified as a GP rather than just qualified as a clinician?

Mr Lejk: We do follow-up checks. Not only do we look at what they have presented to us, but if we have any questions about whether their experience in another country is equivalent we will follow that up to make sure that there is an equivalence there.

Q42 Dr Stoate: He was a cosmetic surgeon, how does that make him qualified to be a GP?

Mr Lejk: As I say, under today's arrangements that would not have happened.

Q43 Sandra Gidley: Dr Wilson, do you think there is too much reliance on locum overseas doctors in out-of-hours primary care?

Dr Wilson: My organisation does not use them at all for various reasons so you might expect me to say yes because if there is any use then there should not be. That would not be quite fair. I think the survey that was done suggested that the way that overseas locums are used rather than whether they are used or not is what is important. The issue is really about cultural differences in practising medicine and there has to be an assurance that the doctor is able to deliver UK general practice or UK primary medical services. The question is that if they come from a medical culture that is different and they have not had any training and have not had at least some basic training in the organisation, how can that be? I would say that if it is being done without quite a substantial training there is too much. Oddly enough, since this happened, we have been approached by a number of doctors from overseas who have overseas GP accreditation and who are on performers lists and we are looking at the sort of training we might need to put in place to make those doctors safe and appropriate and we are working with the deanery on that.

Q44 Sandra Gidley: Are you saying that you employ not just local GPs but GPs from all around the country?

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Dr Wilson: GPs from all around the country do not tend to come and say, “How about some work?” We have GPs from performers lists in different parts of the country who are living and working in Birmingham. We do not rely on the performers list at all in terms of looking at a doctor’s suitability to work in our service.

Q45 Sandra Gidley: Do you think the checks on overseas locum GPs are robust enough? I am getting the impression from what you said that the answer is no.

Dr Wilson: I think the answer is that we would not rely on the checks that a PCT had carried out because we do not have an assurance about all the PCTs. We would check ourselves and the reason we do not use locum agencies is because we would be relying on someone else’s checks. I think that is an employer issue.

Q46 Sandra Gidley: You alluded earlier to the fact that you did not want six lots of KPIs; is there a problem in that each PCT seems to be going off and merrily doing their own thing?

Dr Wilson: There are 90-odd PCTs and we do not know what they are doing. They may all be doing a fantastic job, but our little organisation does not have time to set up a quality assurance process. I know what the GMC does so I know how far I can rely on what the GMC does; I do not know what different PCTs do. I know what some of the local ones do, but how would I know what a PCT in the North West does.

Q47 Sandra Gidley: It would make it easier for everybody if there were more standardisation?

Dr Wilson: Yes.

Q48 Dr Taylor: Antek, you have said your predecessors really accepted that GMC registration was pretty well good enough and did not go into it much more than that.

Mr Lejk: I think it was more than just that but I was not personally involved at that time .

Q49 Dr Taylor: We have the paper from the GMC and I am quoting: “The GMC cannot by law test the language proficiency of European doctors or carry out any assessment of medical knowledge and skills”. I am addressing this to Mike, if I may, should one of our strongest recommendations be that somehow, however it can be done, GMC registration takes into account not only language ability but clinical competence because we gather that this chap Ubani trained in Germany, did just his training then we believe—this is only an allegation—went straight into work as a cosmetic surgeon so had no experience in general practice at all, therefore he did not know the dose of diamorphine. Should we be somehow trying to help the GMC so they could test for language and clinical competence?

Mr Farrar: My sense is that the architecture that we currently have goes an awful long way. You have the beginning of the process with the GMC registration; you have the PCTs with their performers lists and

you have the providers who really should, because of all the points about professional quality, be looking after that. We can focus a lot of attention on more architecture and in my view you can always improve that and make it tougher. The real quality gain for me in this is going to come from looking at the handovers where our out-of-hours services pass on patients to other people and make sure that information is transferred; look at the coherence of out-of-hours services against all other aspects and bring in the multi-disciplinary working that you get during the day. I think the biggest quality gains that we could have would be in that respect. I accept we are looking specifically at one key question here which related to this tragic incident and I think you would want to try to tighten that if you could, but my sense is that good implementation of the architecture that we have got would actually get us quite a long way towards the aim you have. I know you are interviewing the GMC afterwards and I would be very interested to know whether or not they feel that they could do with something else in that mix. I certainly would not be against it but I do not think it is where you will get the biggest step change in quality of out-of-hours care because I think those other things I mentioned can do more.

Q50 Dr Taylor: You could not see the representative of the GMC but his head was shaking very vigorously when you were making those comments. I cannot help thinking that there has to be some way of excluding a doctor who does not know the basic dose.

Mr Farrar: Yes, of course. You would want somebody to be as fit to practise as possible, I am absolutely clear about that, but I think in the overall impact on the quality of care we should also be focussing on those other things.

Q51 Chairman: Mike, you have been around long enough to know that until the changes in the European Union just a few years ago most of the doctors who are coming in now from the wider European Union would have to have sat a test of their medical competence with the regulatory body. Did you think that was wrong when it happened? Do you think it should be overridden effectively by a decision in the European Commission?

Mr Farrar: That is an interesting question to put to me; I should be phoning a friend really.

Q52 Chairman: You are a practitioner; I just read these things, although I did have a history as a member of the General Medical Council. That has been the big change.

Mr Farrar: The NHS has been reliant on overseas medical input for many, many years.

Q53 Chairman: And been reliant on tests by the regulator.

Mr Farrar: We have benefited massively from that. It does not seem to me too difficult to make sure that people coming to this country who are capable of

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practising are subjected to a test on language and I do not think that should just be in the medical profession.

Q54 Chairman: It is not just language, it is the other skills as well.

Mr Farrar: In terms of skills I think there is a question to ask about the standards that we expect of our doctors where people are medically qualified overseas. Slightly more controversially, I think in that mix somewhere there is an element of arrogance about the quality of medical standards that we produce compared with others. Just to give you one experience where at one point there was some concern about South African doctors providing some of the care in ISTCs, some of the practices that the South African doctors had brought were very, very good and in fact better than some of the services

that we were providing, but at the time that was introduced there was a sense that medical training in South Africa would not be at the standard we have. I think we have to be careful about what fitness to practise is. We have to set our standards high and we should have tests on some of those things, but we should not have an automatic assumption that somehow anybody trained in this country is fabulous and anybody trained abroad is worse.

Chairman: I do not normally pass comment but I completely agree with some of those sentiments. I have visited and spoken to South African doctors who look after my constituents as well. I have no problem but of course they had to make sure they were fit and proper to practise in the UK while other doctors do not necessarily have to do that. Could I thank all of you very much indeed for coming in and opening this first session. I know we have over-run a little bit but thank you very much indeed.

Witnesses: **Mr Niall Dickson**, Chief Executive and Registrar, **Mr Paul Philip**, Deputy Chief Executive and Director of Standards and Fitness to Practise, General Medical Council, and **Professor Steve Field**, Chairman of Council, Royal College of General Practitioners, gave evidence.

Q55 Chairman: Gentlemen, welcome to the second session of our inquiry on the use of overseas doctors in providing out-of-hours services. I wonder if I could just ask you briefly to give your name and the current position that you hold.

Professor Field: I am Professor Steve Field; I am a GP in Birmingham. I have done one session on BADGER so there is a conflict of interest, but I am not very good so she would not employ me for any more!¹ I am Chairman of the Royal College of GPs.

Mr Dickson: Niall Dickson, Chief Executive and Registrar of the General Medical Council.

Mr Philip: Paul Philip. I am the Deputy Chief Executive of the General Medical Council. Niall has been with us merely a matter of weeks so we thought perhaps if there were any technical questions I would come along to attempt to respond to them.

Q56 Chairman: You are probably aware from the end of the last session I do not have any interest to declare. I am not a member of the General Medical Council but was for a substantial number of years until the new Council took place. I have a question for Professor Steve Field at this stage. Is the quality of out-of-hours GP services good enough? Are local GPs adequately engaged in designing, commissioning and providing out-of-hours services?

Professor Field: You will have seen from the report that David Colin-Thomé put together with me—that report was our honest feelings about the current situation and we had no interference from anybody else—that it is patchy. I think our patients across the whole of the United Kingdom, not just England, deserve consistently good services out-of-hours as well as they do in-hours. There are actually more hours out-of-hours than there are in-hours and I

think generally we can do better. There are examples of excellent practice and many examples of good practice and unfortunately there are some examples of very poor practice, for example the Ubani case but there are others. The second question about whether GPs are actively engaged is very similar; it is very patchy. When we visited some of the providers we saw excellent engagement. Fay Wilson, to whom you have just been speaking, is a provider of our local out-of-hours service and it is exemplary. I have no criticism of what they do at all. The engagement is excellent; the provision is excellent. Sometimes it is difficult for them working with the PCTs to be clear about what the contract is and I think that came out earlier. Another example of very good practice would be in Greenwich where we visited with a team from the Department of Health. The reason why that is a good example of practice is that it is actually run by a GP company which was a co-operative so GPs lead the provision. They have a waiting list of doctors who all practise locally who want to work out-of-hours and they do that because they have very, very good education linked into the local vocational training scheme. The PCT takes it seriously and has strong clinical leadership. That is an example for everyone.

Q57 Chairman: Is there any evidence to suggest that local GP co-operatives provide better care than their commercial counterparts?

Professor Field: The evidence is very difficult to find actually. Certainly looking at good practice the Dorset Ambulance Service provides very, very good out-of-hours care but they have very good GP and pharmacy leadership there. It does not seem either to be an issue of what the cost is. There is a basic cost by which I guess you can provide care, but it is really in the contract for the provision of the care and the

¹ Note by Witness: This was a light-hearted comment intended to put the committee at its ease and was not intended to be taken too seriously

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clinical engagement. I do, however, feel that co-operatives offer an advantage over private providers in that it does mean that you are more likely to have local GP engagement and local GP provision therefore out-of-hours as well as in-hours, and the communication is better. However the evidence, as far as we can see, is variable.

Q58 Chairman: Would quality and safety be better if responsibility for out-of-hours services was transferred back to GPs as it was prior to the new contract in 2003?

Professor Field: I think the problem is how one uses the English in this and how you define it. Before 2003–04 many of us, including myself in my first six years of practice, were working every other night, every other weekend and every day and doing our own deliveries at home and in a GP unit. We were exhausted, the divorce rate was high and the stress and burnout rate was high. As Howard will know, many years ago we could not consistently get other GPs locally necessarily to join into co-operatives so our small practice was left out of the local provision in Droitwich in Worcestershire and we ended up having to bring locums in at weekends. The system was worse then than after 2004. Coming up to 2004 the majority of doctors were based in co-operatives and it was improving, but the problem is—and this is the use of English—if I am responsible for you, Kevin, as the doctor out there seeing the patients and I am clinically responsible, it is actually very, very difficult then. I can remember having a complaint against me as a senior partner,² which was hugely stressful, and I was not even in the country when the activity happened. That was actually an in-hours issue, which was ridiculous at the time because they happened to be on my personal list. I think the contract has given great opportunities for patients to have high quality care where in some areas they did not. The regulatory system was there to make it happen. What is embarrassing is that PCTs in some areas have not taken this seriously and as a consequence the contracts have been variable and the provision also has been variable. Our document does demonstrate that if everybody did what they should have been doing properly the quality of care would have been good.

Q59 Chairman: You hinted there that you were sort of brought into order for something that happened when you were not in the country. If you, as a GP, are getting other GPs to come and work in your out-of-hours service, do you have professional responsibility for them? This flashed up in a debate in the House of Commons a few weeks ago.

Professor Field: As it stands at the moment the responsibility is for the commissioning of the care. Of course you would have responsibility for what happened while you were looking after the patient in-hours but there is a professional responsibility for the doctor who goes out and visits who sees them in that consultation.

Q60 Chairman: Would any doctor who is running the out-of-hours service have wider personal responsibilities if they do employ somebody to do that?

Professor Field: That came out in the Bristol inquiry. Ian Kennedy was very clear that if you are a medical director or a chief executive who is a doctor you have responsibilities and the GMC might want to comment on that because that is very important.

Q61 Stephen Hesford: In light of recent reviews of out-of-hours services, what action has the GMC already taken to respond to the recommendations made? What further measures do you intend to take?

Mr Dickson: The first thing is we have written to every PCT in the country and indeed to all employers simply setting out first of all what the GMC is able to do in relation to the doctors who are on our Register and what we are not able to do, and drawing attention to the gaping hole in the registration system of doctors who come from the European Union and also reminding employers that while the GMC, where we are able, check language skills and competency, it is the employers and those who contract who have responsibilities not least around fitness for purpose. We are not in the fitness for purpose business, we are in the fitness to practise business and so if you are getting a doctor to perform a set of duties and tasks it is your duty as both a contractor and a provider to ensure they have the competence and skills to be able to carry out those tasks.

Q62 Stephen Hesford: Are you then dodging the issue that Richard Taylor talked about before, that the GMC should do more?

Mr Dickson: No, the GMC should have the ability to test the language skills or to check the competency in terms of language of doctors who come from the European Economic Area, and we cannot do that at the moment.

Q63 Stephen Hesford: They can speak English but they could be a rubbish doctor; that is okay?

Mr Dickson: That is the first point; I was coming onto the second point. We would also wish to test the competency. At the moment there are broadly three categories of doctor who go on to the Register. There are first of all doctors who qualify in the UK, and we are not saying that all doctors who qualify in the UK are all perfect as I think was hinted at earlier, but we are able to quality assure medical education in the country; that is our responsibility. So we have some assurance around the quality of doctors who qualify in this country. Secondly, we require international medical graduates—that is to say all those not from the UK and not from the European Union—to demonstrate proficiency in English and secondly clinical competence, so if necessary we put them through a series of tests, both written tests and practical tests. The third group is doctors from the European Economic Area (the EU plus a couple of others) and for them we are not allowed to language test and we are not allowed to competency test. What we can do is check who they are; we can get

² Note by Witness: Complaint subsequently not upheld

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from the competent European authority a certificate saying they are somebody of good standing, and thirdly we get the qualifications they produce. What we cannot do is look behind those things. We cannot say, "Well that qualification doesn't mean very much". If it is approved and it is on the European list then we simply have to accept them and in the case of Dr Ubani that was of course what happened.

Q64 Stephen Hesford: Would you want to do that or do you devolve that responsibility to the actual provider that the medical practitioner will then work for?

Mr Dickson: We absolutely want to do it. We would like a change in the law. We would like a change in the law both in this country to the 1983 Medical Act which in our view goldplates the European Directive and actually makes it even more difficult in relation to language and we would like a change to the European Directive which would enable us to check competency of doctors coming from the European Union and we are taking active steps to try to bring those things about. We have had discussions recently with the Department of Health about whether there might be a possibility at least of getting the language issue sorted out by changing the 1983 Medical Act through a Section 60 Order. There is concern. The Department of Health is worried about the possibility of infraction proceedings, that is to say that if we change our Medical Act and do it in such a way that the European Union would say we are running against the Directive, then of course the Government could face big fines and all the rest of it. We are having on-going discussions with the Government about that. We believe there is a way forward and we would encourage them to work with us in order to try to achieve that as quickly as possible and at least we would close off the language thing. The competency thing is more difficult and that requires the European Union. The European Union is looking at this Directive again in 2012 and we will continue to put pressure on. I think there is a recognition at least at a political level in Europe, that this is an issue. Free movement of labour is fine but in our view patient safety trumps the free movement of labour and we need to look at this across the whole of Europe because it is not working now. There is not even good exchange of information between regulators at the moment about doctors who are not up to scratch.

Q65 Stephen Hesford: He is not bad, is he, for two or three weeks? Is there anything you want or need to add to that, Paul?

Mr Philip: I do not think there is anything that we need to add. We have for some time been calling for the ability to test the knowledge skills and language skills of doctors from the EU. That has been our position for quite a significant time now and we have not changed that position. From our point of view I was very interested in Mike's comments earlier about the quality agenda. We have minimum standards in practising medicine and that is about fitness to practise. Fitness for purpose in developing quality across the patch is a slightly different issue. I

do not disagree with what Mike Farrar said earlier in that respect but we must, as the regulator of doctors in the UK, be able to maintain the integrity of the Medical Register. We do that easily with UK graduates, we do it through special arrangements we have in place in relation to international medical graduates, yet we do not do it for EEA doctors and that cannot be right.

Q66 Chairman: What proposals do the GMC have in relation to ensuring that there is regular monitoring of doctors' competence and continuing professional development?

Mr Dickson: You are talking about doctors across the piece. At the moment we have just put out a document consulting on the proposals for re-validation which, if we manage to get this through—and I believe we will—will mean that Britain will lead the world in terms of the way that it regulates the medical profession. At the moment our Register provides limited assurance—we have just talked about the limited assurance in relation to doctors from the EEA—in the sense that it is essentially a record of qualification. Of course the longer ago that that qualification took place, the less assurance in a way the Register provides, so what you are talking about is a doctor who, on such-and-such a day, had a primary medical qualification at that time, or indeed went through a course to become some form of specialist such as a general practitioner or some other form of specialty. That is what the Register does and it also demonstrates whether the doctor has had any conditions or restrictions placed on their practice. With revalidation what we will be doing instead of the historical record of qualification is to provide something nearer a contemporary record of performance, in other words demonstrating that that doctor on a continuing basis is competent and fit to practise. That will be a big advance and the healthcare systems will do that by putting in place robust systems of clinical governance underpinned by a good appraisal system over a period of five years so that we would expect all doctors within a few years' time to be able to have access to a good system of appraisal which tests how well they are doing, enables them to reflect on their own practice and then if they have done that five times their licence will be revalidated for another five years. That is an additional form of assurance and we believe we will lead the world if we manage to do that across our whole healthcare system.

Q67 Chairman: How will that affect doctors from the EEA coming in and working on out-of-hours services on a temporary basis?

Mr Dickson: They would be subject to exactly the same rules as any other doctor working in this country. They would be required to have a responsible officer who would be responsible for ensuring their revalidation; they would have to demonstrate that they had a robust system of appraisal and they would be required to do the same things as any other doctors in this country.

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Q68 Chairman: Of course revalidation is not pan-European and it does not happen overnight. Are you confident that doctors coming in will have the same level of checks, for want of a better word?

Mr Dickson: Revalidation does not solve the check problem. What it probably will do over a longer period of time is that it will mean that if doctors from the European Union come here and are subject to a process of appraisal and so on, then it may at an earlier stage identify if there are any problems in relation to their competency and fitness to practise, but it will not deal with the entry point.

Q69 Charlotte Atkins: How will you ensure that a doctor coming in from the EEA has relevant experience? To have a cosmetic surgeon jumping into a role as a GP, surely that does not make very much sense. Would the GMC like a system by which the experience of foreign doctors is taken on board before they are let loose on general practice?

Mr Dickson: We run a number of registers so we have a general register and we also run specialty registers as well, so there is a separate register of general practitioners. The problem in relation to Europe is that again the definition “general practitioner”, which is happily used and we have to accept, does not really apply so that in Germany they do not have general practitioners as they do here. In fact Dr Ubani was supposedly a qualified general practitioner according to the rules of the European Union and we had to register him on the GP register, which simply goes to show that system absolutely does not work. However, I do not think the GMC, even in their post-revalidation world, even if we closed that gap in Europe, would be doing fitness for purpose type checks and, as Paul said, there would still be an obligation on employers to say what job they are expecting that doctor to do. The doctors of course have a responsibility themselves to not practise beyond their competence but the GMC’s role would be to say doctors who have been in practice for a while would have to demonstrate that they were competent and fit to practise and have proof of doing that. We would have an entry system which would say what are your qualifications and then we would put them on specialist registers which entitle them to work in particular settings, but beyond that I do not think it would be the GMC’s role. I think there is still a critical role for employers.

Q70 Charlotte Atkins: So it is really the PCT that has to make sure that the doctor they are employing is fit for purpose in the role they are performing. Do you see a role here for the strategic health authorities? We seem to have been very quiet on what their role is.

Mr Dickson: In a way it is not for us to say exactly how the healthcare system should operate. I should add that we have talked an awful lot about doctors working for PCTs, the NHS and so on. One of the areas of course that we are also concerned with are doctors who work on their own, who are in private practice and who may come from Europe and simply put their badge outside their surgery, as it were. They are relatively small numbers but it is a significant

area of risk. Clearly any healthcare system, whether at SHA or PCT level, has to have systems of supervision and clinical governance and assurance that they are putting those systems in place. I do not think it would be up to us say which bit should do what, but certainly in broad terms and what we said in letters we have sent out to employers is that you have specific responsibilities either if you are directly employing doctors or even if you are contracting or commissioning services to ensure that those doctors are competent and fit for purpose.

Q71 Sandra Gidley: Professor Field, I just wondered if you thought the criteria for admitting doctors to performers lists were robust enough. Do you think it is right that it is possible for a doctor to be admitted on to one list and then just work anywhere else?

Professor Field: It is useful following the example of a doctor going through the system. The short answer is no. I am really worried about the standard of European training which is brilliant in Denmark and Holland, for example, but, as Niall quite rightly said, the definition of GP does vary as you go south and across Europe. In April the GMC takes over the Post-Graduate Medical Education Training Board which has a role for overseas doctors but the European doctors could come in. As the doctors come in we are very worried about the quality. Even those excellent doctors who train arguably at an even better standard in Denmark and Holland to what we have and their training programmes are generally better because they are longer and more intense and they get more experience with patients, they are not accustomed to the NHS in- or out-of-hours and the drug names are slightly different. In 2008 we issued some guidance from the College to PCTs which helped with interpretation of the performers list and we tried to work with the post-graduate deaneries (those who provide the education) so that they might assess the doctors if they were coming in. In Wales, which has a single deanery (a small country, the size of a small SHA) they have a centralised system where they have induction, assessment and they use a knowledge test as well as clinical skills. In England the responsibility is with the PCTs. If the existing rules on the performers list were applied consistently that would be acceptable, but it is the interpretation and the Department of Health did issue further guidance at the end of March last year for PCTs as part of the suite of papers to support revalidation. It is an excellent paper but most PCTs were not aware of it; it was not publicised enough. It was on the DH website but most PCTs were not aware of it. We had issued guidance, the DH has issued guidance and, as you will read in the detail of our report, that, if implemented, is sufficient. I do support the GMC’s need for English language testing before doctors come into the country and a section 60 order to sort that out I believe should be done urgently irrespective of the election; this is really important. Actually the PCTs working with their deaneries locally should be able to provide consistent assessment. When I did my last session out-of-hours the provider—Fay Wilson, who is sitting behind

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me—even though I was a local GP for a couple of decades, made me go to a training session and actually there was an assessment about how we handled people over the phone. I am not very good out-of-hours because I like to see patients and I am not very good at that sort of telephone stuff and do not do it any more,³ but actually that was the provider doing the assessment. The PCT should also do an assessment to go on the performers list. There are enough checks and balances in the system if the system was working. The SHAs frankly also need to take this seriously and make sure that the PCTs are doing their job properly. Clearly Mike Farrar in the North West is doing that. All SHAs should do that in England. There are enough checks and balances to make sure there is a safe system but it is not taken seriously and consistently from PCTs all the way through the system.

Q72 Sandra Gidley: You mentioned the word “patchy” earlier a couple of times; would it be fair to say that a locum doctor wanting to work in this country might be able to get to know where it might be easier to get on the List?

Professor Field: As we have said in the press and in committee many times, we believe that there has been a network where people know which PCTs to target. A number of recommendations in the Department of Health’s own report include sharing information more and tightening this up. Clearly Dr Ubani got in through the performers list in Cornwall and the Scilly Islands. He was rejected in Leeds I understand because of his language. Cambridge PCT took him on and there were no checks. Now you have three PCTs there all meant to be doing similar checks with different outcomes.

Q73 Sandra Gidley: You did say there were recommendations about exchange of information between PCTs and the GMC and you are saying the report back should be improved. Do you think it would be better to have a single performers list that was held nationally?

Professor Field: I believe it would be better to do that and actually the GMC would be the place to do it. There are difficulties about keeping it up-to-date. As Niall said earlier on, your qualifications and your experience are only as good as when you actually go on the list so it has to be a living document. When you have doctors currently working between four, five or six PCTs, different performers lists and maybe five, six or seven different providers, it is hugely difficult to keep track of them. I do believe that revalidation as a system will help this. With any doctor coming from Europe, the UK or wherever having a named responsible officer should be able to manage this. However, again we have evidence of PCTs taking appraisal seriously and not seriously in different PCTs over the last couple of years. We have had doctors writing to us even in the last three months that PCTs in some areas have been considering stopping the appraisal system because of financial issues. None of them have actually done

that but we know three years ago that happened. Unless we have GPs on the boards of the PCT making this work, unless we have robust clinical governance systems, unless the PCTs follow the regulations that are already there, we are going to continue to have this mess as has happened in Cambridge and elsewhere.

Q74 Mr Scott: Professor Field, the Cambridgeshire Coroner recommended that the Royal College of GPs should institute a national training and assessment programme for overseas doctors who want to work as GPs in the UK. What action are you taking on that recommendation?

Professor Field: Before they wrote we had already, at the end of 2008, started working with the deaneries to offer what I suggested before which was an induction offer. We think doctors coming from Europe should actually be spending about three months in the UK before they work in- or out-of-hours to understand the system. If they are serious about working here then that is a good thing. We have started working with the deaneries on some work on knowledge tests and communications skills and I think you heard from those in the West Midlands that the deanery there has started to do some work on that. However, it is very patchy. In Wales it works well; across England it is variable partly because the PCTs do not ask and there is an issue about whether they will fund that system. Personally I think they should not need to fund it, it should be the individual doctor or the provider who actually pays for any additional training. The deaneries are in flux in England as well at the moment; they are going through some re-organisation, some discussion of purchaser/provider splits, and there is an inconsistency there, whereas Wales has an advantage. We welcome the Coroner’s request to do something nationally because we believe we can then tie all these loose ends together. We have written to the Department of Health and look forward to their response about how that might be resourced to set it up. If it is a national system then if a doctor is coming in from Germany the issue is who pays for his induction and who pays for the training and the assessment. It is my belief that it should be the doctor who is responsible or the provider of that care, but that is a debate we need to have because otherwise what we keep doing is providing more and more things people could do which cost more and more money. I think the incentive should be that local providers, local PCTs, should work with local GPs to encourage them to provide the care then we would not need these assessment systems in the first place.

Q75 Mr Scott: Professor Field, you mentioned earlier that from some countries—I think you mentioned Denmark and Holland—where the standard of GPs is high you do not have a personal difficulty with anyone coming in from there, but for other countries—you mentioned going further across southern Europe and perhaps possibly some of the former republics that are now involved in the EEA—do you feel there should a two-tier policy,

³ Note by Witness: This is meant to convey my preference for face to face consultations rather than telephone triage.

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that from some countries we do accept them but from some countries they do need more training perhaps?

Professor Field: I am not an expert in European law and that is the problem. Well, the problem is not that I am not an expert in European law, it is the European law! Our training is modelled on Denmark and we think in England we should have longer training for GPs. I do not believe that our training for out-of-hours is adequate at the moment and that is also in the report asking us to review that. I do not think the training is consistently good in this country. Not all GPs in training in this country can do a placement looking at acutely ill children so there are improvements we have to do with our own training. If you go to Germany or to Italy in some training programmes they do not see children, they do not look after children. If you go to Denmark it is brilliant actually but I would still expect a Danish doctor working in England to be inducted into the British NHS. So it is not just about knowledge, skills and language, it is actually about understanding the environment they are working in and, as you will know from the report from the Coroner, Dr Ubani came in and there was a whole series of errors. Professionally he should never have worked here; as a professional he should never, ever have wanted to work here because he knew he was not competent in the first place. It was the doctor, it was the PCT, the provider who provided the drug bags; there was a whole systems error. I think we have enough commitment now to sort this out and I was really encouraged by the evidence given from the PCTs and the SHA earlier on because they are now taking this seriously. It is just a shame that did not happen before.

Mr Scott: Thank you very much. I guess if we need out-of-hours we should perhaps go to Denmark.

Q76 Dr Stoate: I would like to place on the record an interest and that is I am currently on the GMC List and hope to remain so. I am also a Fellow of the Royal College of General Practitioners and also my practice is covered by the out-of-hours co-operative that Professor Field mentioned, it is called GRABADOC and it does in fact provide an extremely high level of cover to my patients. I just wanted to put that on the record in case there is any confusion. Much of what I wanted to ask has already been covered, but I have a question I would like to ask Niall. Can you clarify the current arrangements regarding indemnity insurance for practitioners in this county?

Mr Dickson: I am going to defer to Paul.

Mr Philip: There is no legal requirement for a doctor to have indemnity insurance to be on the Medical Register at this point in time. However there is legislation which is on the statute books but, as I understand it, is not enacted which would allow such an arrangement to come into place. I understand the Department of Health has a working group at this point in time looking at the feasibility and the proportionality of those arrangements.

Q77 Dr Stoate: So currently there is no requirement for any doctor to have any sort of personal indemnity insurance?

Mr Philip: That is my understanding, yes.

Q78 Dr Stoate: Do you think that should be a requirement?

Mr Philip: I think we need to come up with an arrangement whereby patients who are subject to adverse outcomes—medical accidents or whatever—are appropriately compensated and within the NHS Crown indemnity applies. The real issue is for those independent practitioners who do not practise within the NHS or do not have sufficient funds or have insufficiently deep pockets as it were in order to compensate an individual who has been adversely affected by their care.

Q79 Dr Stoate: So in other words if a doctor is working for an acute trust, the trust covers their indemnity; if a doctor is working for a general practice or a practice organisation they are not covered by indemnity automatically?

Mr Philip: That is my understanding, yes.

Professor Field: That is right; it costs me £1,900 a year to do one session a week.

Q80 Dr Stoate: Is it compulsory?

Professor Field: No.

Q81 Dr Stoate: Is that anything to do with the NHS redress scheme? Does that have any part to play in this issue in terms of covering patients for adverse effects?

Mr Philip: I have to be honest and say it is not my area of expertise.

Q82 Dr Stoate: If legislation is enacted and it is a requirement to have indemnity insurance, would that automatically apply to doctors from outside this country? In other words, would EEA doctors be required to provide the same level of cover? My understanding at the moment is that should a doctor come over from Germany, for example, and damage a patient in this country and then go back to Germany, there is no recourse for that damaged patient or that damaged patient's family against that doctor in terms of claiming indemnity.

Mr Philip: Common sense would mean that should a doctor come onto the Medical Register for any period of time whatsoever they just comply with the arrangements that are in place at the time, so one would suggest that that would be the case but in all honesty I do not know.

Q83 Dr Stoate: So there is need for clarification then?

Mr Philip: Yes.

Mr Dickson: It is worth saying that most doctors who are coming over—and I agree that may not cover some—should be working for an organisation and that organisation, if PCTs are commissioning them, should be making sure that organisation is fully indemnified for the practitioners that it is contracting with. I think the bit that the new

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indemnity is not covering is really around independent practice, people working on their own, not people who are working for the NHS.

Q84 Dr Stoate: That is fair enough; I accept that. I have a question for Paul and that is, is there any reason why doctors qualified outside the UK are disproportionately over-represented in GMC cases?

Mr Philip: First of all, international medical graduates have, for some time, been over-represented in the fitness to practise arrangements at the General Medical Council. We have commissioned various pieces of research to explore this. What has become clear in research which has only just been published is that it has much more to do with their place of qualification than their ethnicity as it were.

Q85 Dr Stoate: I appreciate that and that is a very important point to make. Nevertheless, is there any reason why that should be the case?

Mr Philip: I am afraid I do not have the empirical evidence to postulate in relation to that. What I could say, however, is that doctors coming from the EU are every bit as overly-represented as doctors coming from the wider world.

Q86 Dr Stoate: You do not have any evidence as to why that might be so?

Mr Philip: I am afraid I do not.

Q87 Dr Stoate: Obviously all these EEA rules apply to every country so that if any doctor from, for example, Italy decided to work in Germany they would have the same registration arrangements applied to them as we do here. Is that right?

Mr Dickson: Yes, although I made the point at the beginning around the role of the Medical Act goldplating this. For example in France if you come from a non-French speaking country the regulator will ask to have chat with you and if they think your French is not up to much on an individual basis they might ask you to take a test or to go away and learn French and then come back again. The 1983 Medical Act actually prohibits us from doing that.

Q88 Dr Stoate: Can I just clarify this? The French are allowed to do it but we are not?

Mr Dickson: The French are not allowed to do so systematically. They cannot say that any doctor from anywhere must have a test. What the French can do and do do is that when an individual doctor comes forward they can assess that doctor in an informal way and then decide, "I don't think your French is up to much". We are prohibited. The advice we have from counsel is that we cannot do that because of the 1983 Medical Act which is why I was making the point earlier that we believe we can and should be able to change the 1983 Medical Act.

Q89 Dr Stoate: So it has nothing to do with European law then, it is to do with our law?

Mr Dickson: Our law goldplates a bit of European law. The 2005 Directive actually says that professionals who are moving from one country to

another should—must, as it were—be proficient in the language of the host country they are going to work in. So in one sense the European law pushes us in the right direction, but it also says, "You are not allowed to have systematic testing". We are not allowed to have systematic testing.

Q90 Dr Stoate: That is playing with words. If, for example, I wanted to get onto a French register and I do not speak much French, I would not be allowed to. However, a French person who does not speak much English would be allowed to come and join your list.

Mr Dickson: Yes, that is absolutely right. That is the point.

Q91 Dr Stoate: That cannot be equitable across Europe, can it?

Mr Dickson: It is not equitable; it is about our 1983 Medical Act rather than a European Directive which is the reason why we believe we are not able to do that.

Q92 Dr Stoate: So it is another bit of French *le fudge*, is it? They get away with it and we do not.

Mr Philip: The Directive allows in appropriate circumstances to language test; the question is what is "appropriate circumstances"? The 1983 Medical Act prohibits the General Medical Council in any circumstances from language testing. There is a difference.

Q93 Dr Stoate: That needs to be put right rather urgently.

Mr Dickson: I have had a discussion with the Secretary of State. As I mentioned before, the Department is concerned about infraction proceedings from Europe but we would be very keen to work with the Department, if necessary, to go and get counsel's advice together, as it were, to see if we can get round this because we believe there is a way forward where we could change the 1983 Medical Act without the risk of the Government facing the ire of the European Union.

Q94 Dr Stoate: This is vital. Steve has made the point, quite rightly, that because the word "GP" does not have the same meaning in Europe as it does here, we potentially have people with no experience whatsoever in general practice—Dr Ubani almost certainly fits into that category—and they can do almost what they like in this country.

Mr Dickson: We were only having a discussion a moment ago about language testing; we were not talking about competency and that is again more the European Union that puts up that barrier.

Q95 Dr Stoate: We need to bear in mind he was rejected by Leeds because of his language.

Mr Dickson: Absolutely.

Professor Field: Language is an issue. When we published our report the Minister who has just come in behind was more assertive than we were over making sure the PCTs assessed on skills. The provider—the PCT—is there to look at the

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knowledge skills induction. That is there; they should be doing it. I do believe language is something which should be sorted nationally as well as locally. The problem with when you are on the GMC Register, as you know Howard, is that it is a historical document at the moment. I have not done out-of-hours for many years therefore I would have to go back and be trained and get more experience and have somebody sit with me. That is what BADGER would do to me. Other providers just want to fill the rotas. The PCTs have a responsibility in their contracting. The guidance needs to be there and that is what the Department of Health has done. I must say they have been impressive on how they have taken on all of our recommendations and gone further. I cannot fault the fact that they have supported it. The problem is what went on before at a local level. It must be hugely frustrating being in Whitehall either as a minister or in the Department of Health that this has happened and that there are so many inconsistencies at PCT level.

Dr Stoate: It is pretty frustrating for this Committee which is why we are carrying out this inquiry.

Q96 Chairman: How long is it since the General Medical Council have spoken to the Government about changing the 1983 Act to make this a little bit more flexible? This is news to me.

Mr Dickson: The last time I spoke to them was to the Secretary of State last week.

Q97 Chairman: Was that the first time the GMC had spoken to them about changing this legislation?

Mr Dickson: No. In the eight weeks I have been at the GMC we have had a number of exchanges with the Government both around the 1983 Medical Act and also what other things we could do to help support the Government in its efforts to tighten up this whole process.

Q98 Chairman: The absence of this English language test is several years now, is it not?

Mr Philip: It is, yes. Niall's predecessor, Finlay Scott, has been making this point for some considerable time. There is an issue here—there is a lacuna, as it were—between what the Medical Act stops us from doing and what European legislation might allow us to do. To be absolutely clear, however, the issue is a wonderful EU word “proportionality”; what would be proportionate in order to decide whether an individual could speak English or not, and that is why you cannot simply systematically say that because you are French or Italian or whatever then you have to be tested.

Q99 Mr Scott: I accept what you are saying about proportionality, but surely the basic test is whatever country the doctor comes from they either can understand what a patient is saying or they cannot understand what a patient is saying, and whether it is European law or whether it is the 1983 Act surely the pressure should have been brought, maybe from yourselves, to get this changed? It has to be ludicrous

that we can have doctors coming in, however well qualified and whatever ability they have, to our country when they cannot speak the language.

Mr Dickson: I agree entirely and that is why we are doing everything we can both to put pressure at a European level (Paul gave evidence before Christmas on the subject at European level) and I think there is some political buy-in at the European Parliament level but I am not sure there is at Commission level; we still have a difficulty there. Likewise certainly the Secretary of State's comments to me last week indicated that the Government wanted to do everything it could to try to bring about this change. The legal technicalities are not absolutely straightforward but I believe there is an opportunity now; we should press ahead and try to get this change through.

Q100 Mr Scott: With some urgency?

Mr Dickson: With urgency, I agree.

Chairman: For your information, when this Committee was in the European Commission taking evidence on health inequalities, we did have a meeting with the Commission themselves who were changing Commissioners at the time. I brought this matter up and I do not think there was any disagreement about what I was saying about the ability or the responsibility for communication being thrown back to employers maybe not now as we have more doctors in the system but many years ago we were hard pressed to find doctors to work in these types of areas and consequently had to take what was on offer. I hope it is pursued and pursued nationally as well. If we could alter any Act that we have here that will give some flexibility but not get rid of the rigid system that we have now, I hope that is looked at.

Q101 Dr Taylor: This question is to Niall or Paul, is there sufficient exchange of information between the GMC and your counterpart bodies in other countries? Dr Ubani may be a very good cosmetic surgeon, but he is obviously not a good doctor in any other way. Are there talks about limited registration, if he could be registered just as a cosmetic surgeon and not as anything else?

Mr Dickson: Again we are conflating two issues. First of all, there is the issue of the ability of us to communicate with other regulators and the situation is again, to use the stock phrase, “profoundly unsatisfactory”. The GMC issues a monthly circular to all regulators throughout the world listing the doctors who have come before our fitness to practise procedures, people who have had restrictions and so on. I have to say that from the rest of Europe there is a very mixed and patchy picture and there are regulators who produce absolutely nothing. Again you are not always talking about a national regulator and the picture of medical regulation varies enormously around Europe so, for example, at German level there is an over-arching German body but there are also key bodies at the level of the *länder*. We have written to the German authorities about Dr Ubani. I think we have sent 22 letters, including questioning whether he should still be

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practising given what has happened and we have not had a response. So the level of communication around Europe is unsatisfactory. Paul may wish to comment on this. There have been efforts to try to get a pan-European system and we have been putting pressure on the European Union to have a mandatory system. If you have free movement of labour you should have free movement of information and it is not satisfactory to allow people to wander around without clear issues about the free movement of information.

Mr Philip: That is an extremely good point. We have for some time been lobbying for a mandatory requirement that disciplinary action taken against doctors in Europe is automatically brought to our attention in a systematic way. That is not the position at the moment. We are by far the most open

and transparent medical regulator in Europe if not the world. Our disciplinary outcomes are all on the web; they are automatically updated on a daily basis and, as Niall said, we send a circular round to all regulators on a monthly basis. That is not reciprocated in any shape or form, particularly in old Europe. Scandinavian countries are outstanding in this respect but if you go back to France, Germany, Portugal, Holland, Italy, it is extremely patchy. Part of the problem, as Niall says, is because we are not dealing with a single country competent authority; there are something like 28 in France and in the 50s in Germany, so trying to actually engage with such a fragmented process is extremely difficult.

Chairman: Could I thank all three of you very much indeed for coming along and helping us with this session. Thank you.

Witnesses: **Rt Hon Mike O'Brien QC MP**, Minister of State for Health, **Dr David Colin-Thomé**, National Director for Primary Care and Medical Adviser, and **Mr Gavin Larnar**, Director, Professional Standards, Department of Health, gave evidence.

Q102 Chairman: Good morning. We are running this session a little later than we originally thought because of what has preceded it. Could I ask you for the record if you could give us your names and the current position that you hold.

Mr O'Brien: Good morning, Mr Chairman and colleagues. I am Mike O'Brien MP, Minister of State at the Department of Health. On my right is Dr David Colin-Thomé, Director for Primary Care and Medical Adviser to the Department of Health, and on my left is Gavin Larnar, the Director of Professional Standards at the Department of Health.

Q103 Chairman: Minister, obviously you will be very well aware of what has brought this day's evidence session onto our agenda. Are PCTs failing in their duty to commission safe out-of-hours GP services?

Mr O'Brien: Some of them are and some of them are not. We know from the Ubani case, for example, that Leeds rejected Dr Ubani on the basis of his language incompetence and that Cornwall accepted him onto their performers list and, as a result of that, he was able to get employment in Cambridgeshire and then someone died.

Q104 Chairman: We heard earlier about the variability of PCTs in terms of providing services and indeed from an SHA witness that 15 were satisfactory, seven were not and I cannot remember what the rest were. What is the Department doing about addressing the unacceptable variability in performance monitoring and out-of-hours services between PCTs?

Mr O'Brien: Over a long period of time there have been a whole series of reminders. More recently, on 2 October Dr Colin-Thomé wrote to all PCTs just reminding them of their obligations following the tragic death of a Mr Gray. They were told that they had very clear legal obligations to check on language competence and also to ensure that there was

nothing that they were aware of in terms of the qualifications of someone that meant that they should not be performing as a GP in that area. As a result of that, a number of PCTs have improved the quality of what they have done. We have further written on 4 February. Sir David Nicholson, Head of the NHS, has written to all the PCTs, telling them to make sure that they had checked everyone on their performers list. Cornwall, for example, have assured us that they have now improved the checks they carry out, that they have weeded out some of the people who have been on their list for years and they had not even practised in Cornwall. They should not have been there because they had not practised in the last year, so they have taken them off. We are also pressing the PCTs to improve the way in which they do things through world-class commissioning and also we have asked all the SHAs to look at the PCTs and ask if they are carrying out these checks properly, do they understand what they are supposed to do because it is clear that some of them have not. Further, we have announced, following the review which was done by David Colin-Thomé and also Professor Steve Field, that we want to introduce a national standard contract for all PCTs to engage with those that provide the out-of-hours services to oblige them to carry out checks and also that there should be a standard contract to ensure that all GPs who are employed by the provider will be people who are compliant with the law and have competence in English, but also in terms of their qualifications and their capacity to be a GP.

Q105 Chairman: The review that was done that you have mentioned recommended that PCT improvement programmes be introduced to support commissioning and performance management. Is what you have given me an update of where we are at the moment or has further progress been made on this?

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Mr O'Brien: What we are doing now is working on the national contract which I think is the basis upon which we need to improve the quality of what is done by PCTs. PCTs are the essential gatekeeper here; they are the people who have the legal obligation to provide a competent service to the people in the area. They employ a provider and that is either a co-operative of GPs in the local area, it is a company or there are various local arrangements. The key thing is all the PCTs carry out their duties fully. What we want to do is consult with professions and also with the various NHS organisations, SHAs, PCTs, et cetera, and also with those who actually provide GP services now to work through the detail over the coming months of what that national contract should be and that would, therefore, make very explicit the qualifications that are required and make very clear the obligations, and I think they are clear enough in law anyway, but it is also clear that some of the PCTs have not been delivering. By the end of this year I want that consulted on, in place and obligatory so that it is actually something that we can then say, "This is being done and these checks are being carried out properly".

Q106 Chairman: I accept that the national contract might be the answer obviously nationally, but, as we have been told by a chief executive of an SHA, they have got seven who are not performing well at the moment. We are not waiting for them to catch up with the rest in that particular area. Are we taking action in these areas where we know the variability is and some PCTs are not doing what some of the others are doing? What action is being taken there?

Mr O'Brien: Each SHA has been told to do a quality assurance on the PCTs in their areas to make sure they are carrying out the checks. Every PCT has been directed last year and again more recently to carry out checks on their performers lists and to make sure they are doing things properly. We have made it clear that we intend to put in place regulations to underline that and, as I say, they have been written to on 4 February by Sir David Nicholson, the Head of the NHS, and also again on 2 October last year by David.

Chairman: We will pick up on one or two detailed issues now.

Q107 Mr Scott: Minister, the lapses we have seen in the quality of our out-of-hour services, do you think it shows the Government made a mistake in allowing GPs to opt out of coverage under the new GP contract?

Mr O'Brien: I think it shows this: that the quality of care has been improving since 2004. It was not good enough before 2004, though it is better than it was in 2004, but it is not good enough now and, therefore, it needs to be improved considerably more. The reason the change took place in 2004 was because we had the Carson Report. The Carson Report was a major national report which showed that the way in which GP out-of-hours services were provided before 2004 was inadequate, poor and needed urgent reform. For

example, there is a romantic belief that before 2004, if you called out an out-of-hours GP, up would pop your GP and, therefore, you would see the person you normally saw. In fact that was very rare; it happened in 5% or fewer cases. It was relatively rare, it was somebody else who was probably doing it on a rota, on a co-operative basis, maybe somebody else in the practice, maybe they brought in a locum; there were a number of different arrangements. What was clear following the Carson Report, which was commissioned in 2000, when that came out, it just said basically that this system cannot continue to exist in the way it is now because it is not working properly, it is not working in the way it was originally intended and it needs urgent reform. There was general agreement among GPs that reform needed to take place and it did. I do not think there is any serious support among GP organisations to return to the pre-2004 situation where you basically had knackered doctors, having worked all through the day and then having to go off and see patients in the evening. If they really did what they were romantically perceived as having to do and turn up in the middle of the night both having worked all day and still see their patients in the middle of the night, they would have been just knackered and not fit for work the next day. As a lawyer, when I was practising, I had to do call-outs on occasions to police stations and you certainly felt it the next day, and I have stood up in court the next day and felt worse for wear having been out in the middle of the night. It is not something you want to repeat night after night. I never had to do that, but I can imagine any GP who would have to do that would be in a poor state. David might want to say something about that.

Dr Stoate: Can I just say I am still knackered and I gave up doing out-of-hours years ago!

Mr Scott: I am not calling you out of hours!

Dr Stoate: Good!

Q108 Mr Scott: You are just prejudiced because of my political party!

Dr Colin-Thomé: Can I just add on the 2004 contract and the facts about the out-of-hours, that we had had a major problem, that general practitioners see about 80% of clinical consultations in the Health Service and over the past ten to 20 years before that there had been hardly any new growth in general practice, whereas there had been a huge increase in consultants and there was a major recruitment and, to some extent, a retention problem. That is why we negotiated a contract where partly the out-of-hours was one of the burdens, as you say, plus all the other things and since then we have had a significant growth in new doctors and people wanting to train more and there are higher numbers of trainees wanting to be in general practice than ever before, so there was quite a major issue for us about general practice.

Q109 Mr Scott: Do you think allowing the doctors to opt out for just the loss of £6,000 a year was the right decision?

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Mr O'Brien: I think there was a need for the GPs in effect to put some money into the kitty to provide for the alternative if they were not going to do that out-of-hours duty, and 90% of them of course have taken that step. Some of them still do their out-of-hours themselves and volunteer to do so, but they are very much the exception and normally they do it in a fairly large practice with a rota. Was it right to allow them to do that? It was certainly right for them to make a contribution. Should we have asked more from them? I think we can go and rewrite the 2004 contract; there are all sorts of things which I suspect everyone might like to re-write on that. In many ways, GPs got the best deal they ever had from that 2004 contract and since then we have, in a sense, been recovering. We have upset a lot of doctors because they got such a good deal in 2004 that they probably all voted labour in 2005, but after that we tried to recover some of the money and they were probably less happy with us after the 2005 election, so you might get some GP votes this time.

Mr Scott: I'm banking on it!

Q110 Sandra Gidley: You have mentioned about the performers list that you have put extra guidance out and you have tried to get everything up to standard, but was that the right system in the first place? Do you agree with the coroner's recommendation that there should really be a national database of doctors?

Mr O'Brien: Yes, I do agree with that and we want to consult with the medical profession on how we do this. Is a PCT performers list approach the best one? There was a review that completed in March of last year which recommended 62 recommendations for reform and improvement of the performers list and that did not recommend that we move to a national database, but I do think there is a strong argument for that and what we want to do is work out how we should do that, so the straight answer to your question is yes, we do think we need to move to that, and the question is quite how we do it and what the next steps are.

Q111 Sandra Gidley: You mentioned earlier that you had sent something out a year ago.

Mr O'Brien: Many times they have been warned over the years.

Q112 Sandra Gidley: One of the problems seems to be that the PCTs ignored that advice until there was a high-profile case. Is there just too much stuff coming out of Whitehall for PCTs to cope with?

Mr O'Brien: PCTs have an enormously important job in the health system; they are the local provider for the local community. There is a lot of criticism about managers in the Health Service and how much is spent on them, but at the same time the responsibility of PCTs is, frankly, enormous and it is no wonder, therefore, that the Department of Health has to say to them, "Look, you have broad-based responsibilities and obligations, and a lot of money in order to carry out local good-quality healthcare for all the people in your area", and that is a pretty important job. What we have done is send them

regular Directives and missives saying, "You have to improve this, you've got to make sure you've done that", and it goes with the territory, in a sense, that you are not going to have an organisation holding that degree of responsibility as part of a national system which is not going to be required regularly and constantly to ensure they are checking up things. Policy does change in Government. In a sense, that is what we are elected to do, to make sure we improve things. That does mean there will be guidance but there is also from time to time, as has happened in this case, a particular crisis in a particular area and I do regard this incident as a crisis that requires the Department of Health to say, "What you've been doing isn't good enough; you've got to do more". We recognise there was a real problem and certainly David wrote last October and we have written on a number of occasions reminding them of their duties. Some of them have not done it. They can say "Well, we get too many Directives from the Department of Health", if they like, but actually they are paid a fair amount of money to do a job properly and they have some fairly strong responsibilities and that does require, because lives are at stake, that they do their job properly.

Q113 Dr Stoate: I do not know whether you know, Minister, in 2005 Mercedes brought out a new car called a 'QOF-class' especially for GPs! Most of what I wanted to ask you has already been covered, but I want to clarify something. Are you making absolutely clear in future that PCTs must look at language skills for somebody to get onto a performers list?

Mr O'Brien: I am making absolutely clear that PCTs should have been, by law, since 2004 looking at language skills. They had no discretion on this; it was a legal obligation. They should be doing it now. If they have not been doing it, and we know Cornwall was not doing it, then they were in breach of the law

Q114 Dr Stoate: Again just to clarify, the GMC have said they cannot prevent somebody from the EEA being registered on the GMC List, but you can ensure, and you are ensuring, that, even though they are on the GMC List, they would not get a job in general practice if they have not passed a high-level language test.

Mr O'Brien: That is not quite what I am saying. Let me just run through it. There is within the GMC a request to do language tests on all the EEA nationals. There is a big debate there and I do not want to go into all of it now, but I have some doubts whether we should go down that route and I will explain perhaps later why and whether that is the appropriate role for the GMC. I know they want to do the right thing, but I just have some concerns there, particularly about the time it would take to get all of this done. There are three checks essentially on any GP who comes in from an EEA State. The first is the qualification: is this person a doctor? It is the job of the GMC to register them if they are a doctor. The GMC, under the 1983 Act, is not able, as you have heard, to carry out language checks on EEA

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nationals. However, we were aware of that and that is why the 2004 regulations are the way they are, because we knew that was the case. The second check, therefore, is for the PCT. They have to have a performers list and everyone who wants to act as a GP and do any out-of-hours would need to be on that performers list. There is a legal obligation on the PCT to check that they have language competence and also to check that there is nothing known about their behaviour which means they are not a competent GP to carry out out-of-hours. The third check, and in many ways the most important one and where we have to tighten up a lot, is on the employer because the employer, either a co-operative or a private company, needs to ensure that the competence in terms of the skill and also the language skills are adequate to do GP services. I have some concerns that what the GMC does in terms of the quality of the PLAB 7 test on language, which is a basic degree foundation check, may be okay if you have people working with you for who can speak English, but I am not even convinced that that is an adequate skill for a GP to do out-of-hours. In a sense, what I have found the more I go into this is that we have opened up a bit of a can of worms and there are more questions being raised than we previously realised, but also, not only that, there are a number of checks already in place with the GMC, the PCT and the employer. What we can do is make sure that by the end of this year the checks are being properly carried out and there is both the skill and competence in professional terms and the language skills and that that is being checked. If we go into a long drawn-out discussion about changing EU Directives, what the GMC want and giving them new powers, and they want this for all the right reasons, I do not make any criticism, on the contrary, I think what they are doing is laudable, I think it will just take longer, but I want to sort this out by the end of this year, I do not want to wait any longer and I think we can do that with those three sort of gatekeepers.

Q115 Dr Stoate: I appreciate that. That is fine, but why did you not just change the 1983 Act to bring us in line with the French?

Mr O'Brien: That is interesting and I heard the comments about the legal advice which the GMC have. That is okay but I have different legal advice and, as you know, if you put two lawyers in a room, and I speak as one, you get an argument about the law and that is why you get court cases, so there will be lawyers having different views. The legal advice that I am getting from, I think, very competent lawyers is that it is not quite as simple as that and actually the correct quote which was given, knowledge of the language necessary for practising the profession in the host Member State under Article 53 is accurate, it just does not happen to be in the part of the Directive that deals with the particular issue that we are focusing on. Article 53 is relevant, but not quite as relevant as I think the legal advice says. What it ignores is this: that up until 1981 the tests were actually carried out by the GMC and in 1979 the Commission said, "You can't carry out

those tests, Britain" and there was then an argument about whether those tests could be carried out. In 1981 the then Government negotiated a deal following infraction proceedings by the Commission against the UK saying, "You cannot carry out these language tests" and the result of that deal in 1981 not to continue the infraction proceedings because the legal advice then received by the Government was that the UK would lose was the 1983 Act, so it was very clear back in 1983 that there was a reluctance by the UK Government to change the law. It felt it had to do so. We can go back and look at the precise wording and the wording of the Directive was slightly different then. If it were the case, and I would ask the GMC to share their legal advice with us because they have not done so at the moment and we would like to see their counsel's advice and look at that, that there is a way of changing this, then I am happy to do so. In any event, in 2012 the Directive comes up for review and I want to see some other changes in the Directive. If we were able to change it in 2012 so that the GMC were able to carry out some language tests, I would welcome that and I am certainly happy to press for that, but we cannot do it until 2011–12 when the negotiations start. However, I do not want to wait until then, I want it done this year. I want to use the various gatekeepers we have already to make sure there are competent out-of-hours GPs and everyone knows it, certainly by the end of this year. I do not want to wait until 2012.

Q116 Stephen Hesford: Mike, are you satisfied that PCTs are paying adequate attention to induction and monitoring of doctors, particularly those from overseas, in the contracts they have provided for out-of-hours?

Mr O'Brien: Induction, no. Some of them do very good induction checks and I think this is actually key. In terms of the national model contract that we want to introduce requiring that there is an induction process I think is enormously important. It is clear that if you are doing an induction, you check on the competence, the skills and more importantly, particularly if you have an EEA national or indeed someone from a non-EEA country, they are coming in and they are going to do GP out-of-hours work, they do not understand how the NHS works properly. What was clear about Ubani, for example, he did not understand how you handle various types of drugs. He had not handled the various kinds of drugs which a normal GP in the UK would know. There is a need to understand the NHS; there is a need to have the skills and language competence which we have already discussed, but more than that I think an induction process should be a clear requirement under the model contract that is carried out regularly. In terms of monitoring, we have a revalidation process for GPs which is currently being worked through. GPs are obliged to undertake appraisals. By and large those appraisals are carried out well, but not always. Am I satisfied that appraisals are always carried out well? I think we need to tighten up on the way some of these appraisals are carried out because some of them are

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and some of them are not, and there is a temptation with the annual appraisal to get a mate to do the annual appraisal. They have to be trained to do the appraisal and it has to be done properly, but I just want to be sure that appraisal system works well. It is a sort of annual MoT; I know GPs hate it being called that. At the end of five years they have to get their re-validation certificate which is a sort of super MoT if you like, and they have to be able to show that they are able to be re-validated because they have met a number of competence tests and that requires that they have the five appraisal passes on the appraisal.

Q117 Stephen Hesford: You have mentioned the induction element and the unfamiliarity of overseas doctors coming into the system. What additional training do you think should be directed in this area and when might we see these improvements coming on stream?

Mr O'Brien: Certainly I think the induction and training that an induction involves needs to have someone coming out at the end of it who understands what they need to know about the NHS and how it works, basically the administration, drugs and management. Also we need to be sure that someone from an EEA state is competent to be a GP. I think this is a problem that we are uncovering and again the more we look at it the more problems we are identifying. Let me just flag up a couple of things that I have been told and we are trying to bottom out. One is that Italian doctors who operate as GPs in Italy do not normally do children because they have special paediatricians for that. However they turn up here and of course their qualification can be recognised, but are they really competent to do an out-of-hours call to a child because they would not do it in Italy even though they do adults. I think that is an issue. Of course in Germany they have a very different system. Many German doctors are highly qualified but it is a different system. We have a gatekeeper system, as do Denmark and the Netherlands, where a GP effectively gate keeps and looks at the generality of someone and what they now need and might send them off to see two or three specialists. In Germany it does not quite work like that. You can just go off and see a specialist if you want and that specialist will look at your arm but if you have a problem with your leg he is not going to look at that because he is not qualified to look at your leg. I do not know whether David wants to say something about this, but what we are concerned about is that in the end, when someone comes out of an induction and out of some of this checking on whether they are competent, the employers should do this and the PCT should be satisfied that it is done, or the PCT can do it; either way it has to be done, then we need to know that this person is able to actually do the job of an out-of-hours GP.

Dr Colin-Thomé: I would just add that there is a variation on what a GP does around the world and therefore it is not easily transferable. As the Minister has said, it is up to the employer and the reason why we have a performers list is because a lot of GPs, dentists and optometrists are self-employed,

otherwise your employer would sort it out. There is enough policy to do that and what we are doing with the model contract and the assessment that we have of PCTs by the SHA—of which out-of-hours is a key bit and we have asked for this in our report, saying it had to be on the board agenda of both SHA and PCT for the next six months as a minimum—is to just stop that variation because a lot of people are doing things fine. There has to be recognition that a GP is not a GP, is not a GP. If you look at the international comparison, the nearest thing to us are always the Scandinavian countries and it is interesting that they are the ones who train their GPs more because they seem to value that model much more.

Mr O'Brien: Just to add to that, if you call an out-of-hours GP in this country you will probably get a GP who is totally qualified, very capable, has worked in the NHS for most of his life and gives a good quality of care. We are focusing on a narrow group of people and a particular problem which is limited but serious nonetheless because Mr Gray lost his life as a result of the incompetence of an EEA national who came in.

Dr Colin-Thomé: What we saw on our visits was that many of the providers did not have any real problem getting local GPs and it is the skill of the providers to be engaging with local GPs in lots of cases. Of course there will be times when you need locums but generally we found a great disparity between a small set of providers who seemed to rely almost totally on many locums and locum agencies and others who were saying, "No, we can find enough work." Some of the issue is about the performance of people rather than having more policy, it strikes us, and that is what we are trying to do with contracts and upping the ante for PCTs.

Q118 Chairman: Could we just go back to this issue of language skills. You believe you are going to take action further in terms of re-negotiating Directives; that is admirable and very good. We seem to have had evidence in front of us this morning where the regulator says you could change the 1983 Act to some extent, not to give them the obligation of having to test these people's language skills, but nonetheless they could at least talk to them in the way it was described about how the French talk to doctors who want to practise in France. You say you have evidence that is potentially different from what you heard in this room today; have you tried to share the legal opinions between the regulator and yourselves in relation to this issue.

Mr O'Brien: I think they know our legal view. If we have a look at counsel's advice from the GMC, I am certainly very happy to explain our legal position and understanding and also share the reasons why the Thatcher Government put through the 1983 Act. They clearly did the deal in 1981 on this as a result of the infraction proceedings which were threatened and presumably they got the legal advice that they could not win it so that is why they did the deal. We have looked at the current wording of the Directive and the legal advice that I have is that we are pretty much stuck for the moment, for another year at

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least, before we can enter negotiations and two years before the proper review of the Directive. That is why I want to use the current gatekeepers now. Can we change it in the future? I hope we can but I do not want us to get carried away that the only way of sorting this is through the GMC having extra powers. I applaud their willingness to do it; I am just not convinced that that is the only way of doing it and I want to do it quicker than that.

Q119 Chairman: If you shared that legal advice and it became clear that at least we could do something in the interim between now and the potential changing of the Directive, would you be happy to put that into practice pretty quickly?

Mr O'Brien: Yes. If their lawyers can meet with our lawyers and show us why our advice is not right, and that we would not be subject to infraction proceedings and be in exactly the same position as the Thatcher Government was, then fine. I suspect that they have not shown us their legal advice because their legal advice, as any good lawyer would probably do, says on the one hand and on the other hand you may end up with infraction proceedings.

Q120 Chairman: You will have heard what I said when I questioned the Commission about this when we were out there taking evidence on other things. It was not a hostile response, Members will remember that. I think I know the answer to this but I have to ask it to you anyway, is it acceptable that a doctor found to have unlawfully killed a patient in England cannot face prosecution here, and that he is entitled to continue practising medicine in another EEA country?

Mr O'Brien: It is clearly unacceptable. What we have in the Ubani case is the appalling situation—and the more you look at how this developed, the more appalled you become—whereby this guy has gone back to Germany and it appears that in order to get himself in a position where we could not get at him he voluntarily reported himself, a decision was made to prosecute him and, therefore, he was able to rely on double jeopardy to prevent his removal for prosecution here. It is the first time I heard the GMC saying that they had written 22 letters to the Germans and had not got a reply. I find that shocking. In a sense we cannot run the German system for them but I will be taking up with not just the German minister but also other health ministers across the EU our concerns about reforming the Directive. What I am concerned about is a slightly separate point which is that we should be able to oblige the various medical organisations in each country to provide the data necessary about the backgrounds of doctors. You heard about the monthly report from the GMC and it is clear there is a considerable variability in the quality of some organisations supplying information to the GMC and we need to make a stronger duty when we renegotiate the Directive. On an aside, if we reform the Medicines Act it will probably take 18 months with consultations and everything so we are getting to the Directive renegotiation anyway. I am concerned that the Germans have decided that Ubani can continue

to practise there; it seems to me to be an odd state of affairs. In a sense I cannot tell the Germans what to do, that is their system; I just do not want this guy practising on any patients over here.

Q121 Chairman: Has the Government made any representations to Germany, maybe not the Department of Health but the Department of Justice, about what happened in this case?

Mr O'Brien: Yes, there have been some representations, I gather, to the prosecuting authorities in Germany by the Crown Prosecution Service.

Q122 Chairman: Potentially this sorry episode will strengthen the terms of any renegotiations of any Directive?

Mr O'Brien: What is clear is that we have an opportunity next year and the year after to renegotiate this Directive; that comes up for review in any event. That is the point at which we need to look at what tightening up of the Directive we need to have. Also the GMC is asking us to give them some power and that would require a loosening of the EU Directive in one sense. We need to look at all that. I am less concerned about who does this than it is done; I just want it done. I want a GP who goes out to see a patient to be qualified to do so.

Q123 Dr Taylor: Minister, I am sure you are aware there have been a lot of complaints about Take Care Now not related to the Ubani case. We know that the Care Quality Commission have done a review. Have you had discussions? What discussions have you had with the Care Quality Commission about this review?

Mr O'Brien: I have had some discussions with the Care Quality Commission so I am aware and up-to-date with where they are. However, they are independent of government and they have to make an independent judgment on this. It is not for me to tell them in any way what to do. They clearly have some concerns. They have already done an interim report where they voiced those concerns. They will shortly publish their full report and I think we need to await the outcome of that as far as Take Care Now is concerned. The real problem with Take Care Now is that it is not registered and, therefore, there is no ability to have a penalty. As you know hospitals are being registered by the Care Quality Commission.

Q124 Dr Taylor: Right.

Mr O'Brien: Registration is just about to start in April for hospitals and it will be two years before it will be in place for GPs. Therefore, when that is in place, they will have the ability in effect to impose penalties but as we know some of the contracts for Take Care Now are being discussed and I think we can guess what the outcomes are likely to be. There were clearly concerns by the Care Quality Commission when they published their interim report about Take Care Now.

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Q125 Dr Taylor: Do you think it is right that Take Care Now can sell the remaining years of their contracts before the Care Quality Commission reports?

Mr O'Brien: It is the job of the PCT in the area to be satisfied that they are delivering the quality of care to patients in either Cambridgeshire or Hereford and Worcestershire—I know your local interest in Kidderminster—and they need to be satisfied whoever takes on a contract is going to deliver that competence. I think they are talking to another organisation at the moment, as you are aware.

Q126 Dr Taylor: Do they not have any redress for breach of contract, getting rid of it early?

Mr O'Brien: I am not sure about me giving legal advice to the PCT in Hereford and Worcester; I am sure the chief executive has got his own legal advice that he can refer to. If it were the case that there was a level of negligence demonstrable in Hereford and Worcester then it is likely they would be able to sue for either compensation or breach and to invalidate the contract. However, they would need to show that there had been that level of negligence in that area and at the moment the key issue for the PCT in that area is the complete collapse of confidence rather than clear evidence of negligence, but you would have to ask your previous witnesses about that in detail.

Dr Colin-Thomé: A model contract would help of course. There would be some clarity about what PCTs should be putting in their contracts.

Q127 Dr Taylor: We are never allowed to see the contracts.

Dr Colin-Thomé: This is a model contract.

Mr O'Brien: We want that in place by the end of this year. That will be a national model contract and they will have to comply with various things. They can add to it. I suppose they could have confidential additions to it, but the basic parameters of what they have to deliver will be set out in that national model contract.

Q128 Dr Taylor: It seems as if Take Care Now are going to get safely out of the scene before the Care Quality Commission reports and perhaps condemns them. Are you satisfied that other big organisations which are probably going to take over the care are going to be any better and that PCTs are going to be better at monitoring what is going on?

Mr O'Brien: There are two questions there, one in terms of them getting safely out of the scene. If I was an investor in Take Care Now I would not be counting my dividends. However, in terms of the organisations now operating in this area, first of all the responsible authorities are the PCTs. They have been given the legal powers; they have the legal responsibilities, that is very clear. They are supposed to be accountable to those in their area that it is quality and standard which is acceptable and there is a level of competence there. They should not be employing Harmoni or whoever it is unless they are

satisfied that they can deliver. David can perhaps comment on this, but some of the out-of-hours services are good and are well delivered by these companies. What was interesting from the report, and again I defer to David on this, was that it seemed to be variable. Some of the co-operatives were particularly good (I know you have heard from the leader of one of the co-operatives which has a very good reputation) and some of them are not so good. Again, some of the companies were very good and some of them were not so good. It really must be for the PCT to seriously performance manage on behalf of the local people the quality of that contract.

Dr Colin-Thomé: If a PCT now had to set a contract with the new provider, given the high profile of all this, I cannot believe they would not be more careful about that contract in the light of the out-of-hours review that Steve and I did et cetera. One of the things that we found was that even the national quality requirements we introduced in 2005 had not been delivered on so I would be hugely surprised if PCTs who were setting new contracts with new providers had not put in a lot more fail-safes than they currently have.

Q129 Dr Taylor: It will not be a new contract; it is just the selling on of the same contract.

Dr Colin-Thomé: I do not know how they will renegotiate that. I am not lawyer but if they are getting a new provider just selling the contract across would seem odd to me as a doctor. That is what I would say.

Q130 Dr Taylor: That is exactly what I have been trying to say. The PCT does not have any power to say, "We will do a complete new re-tendering process".

Mr O'Brien: In terms of what the PCT must do, it must ensure that whoever is delivering this contract does so competently. The PCT has to look at the way in which it is doing that. It has an overriding duty to ensure that and if for a moment it thought that whoever else was bidding for this contract was not competent they should not give it to them; they should not find them an acceptable provider.

Q131 Dr Taylor: So they would have the power to prevent—

Mr O'Brien: They would probably end up in a court arguing about it.

Q132 Dr Taylor: Yes.

Mr O'Brien: I think they will have to get their own legal advice. I am not going to sit here and give them legal advice, they are going to have to get their own and we will see what view the good electorate of North Warwickshire and Bedworth take. I may be earning a lot of money giving them legal advice.

Dr Taylor: We have been reassured that they have put safeguards in place so that the monitoring will be much better.

Q133 Chairman: Gavin, your expertise has not been asked for in this morning's session, but I would like to ask you a question. You are obviously the

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Director of Professional Standards, do you think all the areas of what has been looked at post the death of David Gray from a professional standards point of view have been checked? Do you think there are any gaps in all this debate we are having and the report that David and Steve did?

Mr Larnar: I think you have certainly covered the key issues. The issue we have probably not covered in depth is revalidation and how we have a system in place for whether you are in the UK or overseas.

Q134 Chairman: That is out for consultation from the regulatory body, we understand.

Mr Larnar: We are currently piloting in England in ten sites just testing the ground to see how it might work in practice.

Q135 Chairman: In broad terms your reaction to this individual affair in general terms would be that professional standards are being looked at in an appropriate way.

Mr Larnar: Absolutely. Since the 2007 White Paper on Professional Regulation we have been working on a major programme across all the health professionals, whether domestic or overseas, to put in place not just at local level but at national level and reforms to the GMC, the assistance we need to give, the assurances we feel are needed for a modern healthcare system.

Dr Colin-Thomé: Could I just say, we need to up the ante on the appraisal system that we have now and that is something we want to focus on. As you probably heard from your previous witnesses that has been going for some years and it is very patchy. Rather than having a whole monster regulation system, a lot of information that GPs will be gathering for their appraisal will also be used in revalidation. We do not want an industry where people are not seeing patients because they are collecting all this data. There is a continuity there but we need to get the present appraisal system better, which is formative and supportive. If people pick up worrying performance in an appraisal, even if it is meant to be a developmental approach, you have to report that.

Q136 Chairman: Are you confident that GPs coming in from outside other EEA countries on short-term contracts on out-of-hours service will be covered by things like appraisal and revalidation?

Dr Colin-Thomé: They are meant to be yearly but that is where the input is important about what you set in your contract and how you do your induction and training and all the other things we have talked about. If you are employed by an out-of-hours provider the model contract will say that the PCT would be monitoring the provider as to what induction, training, assessment and all the stuff they will do. We have plenty of case histories on some of the visits we have done where people have done this brilliantly. If it is a GP who just wants to go on the performers list I think we have also got enough evidence that PCTs can do that. I think we have

upped the ante before we have done a lot of this because of the sheer awfulness of the case and also the reports and instructions we have put out. The variability of things like appraisals which are there now have been disappointing and that is something we can address.

Mr Larnar: I think the other safeguard that we have not mentioned is that if Parliament approves the regs on responsible officers then by 2010 you will have in every healthcare organisation in the country a doctor accountable to the board who is responsible for making sure that the performers list is run properly and that is a personal responsibility on them which puts more pressure on the system locally to make sure that the obligations on the performers list are carried out.

Q137 Chairman: We have heard stories of people flying in to do an eight hour shift and flying out again. How is it going to be really covered in terms of what we want for continuing professional development of our doctors in this country? The concept of it seems a bit difficult to me.

Dr Colin-Thomé: A lot of GPs now of course do not do out-of-hours. Some old and worn out people like Howard and I were both in-hours and out-of-hours doctors but now we have to look at the training and fitness for purpose for out-of-hours from our own British doctors too because it is a more isolating experience, you are not with people you know and so on.

Q138 Chairman: The regulator is by and large in control, is it not?

Dr Colin-Thomé: Yes.

Q139 Chairman: That is not the case if you are flying in from France or Belgium.

Dr Colin-Thomé: I think that is an issue again about who you get on your list. We have said that we should not be using locum agencies running everything; the provider has to be held to account by the PCT for the contract rather than relying on the locum agency. I think if you look at the Ubani case, as always happens in personal medical defence cases for doctors, there is this inexorable path to disaster where there were too many bits in the chain that were connected and what we are trying to do is shorten that chain, by saying that a model contract applies to a provider and the provider cannot just pass that off to a locum, they are going to be accountable. I think we have tried to shorten and clarify the chain and make it more accountable.

Mr O'Brien: Just to add, Chairman, I think you are right to say that we should have less reliance on foreign doctors.

Q140 Chairman: I am not saying that they are all not competent. My experience is that is not the case and the National Health Service has relied very heavily on overseas doctors for many, many, many years, and it would have been a lot poorer without them.

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Mr O'Brien: I think you are absolutely right and indeed 30% of GPs are not trained in the UK, or at least some of their initial training, and what we do know is we do need to be more self-sufficient and that is why we have doubled the number of training places for doctors, an increase from 3,749 to 6,451 places over the ten years from 1997 and they are still going up at the moment. We have done that and will continue to rely very heavily on highly competent doctors who have been qualified in other countries, but we also need, as a process over a period of time, to move to greater self-sufficiency and we intend to do so.

Dr Colin-Thomé: I think we have said enough in our various bits and reports and things about those pop-in locums. Can I just pick up on a point you made early on. We are also looking at how we can do a development programme for PCTs on top of the model contract and our quality and productivity

work that we are doing is to look at a development programme for PCTs in this area separately. That will be slower to get off the ground but we are going to do that as well.

Q141 Dr Taylor: I have never understood why it was worthwhile for Dr Ubani to do this. Who paid his fare? Who paid for his accommodation? Was he paid through the nose for his work? Do we know what rate of pay he was on? How was it worth his while to do it?

Mr O'Brien: I do not know how much he was individually paid. I imagine Take Care Now were making it worth his while, but who knows? I do not know the detail of that I am afraid.

Chairman: Could I thank you all very much indeed. At this stage we may or may not put some commentary along the evidence that we have taken this morning, but we will let you know in due course if we decide to do so. Thank you very much.

Written evidence

Memorandum by the Department of Health (OHS 01) CREDENTIALS OF OVERSEAS DOCTORS

EXECUTIVE SUMMARY

1. The following memorandum sets out evidence from the Department of Health to the House of Commons Health Committee about the credentials of overseas doctors.

2. Following the recent report into out of hours services by Dr David Colin-Thomé and Professor Steve Field, it is clear that there are already very robust requirements in place to ensure the commissioning and delivery of safe and high quality out-of-hours services. However, that there is some variation in how PCTs apply those requirements and controls.

3. In light of the report the Government announced a series of measures to tighten existing controls to ensure PCTs are meeting their legal obligations through commissioning and contracting arrangements and that providers are employing competent clinicians to practice as GPs in primary care out-of-hours.

4. There are three levels of checks on the credentials of doctors entering the United Kingdom seeking to work in out of hours services.

- (i) The General Medical Council is responsible for ensuring that doctors are appropriately qualified;
- (ii) A doctor must then be included on a performers list held by a local PCT; and
- (iii) The employer of a doctor is then responsible for ensuring that the doctor is appropriately qualified and otherwise competent to undertake the role for which he or she is being recruited.

5. In addition to the specific measures which we have proposed to address the concerns which have been raised about a small minority of doctors working in GP out of hours services, there are a number of initiatives that the government is currently taking forward which will strengthen the systems in place for ensuring that all doctors are fit to practise.

- (i) We plan to work with the GMC to introduce a new system of revalidation in the future;
- (ii) Responsible Officers, subject to Parliamentary approval, will be in post from 1 October 2010 and will have a key role in the management of doctors and of the quality of care; and
- (iii) New regulations setting out a duty to share information between prescribed bodies, are expected to be consulted on in early 2010.

6. These measures will further strengthen the existing framework for identifying and addressing concerns about doctors, in the small number of cases where they arise.

INTRODUCTION AND CONTEXT

1.1 The following memorandum sets out evidence from the Department of Health to the House of Commons Health Committee about the credentials of overseas doctors.

1.2 It is important to note that overseas doctors generally fall into one of two categories.

- Doctors from European Economic Area Member States, hereafter referred to as EEA Doctors; and
- Doctors from outside the EEA, hereafter referred to as International Medical Graduates.

1.3 The Department's understanding is that the Committee is seeking evidence in light of the Coroner's Inquest into the death of Mr David Gray, following treatment by Dr Daniel Ubani. The memorandum therefore focuses primarily on the arrangements as they apply to doctors seeking to work in out of hours services and restricts itself to the arrangements in England.

1.4 The Committee will be aware that there are complex arrangements with respect to devolution and the registration and employment of doctors from overseas.

1.5 Policy on the role of the doctors' regulatory body—the GMC—is reserved to Westminster and therefore the arrangements for including doctors on the register of medical practitioners apply across the United Kingdom, whereas policy on the health service is devolved to Northern Ireland, Scotland and Wales.

OUT OF HOURS GP SERVICES

Carson review

1.6 Before the introduction of the new General Medical Services contract, GPs were responsible for the provision of out-of-hours services for their own patients.

1.7 However this twenty four hour responsibility for out of hours care was unpopular with GPs who felt it was discriminatory and so, as part of the negotiations for the 2004 General Medical Services contract, which came into force on 1 January 2005, it was agreed to allow GPs the option to transfer their responsibility for out-of-hours services to PCTs. This was key to the acceptance of the contract by GPs.

1.8 The quality of care varied considerably between different provider types and different geographical areas, and in early 2000, a rising number of complaints and negative reports in the media led the Health Service Commissioner (Ombudsman) to raise concerns about out-of-hours services with the Department.

1.9 This evidence led the Department to conclude that the existing model of out-of-hours was not sustainable.

1.10 As a result, in March 2000 the Department announced an independent review of the arrangements for GP out-of-hours services across England—the Carson review. The review was led by Dr David Carson and his report—*Raising Standards for Patients New partnerships in out-of-hours Care*¹—was published in October 2000.

1.11 All 22 recommendations were accepted and have been implemented including the introduction of a new integrated model of delivery, new national quality requirements and better use of health professionals and their skills in the delivery of out-of-hours care.

Introduction of current arrangements

1.12 The 2004 GMS contract allowed GP practices to opt out of providing out of hours services and transfer the responsibility for providing these services to PCTs. From 1 January 2005, GP practices were able to do so as a right.

1.13 At the beginning of 2004, approximately 70% of GPs had delegated the responsibility to a GP co-operative, and around 25% to a commercial provider.²

1.14 The vast majority of practices (90%)³ transferred their OOH responsibility to the PCT. Where PCTs assumed responsibility for OOH services, they either provide OOH services directly themselves, or commission services from provider organisations

1.15 The quality of Out of Hours care for most people is better than it was in 2004. A 2006 review of Out of Hours care by the National Audit Office⁴ said, “England is at the forefront of thinking internationally” on Out of Hours care and that “England compares well on cost and quality against the rest of the UK”.

1.16 A 2008 Healthcare Commission report on urgent and emergency care⁵ also said that, “There have been significant improvements over recent years in the . . . number of out-of-hours GP services meeting national quality requirements”. “These achievements have taken place despite the pressure from the significant growth in demand for many of these services”. While these reports rightly indicate that quality improved following the 2004 changes, local implementation of the new arrangements has not always been perfect.

Current issues with GP OOH services

1.17 In June 2009, the Care Quality Commission (CQC) began an investigation into the provision of out-of-hours primary care services in five PCTs by Take Care Now (TCN). The CQC’s enquiry was prompted by the tragic death of Mr Gray in February 2008 after he was administered 100mg of diamorphine by Dr Daniel Ubani, a locum doctor from Germany.

1.18 In October 2009, the CQC issued an interim statement on this investigation, which prompted Dr David Colin-Thomé, the Department of Health’s National Clinical Director for Primary Care, to write to PCTs⁶ reminding them of their legal responsibilities to provide safe, high quality out-of-hours care for their patients.

1.19 Concerns about out-of-hours care were raised with the Department last summer. These concerns coupled with the CQC investigation led Ministers to ask Dr David Colin-Thomé and Professor Steve Field, Chairman of Council, Royal College of General Practitioners, to jointly lead a review of the current arrangements for the local commissioning and provision of out-of-hours services.

1.20 The report,⁷ published on Thursday 4 February, considered the commissioning and performance management of out-of-hours services, the selection, induction, training and use of out-of-hours clinicians, and the management and operation of PCT performers lists.

¹ *Raising Standards for Patients: New Partnerships in Out-of-Hours Care, An Independent Review of GP Out-of-Hours Services in England*, Commissioned by the Department of Health, October 2000.

² “*The Provision of Out-of-Hours Care in England*”, The Comptroller and Auditor General, National Audit Office, 2006.

³ “*The Provision of Out-of-Hours Care in England*”, The Comptroller and Auditor General, National Audit Office, 2006.

⁴ “*The Provision of Out-of-Hours Care in England*”, The Comptroller and Auditor General, National Audit Office, 2006.

⁵ *Not just a matter of time: A review of urgent and emergency care services in England*, Commission for Healthcare Audit and Inspection, September 2008.

⁶ *Out of hours (OOH) primary care services: PCTs contract and performance management arrangements*, David Colin-Thomé, National Director for Primary Care, 2 October 2009, published on www.dh.gsi.gov.uk

⁷ *General Practice Out-of-Hours Services: Project to consider and assess current arrangements*, Dr David Colin-Thomé and Professor Steve Field, Department of Health, January 2010.

1.21 It is clear from this report that there are already very robust requirements in place to ensure the commissioning and delivery of safe and high quality out-of-hours services. The report's authors saw several examples of good practice from both commissioners and providers. However there is variation in how PCTs apply those requirements and controls. The report set out twenty-four recommendations which the Department accepted in full, insofar as they apply to the Department or the NHS. The recommendations included:

- PCTs should review the performance management arrangements in place for their out-of-hours services, ensure they are robust, and fit for purpose;
- The Department of Health should issue guidance to PCTs to assist them in making decisions about whether or not a doctor has the necessary knowledge of English to be included on a PCT's medical performers list;
- The Department of Health should develop and introduce an improvement programme for PCTs to support their commissioning and performance management of out-of-hours services;
- Out-of-hours providers should consider the recruitment and selection processes in place for clinical staff, ensure they are robust, and follow best practice; and
- Strategic Health Authorities should consider how they monitor action taken by PCTs in response to the report and in carrying out appropriate performance management of out-of-hours providers.

1.22 The Department also announced a further range of new measures to strengthen arrangements for the commissioning and provision of out of hours services:

- Reviewing the existing National Quality Requirements in order to develop a stronger set of national, minimum standards with which all out-of-hours providers will be required to comply;
- Developing a new model contract for out-of-hours provision, based on the new national minimum standards, to be introduced by the end of the year to reflect the characteristics of existing high quality provision;
- Through stronger performance management by SHAs, tightening existing controls to ensure PCTs are meeting their legal obligations through commissioning and contracting arrangements and that providers are employing competent clinicians to practice as GPs in primary care out-of-hours. Ministers will also be directing PCTs to review their current procedures and to ensure that they have a clear policy in place for assessing the language knowledge of persons applying for inclusion on the PCT's performers list;
- Requiring PCTs to involve GPs much more in ensuring high quality provision of out-of-hours services through, for example, Local Medical Committees, RCGP groups, Faculties, clinical executive groups, local and with practice-based commissioning consortia; and
- The NHS Chief Executive David Nicholson has written to NHS organisations to bring this report to their attention and seeking assurances that they are meeting their obligations as set out in the report.

1.23 The issues surrounding the report and the report of the Coroner's Inquest have raised concerns about the credentials of some doctors from outside the UK, particularly the employment and regulatory checks on EEA doctors and the use of EEA doctors in out-of-hours GP services.

DEPENDENCE ON OVERSEAS DOCTORS

1.24 For most of its history, the National Health Service has relied upon the contribution of doctors who trained outside Europe. The service has always been open to the exchange of experience and expertise that flows from operating within an increasingly global workforce.

1.25 Although medical practitioners who qualified outside the United Kingdom have probably been a feature of the NHS since its inception in the 1940s, it is clear that by the 1960s the NHS benefitted significantly from the contribution to it made by doctors of Indian and Pakistani origin.⁸ In that decade there was an expansion in the capacity of the NHS and this was largely filled by recruitment of doctors from the Indian Subcontinent.

1.26 Throughout the 1970s there was a concern that domestic workforce supply would be insufficient to maintain existing staffing numbers^{9,10} and by the 1980s and 1990s numbers of overseas doctors increased substantially to fill a capacity gap created by NHS reforms, demographic change and various other factors.¹¹

1.27 The number of doctors qualified outside of the European Economic Area increased gradually from 15,190 in 1992 to 20,737 in 2000.¹²

⁸ Aneez Esmail, PhD, MRCP, FRCP, MFPHM, *Asian doctors in the NHS: service and betrayal*, British Journal of General Practice, 2007.

⁹ David J Smith, *Overseas Doctors in the National Health Service, Policy Studies*, 1470-1006, Vol 3, Issue 1, 1982, pp 12–20.

¹⁰ James Parkhouse, *Talking Point: Simple model for medical manpower studies*, British Medical Journal 20 August 1977.

¹¹ Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS*. King's Fund, London, 1997.

¹² The Information Centre, Medical and Dental Workforce Census, 1992 & 2000

1.28 In 2000, the Government published the NHS Plan.¹³ The demand for additional NHS staff in England in the short term was such that international recruitment had to be a key contributor in helping expand the workforce and this was explicitly recognised in the NHS Plan which stated:

“5.22 To further boost NHS staff numbers in the short term, the Department of Health will work with the leaders of the professions and with other government departments to recruit additional suitably qualified staff from abroad where this is feasible, meets service priorities and complies with NHS quality standards. The NHS will not actively recruit from developing countries in order not to undermine their efforts to provide local healthcare.

There will be a targeted, nationally co-ordinated campaign using short-term contracts to boost the number of medical consultants and the overall number of doctors in the next three years. There are surpluses of trained doctors in some European countries. We will also recruit from other developed nations, especially in key specialties such as oncology and cardio-thoracic surgery, where expertise is concentrated. Carefully planned and targeted international recruitment for nursing and midwifery also remains part of our strategy”.

NUMBERS OF OVERSEAS QUALIFIED MEDICAL STAFF IN GENERAL PRACTICE

1.29 The NHS Information Centre holds information relating to numbers of doctors in medical (non-dental) specialties within the hospital and community health services and general practitioners in the NHS in England by country of qualification. That is, the country in which they obtained their primary medical qualification, grouped into UK, EEA and Elsewhere.

1.30 In 2008 there were 34,010 practitioners in general practice in England¹⁴ of these 26,648 (78%) qualified in the UK compared with 22,807 (81%) out of 28,251 in 1998.

1.31 Within the 22% of practitioners qualifying overseas in 2008, there was a modest increase in those qualifying in the rest of the EEA. Practitioners qualifying in the rest of the EEA rose from 884 (3%) in 1998 to 1,619 (5%) in 2008.

SELF-SUFFICIENCY

1.32 The NHS in England has been working towards greater self-sufficiency by recruiting home-grown staff and getting a more diverse workforce that reflects local communities since the *NHS Plan* was published. However, the enormous investment in extra training and improving retention that followed the *NHS Plan* could not deliver immediate expansion.

1.33 Now however, due to the rapid levels of workforce expansion in the NHS over the past nine years, a steady state has been reached where, for most staff groups, the supply of UK-trained staff more closely matches the demand for healthcare services. Consequently, the emphasis on international recruitment has fallen and the international recruitment programmes funded by the Department of Health have now stopped.

1.34 The number of medical training places made available at undergraduate and postgraduate levels is based on the long-term forecast demand for trained doctors and Government policy to move towards self-sufficiency in the supply of trained doctors. Medical school intake in England almost doubled from 3,749 in 1997 to 6,477 in 2008.¹⁵ This will enable us to move towards a greater degree of self-sufficiency in the future.

1.35 The aim is that the increase in UK supply will, over time, reduce reliance on international medical graduates to take up specialist training in order to meet the demand for trained specialists. Operational increases in numbers are not filled immediately with UK graduates because of the time lag. Training takes seven years so there may be a proportionate decline while the increased numbers of students progress through seven years' training.

1.36 International recruitment will continue to have a much smaller role as part of a comprehensive workforce strategy, with NHS employers co-ordinating their own activity.

1.37 The policy for greater self-sufficiency in the supply of healthcare professionals and less reliance on doctors and nurses from developing countries, requires a balancing policy for managing healthcare migration.

MOTIVATION OF OVERSEAS DOCTORS

1.38 There are a number of different reasons why doctors from overseas want to work in the UK:

- Graduates from Medical schools outside the UK and EEA are at times unable to secure appropriate posts in their home countries;

¹³ *The NHS Plan: a plan for investment, a plan for reform*, Department of Health, July 2000.

¹⁴ *General and Personal Medical Services: England 1998–2008*, The NHS Information Centre, March 2009.

¹⁵ Higher Education Funding Council for England (HEFCE) data 1997 & 2006.

- The UK provides high quality post-graduate and specialty training that is well regarded around the world making it attractive destination for International Medical Graduates to undertake postgraduate medical education and training; and
- Others may be motivated by their personal circumstances.

Specialty Training.

1.39 Graduates of UK medical schools—Doctors (regardless of nationality) who have completed full undergraduate medical degree in the UK can go on to have permanent careers in the NHS with the ability to compete for access to foundation programmes and specialty training.

1.40 Where doctors from the EEA seek to gain access to specialty training they compete in open competition with UK nationals for foundation and specialty training programmes. In practice though, very few EEA doctors who have trained in medical schools outside the UK apply for UK foundation and specialty training programmes.

1.41 There is far greater competition from doctors who are not EEA nationals. The UK provides high quality post-graduate and specialty training that is well regarded around the world. Doctors in training in the NHS are paid whilst they train—starting pay for doctors on specialty training programmes is around £28,000 per annum. There are no fees charged to doctors for post-graduate and specialty training programmes. This makes the UK a very attractive destination for International Medical Graduates who want to progress their careers, particularly if their home country has limited opportunities for post-graduate and specialty training.

MEDICAL TRAINING INITIATIVE.

1.42 On Friday 29 February 2008, a new immigration system was launched to ensure that only those with the right skills or the right contribution will be able to come to the United Kingdom to work and study. The points-based system enables us to control migration more effectively, tackle abuse and identify the most talented workers.

1.43 Underpinning the new immigration system is a five tier framework. This will help people understand how the system works and direct applicants to the category that is most appropriate for them. The tiers are:

- Tier 1: Highly skilled individuals to contribute to growth and productivity;
- Tier 2: Skilled workers with a job offer to fill gaps in United Kingdom labour force;
- Tier 3: Limited numbers of low skilled workers needed to fill temporary labour shortages;
- Tier 4: Students; and
- Tier 5: Youth mobility and temporary workers: people allowed to work in the United Kingdom for a limited period of time to satisfy primarily non-economic objectives.

1.44 One effect of the tremendous contribution, which doctors from outside Europe have made to the NHS over its sixty-year history, has been to establish an exchange of expertise and experience between the UK and other parts of the world. It is the aim of the Department of Health to support action to reinforce their continuation. Expanding the existing Medical Training Initiative, streamlined under the new immigration rules, would be one way to achieve this, amongst other benefits.

CHECKS ON THE CREDENTIALS OF DOCTORS—THE ROLE OF THE GMC

2.1 There are three levels of checks on the credentials of doctors entering the United Kingdom seeking to work in out of hours services.

- (i) The General Medical Council is responsible for ensuring that doctors are appropriately qualified to be included on the register of medical practitioners and the GP Register and for liaising with the authorities in the doctors home country to ensure that there is no evidence that their fitness to practise is impaired;
- (ii) A doctor must then be included in a medical performers list held by a PCT. Before including a doctor in its performers list, a PCT is required to undertake certain checks including assuring itself that it is satisfied that he has the knowledge of English necessary to perform primary medical services; and
- (iii) The employer of a doctor is then responsible for ensuring that the doctor is appropriately qualified and otherwise competent to undertake the role for which he or she is being recruited.

2.2 The following section deals with the checks on the credentials of doctors which are undertaken at a national level.

THE ROLE OF THE REGULATORY BODY

2.3 There are currently two bodies involved in the process of setting and maintaining standards for medical education and training at a national level and which act as the UK competent authorities for certain purposes under Directive 2005/35/EC—the General Medical Council (GMC) and the Postgraduate Medical Education and Training Board (PMETB). Further details are attached at Annex A.

2.4 The GMC is the professional regulatory body for doctors and it has responsibility for administering the Register of Medical Practitioners which lists all the persons recognised in the UK as holding qualifications entitling them to practice as a medical doctor.

2.5 Following approval of the General Specialist Medical Practice (Education, Training and Qualifications) Order 2010 by the Privy Council on 10 February 2010, the functions of the PMETB are due to be transferred to the GMC on 1 April 2010.

REGISTRATION WITH THE GMC

2.6 All doctors practising in the UK, either in the NHS, or in private practice, are required to be included on the GMC's register of medical practitioners and to hold a licence to practise. They are also bound to abide by the professional standards set by the GMC.

2.7 Full Registration with the GMC indicates that a person is a qualified medical practitioner, but it does not mean that they are necessarily qualified, or competent, to undertake any given, specific role.

2.8 The GMC requires migrants from both the EEA and outside the EEA to provide proof of their identity and qualifications. It also requires proof that their fitness to practise is not impaired: this takes the form of a certificate from the host competent authority confirming that they are of good standing.

International Medical Graduates

2.9 International Medical Graduates applying for full registration must hold an acceptable primary medical qualification and will be required to submit evidence that they have satisfactorily completed either Foundation Year (F1) training in the UK or a period of clinical experience that provides an acceptable foundation for future practice as a fully registered medical practitioner.

2.10 In addition, they will be required to demonstrate their medical knowledge and skills in one of the following ways:

- (i) A pass in the PLAB test (see paragraphs 2.13 to 2.15).
- (ii) Sponsorship (see paragraph 2.12).
- (iii) Possession of an acceptable postgraduate qualification.
- (iv) Eligibility for entry on the Specialist or GP Register.

2.11 All International Medical Graduates who apply for either provisional or full registration with a licence to practise must satisfy the GMC that they have the necessary knowledge of English. They are accordingly required to obtain satisfactory scores in each of the four academic modules (speaking, listening, writing and reading) of the International English Language Testing System (IELTS) test administered by the British Council.

2.12 In certain circumstances a select group of bodies approved by the GMC, including the Medical Royal Colleges, may act as sponsor for an applicant's GMC registration and licensing as an alternative to taking the PLAB assessment. In these circumstances the Medical Royal Colleges (or other sponsoring bodies) provide professional sponsorship of candidates to the GMC, and facilitate a non-PLAB route to GMC registration. In these cases the sponsor takes responsibility for attesting to the level of competence of the individual.

THE PROFESSIONAL LINGUISTIC ASSESSMENT BOARD (PLAB) TESTING SYSTEM

2.13 The PLAB test is the main route by which International Medical Graduates demonstrate that they have the necessary skills and knowledge to practise medicine in the UK (except in certain circumstances, for example where they already hold an approved specialist or GP qualification). Doctors need to undertake a PLAB test if they are the national of a country outside the UK, European Economic Area (EEA) or Switzerland who graduated from a medical school outside the UK and in certain other circumstances.

2.14 The test is in two parts:

- (i) Part 1 is a computer-marked written examination.
- (ii) Part 2 is an Objective Structured Clinical Examination which takes the form of 14 clinical scenarios or 'stations', a rest station and one or more pilot stations run for statistical purposes.

2.15 The PLAB test is designed to test a doctor's ability to practise medicine safely in a UK hospital. It is set at the level expected at the end of Foundation Year 1 (F1). This means that doctors must show that they are capable of applying knowledge to the care of patients at the level expected of a doctor who has had one year of clinical experience following graduation.

GP registration

2.16 The GP Register is a register of doctors who are eligible to work in general practice in the health service in the UK. From 1 April 2006, all doctors working in general practice in the health service in the UK, other than doctors in training such as GP Registrars, are required to be on the GP Register. This requirement extends to locums.

2.17 The GP Register was introduced alongside the changes to the system for postgraduate medical education and training under The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003.

2.18 Being included on the GP Register is one requirement for entry to a medical performers list for GPs, although this does not apply to doctors in training, such as GP Registrars. When a doctor applies to join a performers list, the PCT should contact the GMC to check whether that doctor is on the GP Register, and make other checks.

EEA DOCTORS

2.19 Doctors applying for inclusion on the register of medical practitioners from the EEA must hold a recognised qualification, listed in the Directive and issued by an EEA competent authority.¹⁶

2.20 Identity checks are undertaken and character references are sought from the host competent authority, but there is no requirement on EEA nationals to undergo a PLAB test, or to satisfy the GMC about their level of knowledge of English.

2.21 EEA doctors restored to the Register after prolonged absence from UK practice are advised by the GMC to work initially in an approved practice setting.

The Medical Act 1983 and Directive 2005/36/EC on the Recognition of Professional Qualifications

2.22 The Medical Act 1983 gives effect, inter alia, to the UK's obligations in European law. These are currently set out in Directive 2005/35/EC, (whose introduction and policy intent are described in paragraphs 2.26 to 2.35, below). Previous EU legislation provided for mutual recognition of numerous professions and trades in a series of instruments, but the 2005 Directive brought the procedures and requirements for most occupations together, and covers the clinical professions, including medical practitioners.

2.23 When the Medical Act 1983 was passed, its registration provisions reflected the automatic recognition provisions applying in relation to Member State nationals. Nationals of Member States with primary European qualifications listed in the European legislation, and set out in Schedule 2 to the Act, were registered on equal footing with UK qualified doctors. Later, after Directive 2005/36/EC was made the same principles were implemented by an amending order which updated¹⁷ the Medical Act to give effect to the new Directive (see paragraph 2.28 and its footnote, below).

2.24 In terms of the wider EU obligations which the Medical Act 1983 reflects, the current Directive and its predecessor EU instruments derive from the principles of freedom of movement of persons, services and freedom of establishment in the Treaties which serve as the basis for the European Union.

2.25 Articles 49 and 56 of what is now the Treaty on the Functioning of the European Union deal with free movement between EU Member States. Those Articles provide that restrictions on the freedom of establishment of EU nationals in another Member State, or restrictions on the freedom to provide services in another Member State, are prohibited. For nationals of the Member States, this includes, in particular, the right to pursue a profession, in an employed or self-employed capacity, in a Member State other than the one in which they have obtained their professional qualification. Article 45 relates to freedom of movement of workers.

2.26 The proposal for the current Directive on the recognition of professional qualifications was introduced at the Barcelona Summit in March 2002 and presented to the Internal Market Consumer and Tourism Council on 21 May 2002. The Commission presented the draft legal text to Member States on 4 June 2002.

2.27 Consultation on the draft Directive was launched in the UK on 1 July 2002 and closed on 30 September 2002.

2.28 European Directive 2005/36/EC replaced Council Directive 93/16/EEC (free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications). The new Directive was formally adopted on 7 September 2005 and all Member States were required to transpose it into domestic law by October 2007. The requirements of the Directive as it applies to doctors have been transposed into UK legislation principally through amendments to the Medical Act 1983.¹⁸

¹⁶ Under the Directive, doctors not entitled to automatic recognition by virtue of holding a listed qualification may nonetheless be registered by virtue of rights acquired in an EEA state.

¹⁷ Eg, additional certification to confirm the practitioner's experience, where Member States issued these, were provided for in the Directive and added into the Act.

¹⁸ The European Qualifications (Health and Social Care Professions) Regulations 2007 (SI 2007/3101) amended the Medical Act 1983. The European Communities (Recognition of Professional Qualifications) Regulations 2007 (SI 2007/2781) designated competent authorities.

2.29 The intention behind the Directive is to make it easier for qualified professionals (architects, accountants, teachers, health professionals, etc) to practise their professions in European countries other than their own, with a minimum of red tape but with due safeguards for public health and safety and consumer protection. It provides for the mutual recognition of diplomas, certificates and other evidence of formal qualifications in order to assist the free movement of professionals throughout the EU.

2.30 The Directive achieves facilitation of free movement of (effectively) EEA nationals¹⁹ through the competent authorities (regulatory bodies including, in the case of doctors, the General Medical Council (GMC) for the UK). In relation to doctors, the Directive requires all competent authorities to recognise qualifications from other States if they meet the minimum conditions set out in the Directive.²⁰ The GMC must accept a migrant's qualifications if they meet this minimum standard. This is known as "automatic recognition".

2.31 This also applies to other EEA competent authorities where UK nationals seek to register in another EEA State.

2.32 In order for qualifications to receive automatic recognition under the Directive basic medical training must comprise a total of at least six years of study or 5,500 hours of theoretical and practical training provided by, or under the supervision of a university.

2.33 Basic medical training must provide an assurance that the person has acquired the following:

- Adequate knowledge of the sciences on which medicine is based;
- Sufficient understanding of the structure, functions and behaviour of healthy and sick people;
- Adequate knowledge of clinical disciplines and practices; and
- Suitable clinical experience in hospitals under appropriate supervision.

2.34 While the subject matter of medical education is often perceived to be similar in Europe, the context and conditions in which the programmes operate are very diverse.²¹ Objective qualitative assessments of the relative merits of different training systems are therefore difficult to make and the Department has no information available to it to enable a qualitative comparison to be made between UK postgraduate training and postgraduate training elsewhere in Europe.

2.35 The Directive only imposes a requirement on Member States' competent authorities to recognise professional qualifications: it does not confer an automatic right to be employed. This requirement therefore does not absolve employers of the responsibility to ensure individual professionals are fit and suitable for the appropriate job.

Numbers of EEA Migrants Registering with the GMC

2.36 Data provided to the Department of Health by the General Medical Council for the purposes of monitoring the implementation of Directive 2005/36/EC shows that in 2008 there were 2,097 migrants registered by the General Medical Council (GMC) under the automatic recognition procedure and 106 applications were accepted under the General System regime without the need for a compensatory measure. Two applications were rejected under automatic recognition, while there remained 335 applications under consideration.

2.37 In 2008 almost 1300 applications came from Germany, Greece, Hungary, Italy, Poland and Romania. In 2008 the GMC updated their management information system and unfortunately data cannot now, without intensive interventions, be retrieved from that database. The only data available for 2007 is that there were 2,510 applications for mutual recognition from EEA applicants of which 2,140 registrations were granted. The difference may be attributed to withdrawals and perhaps open applications that did not conclude until 2008.

2.38 Data for 2009 shows that there was an increase in numbers of EEA migrants obtaining registration with the GMC. 2,291 migrants (an increase of around 9% on 2008) were registered under the automatic recognition procedure and 162 registered under the General System. One application from Hungary was rejected. The bulk of the applicants came from Italy (340), Greece (254), Romania (252), Germany (202), Poland (198) Hungary (169) and Bulgaria (142).

2.39 A small number of migrant doctors have taken advantage of the provision concerning temporary provision of services. In 2008 the number of doctors registered for temporary provision amounted to 38. The bulk of these applications came from migrants holding French and Belgian nationality (there were 10

¹⁹ The provisions of the Directive have been extended to Liechtenstein, Norway and Iceland under the EEA Agreement.

²⁰ This is subject to there being no impairment of the migrant's fitness to practise. Section 55, read with section 35C of the Medical Act 1983, provides that a person's fitness to practise is regarded as "impaired" by reason only of misconduct, deficient professional performance, adverse physical or mental health, or a conviction or caution in the British Islands for a criminal offence or other disciplinary finding in the UK (although the allegations giving rise to the criminal or disciplinary proceedings may refer to events arising outside of the UK). Section 44 of the Act also disentitles an EEA migrant from registration if he/she has been subject to a disciplinary decision in another EEA state where the migrant is or has been established or obtained his/her qualification, which results in the migrant's being disqualified or prohibited from practising in that state.

²¹ Statement On The Bologna Process And Medical Education, Association for Medical Education in Europe (AMEE) and the World Federation for Medical Education (WFME), February 2005.

applications from each country). In 2009, the numbers of migrant doctors registering under temporary provision of services increased from 38 to 46 with migrants holding French and Belgian nationality each totalling 11.

Exchange of Information Between Competent Authorities

2.40 There are already requirements on EU competent authorities to exchange information with each other under Directive 2005/36/EC, both when a health professional seeks to register in a new Member State and at other times.

2.41 The European Commission's Code of Conduct makes it clear that migrants from the EEA can be asked for various documents, including evidence attesting that the migrant is of good character as part of the registration process. The GMC seeks evidence that a doctor is of good character from the competent authority in the host Member State.

2.42 To enable effective communication between competent authorities, the European Commission has set up a secure web based system known as the Internal Market Information System (IMI system). The IMI system is designed to provide Member States with the tools required for them to cooperate with each other in order to improve the implementation of Internal Market legislation. The fundamental objective of the IMI system is to create the conditions in which day-to-day administrative cooperation between the Member States can take place.

2.43 The system is an enabling mechanism. It provides Member State administrations with a multilingual, open and flexible tool to support the mutual assistance and information exchange required to implement Internal Market legislation efficiently. The IMI system, which is operated and maintained by the Commission can translate specific questions in to other languages and can help track that requests for information have been answered.

2.44 The GMC has advised us that the IMI system is a useful vehicle for the exchange of information, and the Government would like to see the system strengthened in a number of ways in future:

- The system should be opened up to all the regulated professions as soon as possible;
- Use of the system should be mandatory for all regulators; and
- The possibility of exchanging Certificates of Current Professional Status through the system.

Language Knowledge Assessment

2.45 The Medical Act 1983 provided for registration without reference to language knowledge. Following the recommendations made by the Chief Medical Officer in *Good doctors, safer patients*²² and the Government White Paper *Trust, Assurance and Safety*²³ the Department has explored whether there is scope to reintroduce a form of language testing. We have concluded that the most effective and proportionate approach remains the focussing of checks at the point at which the migrant was taking up work.

2.46 Article 53 of Directive 2005/36/EC deals with the issue of language knowledge:

“Persons benefiting from the recognition of professional qualifications shall have a knowledge of languages necessary for practising the profession in the host Member State”.

2.47 The Directive makes it clear that persons benefiting from the recognition of professional qualifications shall have a knowledge of languages necessary for practising the profession in the host Member State. However, lack of language knowledge is not a ground for refusing recognition of the qualifications of a national of another Member State—the Commission's own guidance is clear about this.

2.48 Registration with the GMC is about the recognition of a doctor's qualifications and their right to refer to themselves as a registered medical practitioner. Language knowledge, while essential for providing good patient care, is separate from ability to practice medicine and systematic language testing by the competent authority is therefore not permitted as a check on the recognition of qualifications. However, language knowledge can be checked and tested after registration with a regulatory body, eg, by a prospective employer. Any language testing after registration would have to be proportionate and appropriate for the post's requirements.

2.49 The grasp of English required by a person practising solely in a medical research capacity may be quite different from that of a general practitioner. The Department's view therefore is that, while a national standard of language assessment is superficially quite attractive as an additional safety requirement, what is more important is that local NHS organisations take responsibility for ensuring that any person they employ or contract with has the necessary grasp of English for the role they will undertake.

²² *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*, A report by the Chief Medical Officer, Department of Health 2006.

²³ *Trust, Assurance and Safety—The Regulation of Health Professionals in the 21st Century*, Published by the Stationery Office, February 2007.

2.50 To this end the NHS (Performers Lists) Regulations 2004, place a requirement on a PCT to satisfy itself that a doctor has the knowledge of English necessary to perform primary medical services in its area, before admitting a doctor to its performers list (see paragraphs 3.8 to 3.12).

2.51 The Department of Health also issued Health Service Circular 1999/137²⁴ in June 1999 (which replaced Personnel Memorandum (87)7). The circular made it clear to all NHS employers that they are responsible for ensuring that the staff they employ have the necessary language and communication skills needed to do their job safely and effectively.

2.52 A doctor who was a national of an EEA state and holding a qualification from an EEA competent authority which was listed in the Directive would be automatically registered by the GMC, subject to providing the necessary certificate of good standing and proof of identity. However, when the doctor applied for inclusion in a PCT's performers list he or she would have to produce evidence of appropriate language knowledge. If the doctor sought employment with an NHS body, in accordance with the circular's guidance to NHS employers, the doctor would also be expected to produce evidence of appropriate language knowledge to prospective employers.

ENFORCING PROFESSIONAL STANDARDS

2.53 Once a migrant is registered with the GMC, that migrant's continued registration is subject to the normal rules and procedures set out by the GMC. The GMC would be expected to investigate if any concerns were raised with it about the fitness to practise of that doctor. Language competency can be considered as a fitness to practise issue by the GMC.

Overseas Doctors and the GMC's Fitness to Practise Procedures

2.54 Overseas doctors have historically been disproportionately represented in the numbers of doctors appearing before the GMC's fitness to practise panels. The GMC has commissioned research into this issue from both the Policy Studies Institute and York Health Economics Consortium. The GMC's research showed that some, but not all, of the difference in outcomes was explained by reference to the nature of the source of the complaint.²⁵

2.55 5,195 doctors were the subject of an Enquiry by the GMC in 2008.²⁶ The GMC defines an enquiry as information received (from a single source) that may raise concerns about one or more doctors' fitness to practise.

2.56 Of all concerns raised with the GMC, 26.9% related to enquiries about International Medical Graduates and 8.8% to doctors who qualified in other EEA states (ie other than the UK). These proportions were slightly higher than the proportions of International Medical Graduates and EEA qualified doctors in the medical workforce in England.

2.57 However enquiries were more likely to originate from 'persons acting in a public capacity' (ie on behalf of a public organisation) rather than members of the public. 27% of all enquiries relating to International Medical Graduates and 25% of enquiries relating to EEA qualified doctors were raised by person acting in a public capacity. This compared with only 13% of complaints about a UK qualified doctor which were raised by a person acting in a public capacity. The majority of Enquiries from this source come from NHS Bodies or police forces.

2.58 Overseas doctors were proportionately more likely to be referred to a fitness to practise panel after investigation by a case examiner than UK qualified doctors. Of all the 1,297 cases which were passed to a GMC case examiner, 359 (27.7%) were referred for a full hearing. 147 International Medical Graduates (31.8%) and 42 EEA doctors (33.1%) were referred for a full hearing, compared with 169 UK qualified doctors (24.2%).

2.59 Of the 204 fitness to practise hearings which concluded in 2008 a disproportionate number related to cases against overseas doctors. 85 (42%) of hearings related to International Medical Graduates and 33 (16%) related to EEA doctors. Of those fitness to practise hearings which concluded in 2008 the ultimate sanction of erasure was imposed on proportionately more overseas doctors (27.1% of international medical graduates and 21.2% of EEA qualified doctors) compared with UK qualified doctors (13.1%).

2.60 The Department understands that the GMC is continuing to carry out research into this issue as it is unclear what all the factors behind the disproportionate representation of overseas doctors in fitness to practise proceedings are. It is possible that local employers or other professionals are more likely to refer overseas doctors to the GMC when there are concerns about practice.

²⁴ Health Service Circular 1999/137: Employment of European Economic Area (EEA) nationals ensuring language competence.

²⁵ Council Paper 6b, Fitness to Practise Annual Statistics for 2008, Council Meeting of 7 May 2009.

²⁶ *Fitness to Practice Annual Statistics 2008*, The General Medical Council, Council Papers, May 2008.

 CHECKS ON THE CREDENTIALS OF DOCTORS—THE ROLE OF LOCAL NHS BODIES

3.1 The employer of a doctor in England is ultimately responsible for the quality of services provided by its employees and it has a duty to ensure that any person it appoints to a post is suitably qualified and otherwise competent to undertake the role. Similarly, a PCT is responsible for ensuring that any person it contracts with delivers their contractual responsibilities to an acceptable standard.

3.2 The PCT or the employer also has an ongoing role in monitoring the quality of services provided by persons it employs, or contracts with, and it is responsible for taking any action required where concerns are raised about the performance of a person with whom it contracts or an employee.

PRACTISING AS A GP

3.3 The position with regards to general practitioners in England is more complex as many are self-employed. Therefore, the Government has introduced an intermediate tier of scrutiny over the quality of doctors entering general practice through the NHS (Performers Lists) Regulations 2004 (“Performers Lists Regulations”).

3.4 Doctors cannot work in general practice providing services to NHS patients in England unless:

- They are on both the GMC Register of Medical Practitioners and the GP Register. Entry to the GP Register requires the doctor to have completed training in general practice in the UK or its equivalent; so being on the GP register is evidence that the doctor’s qualification is acceptable to work in the UK in general practice; and
- A PCT has, in compliance with the provisions of the Performers Lists Regulations, ensured that the doctor has the necessary clinical skills and experience to perform primary medical services and has included a doctor in its medical performers list.

3.5 Under the Performers List Regulations 2004 there are a number of checks that a PCT is required by law to carry out before admitting a doctor onto its list. The Regulations include a requirement at regulation 6(2)(b) that a Primary Care Trust must refuse to include a performer in its performers list where:

“it is not satisfied he has the knowledge of English which, in his own interests or those of his patients, is necessary in performing the services, which those included in the relevant performers list perform, in its area”.

3.6 Where a PCT refuses to admit a doctor to its Performers List it must notify the General Medical Council. Equally, where a PCT has (or is made aware of) concerns that a doctor’s ability to perform his duties as a medical practitioner may be impaired they should consider the need to make a referral to the General Medical Council.

3.7 Where a GP is also an employee, it is up to employers to satisfy themselves that the person will be able to communicate effectively with patients and colleagues.

The Performers List System

3.8 Following criticisms about the way the NHS handled concerns around healthcare professionals’ suitability, efficiency and probity in the primary care setting, the modern list system was developed from 2001. Its current form was established in the Performers List Regulations 2004 (as amended). The Performers List Regulations provide a framework which enables PCTs to assure the suitability of all general practice doctors, dentists and optometrists who undertake clinical services in their area through admission, conditions, suspension and removal procedures. The Regulations provide a framework to protect patients from unsuitable or inefficient practitioners.

3.9 In the White Paper *Trust, Assurance and Safety* the Government announced that it would be reviewing the Performers List arrangements in England to consider whether they were being used effectively.

3.10 In May 2007, the Department issued a call for ideas inviting comments on the future shape of the performers list system. It also established a Working group under the Tackling Concerns Locally Workstream to take the review forward and to publish a report that would contain recommendations for change.

3.11 The review, published in March 2009²⁷ reiterated the importance of the safeguards provided by the performers list system and recommended that it should be retained for doctors, dentists and optometrists. However, the report acknowledged that there was room for improvement and it made 64 recommendations covering: admission to the list; maintaining and updating the list; suspension and removal from the list; sessional and locum staff; building capacity in PCTs; and the remediation, reskilling and rehabilitation of health professionals.

3.12 Detailed work on the implementation of the recommendations has begun. The Department expects to undertake a public consultation on revised performers list regulations and guidance in summer 2010. The revised regulations are expected to be placed before Parliament at the end of the year.

²⁷ *Tackling Concerns Locally: The Performers List System*, A review of current arrangements and recommendations for the future, Department of Health, March 2009.

THE NHS PRE AND POST APPOINTMENT CHECKS DIRECTIONS 2002

3.13 The NHS Pre and Post Appointment Checks Directions 2002 came into force in England on 1 July 2002. The Directions were introduced following a commitment given by Sir Nigel Crisp in his capacity as Accounting Officer to the NHS at the Public Accounts Committee hearing on 14th January 2002 concerning the use and availability of references.

3.14 The Directions, which confer a legal obligation on NHS bodies, require them to undertake a number of pre-employment checks and enquiries on persons they intend to appoint. The Directions include (amongst other things) a requirement to:

- Identify whether a person has ever been subject to a criminal conviction; and
- Obtain references—for doctors these should include references from the applicants line manager, Medical Director, or Chief Executive—which comment on clinical competence.

3.15 If pre-appointment checks are delegated to an agency or some other body, then NHS bodies must satisfy themselves those checks are carried out.

INDUCTION.

3.16 Induction is not intended to provide a “check” on the credentials of a doctor, but it is important that an adequate induction into a new role is provided and patient safety may be compromised if the basic information that a doctor needs to do their job is not provided to them by their employer.

3.17 Employing organisations have an obligation to ensure that any services they provide are safe and they owe a general duty of care to both their employees and to patients. It is therefore for employers to provide a relevant induction. The content of induction needs to be role specific and reflect the local circumstances in which the doctor will be working.

3.18 The recent review of the Performers List system undertaken by the Department of Health (England) contains the following recommendation:

There should be a formal NHS induction process to help new performers settle into local health economies. This would be tailored to the needs of the individual but would typically cover both local and (for those who had not previously worked in primary care in the UK) national elements.

3.19 This recommendation will be taken forward as part of the implementation of the Performers List review.

3.20 It is also a term of a GMS Contract that arrangements are in place for training and maintaining skills and knowledge, as well as conditions for employment and engagement (see paragraph 53 to 62 of Schedule 6 to the GMS Regulations). Similar mirror requirements apply in respect of PMS Agreements, APMS contracts and requirements where a PCT is providing services themselves.

Postgraduate Deanery Assessment and Induction Programmes

3.21 The Royal College of General Practitioners has issued advice to primary care organisations to the effect that if they cannot be certain that an applicant for a performers list meets all the following criteria, patient safety could be compromised and further information on the applicant should be sought:

- (i) The applicant can demonstrate a knowledge of English which, in the interests of the applicant and of patients, is necessary for performing primary medical services;
- (ii) The applicant is familiar with primary care in the NHS; and
- (iii) The applicant has worked in a healthcare system which has exposed him/her to the generality of patients and conditions routinely managed by GPs in the NHS.

3.22 The RCGP advises that compliance with these criteria should be assessed by the local postgraduate deanery, though decisions under the Performers List Regulations must always be taken by PCTs (who are legally responsible and accountable for such decisions). Deaneries are however experienced in making assessments of educational need and, resources permitting, can provide tailored assessment and induction programmes to help PCTs meet their statutory functions.

ROLE OF NHS BODIES IN MONITORING THE FITNESS TO PRACTISE OF DOCTORS AND ADDRESSING CONCERNS

3.23 Once doctors are working for an NHS Employer, or as a contractor to a PCT, the NHS body is responsible for the quality of services provided by its staff/contractors. As part of their responsibilities NHS organisations are expected to ensure that any complaints or concerns are acted on and that clinical governance systems are maintained. Good clinical governance is particularly important as it provides a means for detecting concerns before a serious incident occurs.

Clinical Governance

3.24 Clinical governance is a framework through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. This framework includes a number of specific processes and structures that are more generally focussed on organisational culture change.

3.25 This framework includes the following clinical governance processes:

- Confidential arrangements to enable healthcare professionals and other colleagues, trainees or employers/employees to raise concerns over the performance, conduct or health of a colleague;
- Systems for reporting patient safety incidents (errors leading to actual patient harm or ‘near misses’) and for analysing their ‘root cause’ in order to draw lessons to minimise the risk of recurrence in the future;
- Monitoring routine indicators of service quality and for drawing attention to any clusters or trends which might give cause for concern;
- arrangements for objective investigation of any complaints or concerns relating to individual healthcare professionals;
- Access to confidential occupational health services and to arrangements for assessment of the professional skills of healthcare professionals;
- Fair and transparent disciplinary processes; and
- Access to arrangements and resources for remediation, re-skilling and rehabilitation of individual healthcare professionals.

3.26 The concept of clinical governance was first described in *The new NHS: modern, dependable*.²⁸

3.27 The Department published “Clinical governance reporting processes” in November 2002.²⁹ This clearly sets out the expectation that all NHS Trusts have responsibility for ensuring that clinical governance principles, processes and systems are reformed.

3.28 In *Safeguarding patients*,³⁰ the government accepted that, despite progress in implementing the structures and processes of clinical governance, further work was needed, in particular to achieve the cultural change which the structures and processes of clinical governance are intended to promote.

3.29 In March 2009, the Department of Health published reports produced by the Tackling Concerns Locally working group.³¹ The group included a wide range of stakeholders with considerable expertise in this area. The reports set out principles of best practice and make recommendations to the Department and the NHS regarding how local systems of clinical governance could be strengthened to promote continuous improvement in the quality of care and enable healthcare organisations to identify and deal with those healthcare professionals whose performance, conduct or health could put patients at risk.

3.30 Current developments in clinical governance focus on strengthening local arrangements for clinical governance and reforming the national arrangements for professional regulations and patient safety. This integrated approach will deliver greater benefits than a pure focus on clinical governance alone.

Appraisal

3.31 An annual appraisal is a requirement for all doctors working for the NHS in England, and has been so since 2002.

3.32 Medical appraisal aims to help doctors consolidate and improve on good performance, and identify areas where further development of knowledge or skills may be required, or useful. The content of the appraisal discussion is based on the GMC’s publication Good Medical Practice which describes the standards of good medical practice, and standards of competence, care, and conduct which are expected of all doctors. Doctors provide data and supporting information to their appraiser to illustrate how they are meeting the requirements of Good Medical Practice.

3.33 While appraisal is primarily intended as a mechanism to support the continuing professional development of doctors, if any serious concerns about a doctor’s practice are identified during the appraisal meeting, which may affect the safety of patients, discussion is stopped, and the appraiser must urgently refer the matter to the senior clinician, and Chief Executive in the case of a PCT. If concerns are such that they call into question a doctor’s fitness to practise, then they should be reported to the GMC.

3.34 It is a requirement under the GMS contract that a doctor participates in the appraisal system provided by a PCT unless he participates in an appropriate appraisal system provided by another health service body or is an armed forces GP and co-operates with an assessment by the NPSA when requested to

²⁸ *The new NHS: modern, dependable*, Department of Health, December 1997.

²⁹ Clinical governance reporting processes, Department of Health, November 2002.

³⁰ *Safeguarding Patients*: The Government’s response to the recommendations of the Shipman Inquiry’s fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam Inquiries, the Stationery Office, February 2007.

³¹ Tackling Concerns Locally: Report of the working group, Department of Health, March 2009 and Tackling Concerns Locally: report of the Clinical Governance subgroup, Department of Health, March 2009.

do so by the PCT. The PCT must provide an appraisal system after consultation with the LMC for its area.³² Similar mirror provisions exist in respect of PMS Agreements and in an APMS contract. The Performers List Regulations also require participation in the appraisal system provided by a PCT unless an armed forces GP.³³

3.35 Although participating in appraisal is a requirement for all doctors, the implementation of appraisal is not currently of a consistent quality across England. New processes, which will be introduced as part of medical revalidation, will strengthen appraisal, and introduce a more consistent approach.

Addressing concerns

3.36 Where concerns are identified about a practitioner the employer is responsible for deciding on the most appropriate course of action to be taken. In many cases concerns will be resolved locally, either through informal action or through formal disciplinary procedures. Where there are concerns about a doctor's performance employers may seek advice from the National Clinical Assessment Service (and they must notify them where a doctor is suspended).

3.37 Where there are concerns about the fitness to practise of a doctor then the doctor should make a referral to the GMC.

REFERRAL OF OVERSEAS-QUALIFIED DOCTORS TO NCAS

3.38 Information about the extent of concerns raised about overseas doctors is held by the National Clinical Assessment Service (NCAS). Information from NCAS suggests that concerns, which result in a referral to NCAS or a suspension or exclusion, are more likely to arise in respect of the performance of International Medical Graduates and EEA doctors than UK doctors. Further details are attached at Annex B.

3.39 It remains unclear why it is the case that overseas qualified doctors are more likely to be referred to NCAS, or suspended or excluded, than UK qualified doctors.

ROLE OF CQC

3.40 The system regulator also has a role in ensuring that the relevant checks on the credentials of doctors are undertaken by NHS bodies. From 1 April 2010, subject to approval of secondary legislation, NHS providers of regulated activities in England will be required to register with the Care Quality Commission (CQC).

3.41 The draft Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 set out the requirements that providers of regulated activities must meet in order to be registered with the CQC. Regulation 21 sets out requirements relating to workers. The regulation requires providers to operate effective recruitment procedures to ensure that employees are of good character, have the necessary qualifications, skills and experience and are physically and mentally fit for the work.

3.42 The provider is required to ensure that, where a CRB or enhanced CRB certificate is required under the Police Act 1997, this is available along with evidence of conduct in relevant previous employment. The provider must also ensure that documentary evidence of relevant qualifications is available along with a full employment history and, where a person has previously been employed in work involving children or vulnerable adults, satisfactory verification of why their position ended.

3.43 The CQC will inspect providers for compliance with the Regulations and if the provider is found to be in breach of the regulation, it will be able to take enforcement action.

FUTURE DEVELOPMENTS : ENHANCING PUBLIC PROTECTION

4.1 In addition to the specific measures which we have proposed to address the concerns which have been raised about a small minority of doctors working in GP out of hours services, there are a number of initiatives that the government is currently taking forward as part of the Professional Standards Programme which will, in future, strengthen the systems in place for ensuring that all doctors, including those from overseas, are fit to practise.

Revalidation

4.2 The GMC introduced a new requirement for all doctors to hold a licence to practise on 16 November 2009 and we plan to work with the GMC to introduce a new system of revalidation in the future. This will mean that all doctors will regularly have to prove to the GMC that they are up to date and fit to practise medicine.

4.3 A system of revalidation for doctors will be phased in during 2011/2012, whereby all doctors licensed by the GMC will have their licence to practice reconfirmed every five years.

³² See para 68 of Schedule 6 to the GMS Regulations.

³³ Regulation 9(7).

4.4 Revalidation will be underpinned by a number of elements which build on what is currently best practice: a strengthened form of annual medical appraisal; feedback from colleagues and patients; and evidence of Continuous Professional Development. Doctors will build a portfolio of supporting information over five years which will be brought to their annual appraisal and which will demonstrate how they are meeting the requirements of Good Medical Practice and any specialist standards set by their Royal College.

4.5 Revalidation will provide patients with the assurance that their doctor is up to date and fit to practise, and will support doctors in developing their expertise throughout their career.

4.6 The revalidation processes are being piloted during 2010 and the first quarter of 2011 in a variety of settings. These pilots will be independently evaluated to test that the processes provide the right degree of rigour to make a revalidation recommendation to the GMC about the doctor without imposing unnecessary administrative burdens.

Responsible Officers

4.7 The Medical Act (as amended by Health and Social Care (Community Health and Standards) Act 2008) enables the role of Responsible Officers to be set out in Regulations. Draft Regulations will be laid before Parliament shortly and, subject to Parliamentary approval, Responsible Officers will be in post from 1 October 2010.

4.8 Responsible Officers will have a key role in the management of doctors and of the quality of care, they provide including ensuring that pre-employment checks are undertaken. In Primary Care, in England, Responsible Officers will also be given personal statutory responsibility for managing admission to the Performers List. Bringing the two functions together will improve the management of Performers Lists and enable issues to be identified and addressed earlier.

4.9 The role of Responsible Officers, in England, is integral to improving quality of care and ensuring a focus on the three core components of quality described in the 'High quality care for all'.³⁴ Where concerns arise about a doctor, the Responsible Officer will have responsibility for deciding whether local processes of remediation are appropriate, or whether the concerns are serious enough to warrant a referral to the GMC on the grounds that the doctors fitness to practise may be impaired.

4.10 They will have a key role in the oversight of doctors and improving the quality of care they provide. Responsible Officers in England will be responsible for ensuring that their organisation has appropriate clinical governance systems in place to monitor the performance and conduct of doctors. Where an issue is identified, they will need to take appropriate action to ensure the safety of patients and improve the quality of care.

4.11 It is also envisaged that in future Responsible Officers may have a role in evaluating a doctor's fitness to practise and making a recommendation to the GMC regarding whether a doctor should be revalidated..

4.12 We propose to issue guidance to accompany the new Responsible Officer Regulations to make it clear that the proposed new duty on Responsible Officers to "manage admission to the performers' list in accordance with the National Health Service (Performers Lists) Regulations 2004" includes assuring themselves that the PCT has adequately discharged its duty to assess language knowledge.

4.13 The draft regulations were consulted on between August and October 2009 and are due to be made later this year. In effect, the proposed new duty would provide a clear point of accountability for ensuring that the necessary checks have been undertaken.

Duty of Cooperation Regulations

4.14 New regulations setting out a duty to share information between prescribed bodies, are expected to be consulted on in early 2010. The proposed new regulations will require a designated body (in England and Wales) to share information about a healthcare worker's conduct or performance which may show that there may be a threat to patient safety. These regulations will be aimed at fostering greater cooperation between a range of bodies, particularly the employers of healthcare workers and the national regulators.

1 March 2010

³⁴ High quality care for all: NHS Next Stage Review final report, Professor the Lord Darzi of Denham KBE, Department of Health, June 2008.

Annex A

RESPONSIBILITY FOR SETTING AND MAINTAINING STANDARDS

1. This Annex summarises the functions of the two bodies involved in setting standards for postgraduate medical education and training—the General Medical Council (GMC) and the Postgraduate Medical Education and Training Board (PMETB).

GENERAL MEDICAL COUNCIL

2. The General Medical Council (GMC) is the independent regulator for doctors in the UK. It was established under the Medical Act of 1858 and its function is to protect patients and the public from poorly performing doctors.

3. The Medical Act 1983 sets out the current legislative basis for the GMC. The GMC's main statutory objective is to protect, promote and maintain the health and safety of the public. The Medical Act 1983 gives the GMC four main functions:

- Keeping up-to-date registers of qualified doctors and whether they hold a licence to practise;
- Fostering good medical practice;
- Promoting high standards of medical education; and
- Dealing firmly and fairly with doctors whose fitness to practise is in doubt.

4. The GMC has strong and effective legal powers designed to maintain the standards the public have a right to expect of doctors. Where any doctor fails to meet those standards, it acts to protect patients from harm—if necessary, by removing the doctor from the register and removing their licence to practise medicine.

5. The GMC is independent of control by Government, the employers of doctors and the profession it regulates. It is accountable to Parliament, through the Privy Council for the discharge of its statutory functions. The Government and the GMC work together to deliver certain policies, however—eg, licensing and revalidation of medical practitioners.

6. The GMC is a registered charity in England and Wales and Scotland. Its governing body, the Council, has 24 members of which 12 are doctors and 12 are lay members, all appointed by the Appointments Commission.

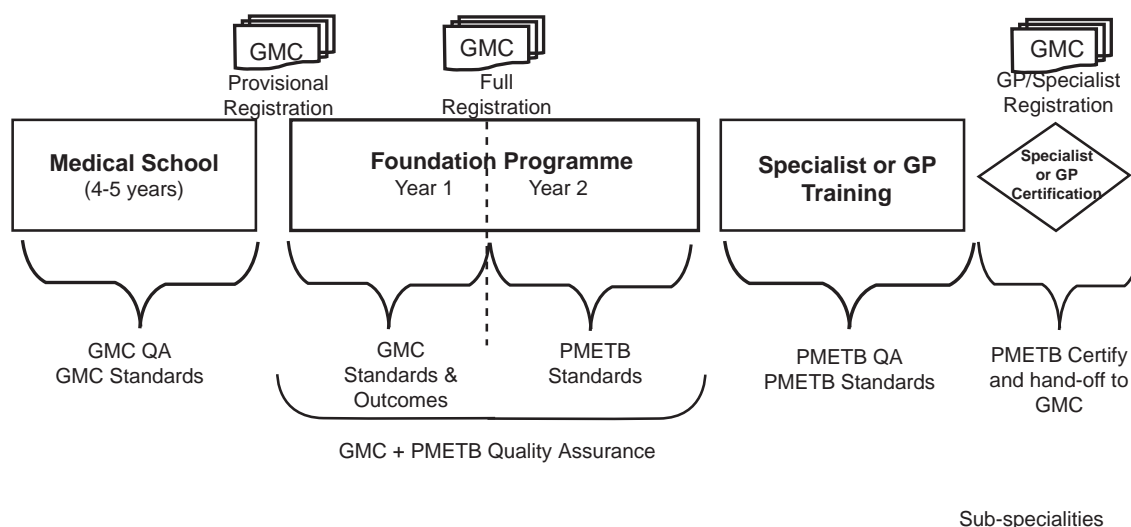
THE POSTGRADUATE MEDICAL EDUCATION AND TRAINING BOARD

7. The Postgraduate Medical Education and Training Board (PMETB) is an independent statutory body responsible for overseeing and promoting the development of postgraduate medical education and training for all specialties, including general practice, across the UK.

8. The PMETB assumed its statutory powers on 30 September 2005, taking over the responsibilities of its two predecessor bodies the Specialist Training Authority of the Medical Royal Colleges and the Joint Committee on Postgraduate Training in General Practice. Its statutory responsibilities include establishing, promoting, developing and maintaining standards and requirements for postgraduate medical education and training across the UK.

9. PMETB's functions include awarding Certificates of Completion of Training (CCT) and determining the eligibility of doctors for inclusion on the Specialist and GP Registers.

10. Unlike the Specialist Training Authority, which was a body of the medical Royal Colleges, PMETB was created by statute and is independent of the medical Royal Colleges. Although PMETB works closely with the medical Royal Colleges, relationships are governed by PMETB commissioning services from the medical Royal Colleges



MERGER OF PMETB WITH THE GMC

11. From 1 April 2010 the functions of the PMETB will be transferred to the General Medical Council and the PMETB itself will be abolished.

12. Following the merger the GMC will take over responsibility for approving standards for postgraduate medical education and training, for awarding Certificates of Completion of Training (CCTs) and for determining the eligibility of doctors for inclusion on the Specialist and GP Registers.

13. The merger will enable a common approach to both undergraduate and postgraduate education and training to develop, and facilitate sharing of expertise, which will in time improve efficiency in processes which themselves support the continued improvement of medical practice and more importantly, in patient care. The merger will also create a single competent authority for medical education and training and a single point of contact for doctors, employers and other partner organisations.

Annex B

NCAS DATA ABOUT DOCTORS BY PLACE OF QUALIFICATION

1. NCAS is a division of the National Patient Safety Agency. Where there are concerns about the performance of doctors NCAS can be asked to advise.

2. A range of services is offered including formal assessment. Over 700 referrals of doctors are made each year, from all parts of the UK and surrounding jurisdictions. NCAS also advises on the performance of dentists and pharmacists.

DATA HELD BY NCAS

3. NCAS was set up in 2001 and has collected demographic data about its cases since starting operations. Cases are classified using standard NHS groupings so that comparisons with the NHS medical workforce can be made. This can identify doctor groups where referrals may be occurring relatively more or less frequently.

4. Care must be taken in interpreting these comparisons because groups of practitioners can vary in many ways and a referral association with one doctor characteristic may actually be reflecting associations with other characteristics outside the immediate comparison—age or gender or grade differences, for example. NCAS therefore used regression methods as well as descriptive comparisons, to establish whether associations are statistically significant. This work was published in ‘NCAS Casework: The First Eight Years’³⁵ in 2009.

³⁵ *NCAS Casework: The first eight years*, National Patient Safety Agency, September 2009 <http://www.ncas.npsa.nhs.uk/resources/publications/key-publications/>

5. *NCAS Casework: The First Eight Years* also examined use of suspension and exclusion from work, as a subset of NCAS referrals. The report's detailed comparisons with the NHS workforce were confined to England because it is difficult to assemble fully consistent workforce comparator data covering the whole of the UK.

6. NCAS recording of place of qualification distinguishes the UK from other EEA countries and countries outside the EEA. Over eight years 2001/02–2008/09, 4264 doctors were referred to NCAS. Place of first qualification was recorded for 79% of them. For suspension or exclusion cases (included in the 4264) place of first qualification was recorded in 90%. NCAS data are therefore reasonably complete. 3828 referrals of the 4264 came from England.

7. In “NCAS Casework: The First Eight Years” comparisons of doctors by place of qualification were limited to UK and “the rest” because only 367 practitioners were identified as qualifying in the EEA. Further analysis is planned as more referrals are made.

FINDINGS

8. The following findings were reported by NCAS based on a comparison using three place-of-qualification groups.

- (i) Hospital and Community doctors qualifying outside the UK are more likely to be referred to NCAS than UK-qualified doctors but the association with place of qualification is relatively weak. Gender and grade associations are stronger;
- (ii) Hospital and Community doctors qualifying outside the UK are more likely to be excluded from work;
- (iii) GP's qualifying outside the UK are more likely to be suspended from work (though this has not been tested with regression); and
- (iv) Doctors qualifying outside the UK account for about 60% of NHS suspensions and exclusions.

9. Tables 1 and 2 use *NCAS Casework: The First Eight Years* datasets to expand on these conclusions by distinguishing EEA-qualified doctors from other doctors qualifying outside the UK. “Not knowns” are assumed to be randomly-distributed amongst the three place of qualification groups. Only England cases are included to aid comparison with the workforce.

Table 1
NCAS DOCTOR REFERRALS, 2001–02 TO 2008–09, ENGLAND.

<i>Place of first qualification</i>	<i>Number of referrals</i>			<i>Per cent of referrals*</i>		
	<i>GP</i>	<i>H&C</i>	<i>All</i>	<i>GP</i>	<i>H&C</i>	<i>All</i>
UK	553	964	1,517	51	50	50
Other EEA	88	163	251	8	8	8
Outside EEA	439	811	1,250	41	42	41
Not known	318	492	810			
	1,398	2,430	3,828	100	100	100

*Note that percentages may not add up to 100% because of rounding

Table 2
DOCTOR SUSPENSIONS AND EXCLUSIONS, EPISODES STARTED BY END 2007–08

<i>Place of first qualification</i>	<i>Number of suspensions/ exclusions</i>			<i>Per cent of suspensions/ exclusions*</i>		
	<i>GP</i>	<i>H&C</i>	<i>All</i>	<i>GP</i>	<i>H&C</i>	<i>All</i>
UK	84	125	209	41	40	41
Other EEA	17	24	41	8	8	8
Outside EEA	103	163	266	50	52	52
Not known	23	28	51			
	227	340	567	100	100	100

*Note that percentages may not add up to 100% because of rounding

10. Table 3 shows the place of qualification profile of the GP and Hospital and Community doctor workforce in England in 2008 and table 4 compares the workforce profile with the profiles of exclusions and suspensions in tables 1 and 2:

Table 3
NHS WORKFORCE, ENGLAND, 30 SEPTEMBER 2008³⁶

Place of first qualification	England medical workforce, September 2008			Per cent of workforce*		
	GP	H&C	All	GP	H&C	All
UK	26648	59719	86367	78	63	67
Other EEA	1619	5956	7575	5	6	6
Outside EEA	5743	28807	34550	17	30	27
	34010	94482	128492	100	100	100

*Note that percentages may not add up to 100% because of rounding.

Note that GP figures exclude GP retainers and registrars

Table 4
PLACE OF QUALIFICATION PROFILE OF REFERRALS, SUSPENSIONS/EXCLUSIONS AND WORKFORCE

Place of first qualification	General practice, per cent			H&C doctors, per cent		
	Referrals over 8 years to 2008–09	Suspensions to end of 2007–08	Workforce, September, 2008	Referrals over 8 years to 2008–09	Exclusions to end of 2007–08	Workforce, September 2008
UK	51	41	78	50	40	63
Other EEA	8	8	5	8	8	6
Outside EEA	41	50	17	42	52	30
	100	100	100	100	100	100

11. Table 4 suggests that both groups qualifying outside the UK are over-represented amongst referrals and suspensions/exclusions. The comparison is not perfect because NCAS data relate to an eight year period so use of a mid-period workforce profile would be more accurate. Since the non-UK-qualified workforce is growing, relatively, this would strengthen a conclusion that doctors qualifying outside the UK are over-represented in referrals to NCAS and in suspensions and exclusions reported to NCAS.

12. *NCAS Casework: The First Eight Years* comparisons therefore also looked at associations with ethnicity, which is closely associated with place of qualification. For the Hospital and Community sector, *NCAS Casework: The First Eight Years* conclusion was that there is an increased likelihood of performance measures amongst non-white non-UK qualified doctors but not amongst non-white doctors qualifying in the UK. General practice lacks workforce comparator data on ethnicity.

13. These comparisons are made by NCAS as part of an on-going equality monitoring programme.

Memorandum by the Royal College of General Practitioners (OHS 02)

OVERSEAS DOCTORS' CREDENTIALS

1. Thank you for the opportunity to contribute to the Health Committee's inquiry into Overseas Doctors' Credentials.

2. Doctors from Europe who come to the UK to work in out-of-hours services must prove they are of the same quality as those who trained in the UK. It is the responsibility of Primary Care Organisations (PCOs) to ensure that patients receive good quality care by commissioning appropriate services. This is obviously not working and I am anxious that patients are not getting the care they deserve.

3. There is a lack of competence—clinical and linguistic—of some of the GPs entering the UK to work in the NHS. I have consistently raised this issue with senior officials and politicians at the Department of Health (England).

4. The recent review³⁷ of general practice out-of-hours services, which I carried out with Dr David Colin-Thomé, outlines a number of important recommendations which will remind Primary Care Trusts (PCTs) of their legal obligation to provide safe, high quality, out-of-hours care. Although it focused on England,

³⁶ Source: NHS Information Centre website.

³⁷ Dr David Colin-Thomé & Professor Steve Field (2010). *General practice out-of-hours services: project to consider and assess current arrangements*. London: Department of Health. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111892.

all four UK countries should note its findings. I am pleased that Health Minister, Mike O'Brien, has accepted the report's recommendations in full and announced a range of further measures to strengthen arrangements for the commissioning and provision of out-of-hours services.

The Legal Framework and Guidance Governing Performers Lists

European Union (EU) / European Economic Area (EEA) Nationals:

5. Tougher criteria are needed for EEA GPs to gain a place on PCO Performers Lists, including a supervision period.

6. Doctors must be on the GMC's GP Register before they can be included on a Performers List. An EU Directive³⁸ facilitating the free movement of EU nationals gives GPs qualified within the EU automatic right of entry to the Register if they have either a certificate of specific training in general practice or an acquired right to practise from their own Member State. They do not need an evaluation by the GMC or the Postgraduate Medical Education and Training Board (PMETB), nor do they need to have any familiarity with the NHS.

7. Research shows that there are misunderstandings among PCTs about whether the GMC can perform language tests in respect of doctors from the EEA. This has resulted in uncertainties around whether they should check the knowledge of English of applicants to their Medical Performers Lists and how to handle this issue. Confusion over whether doctors could be admitted to a list if they needed to improve their knowledge of English was also apparent. The Department of Health (England) needs to issue guidance on this matter.

8. All doctors should be able to converse with patients, their carers, pharmacists and other healthcare professionals; be able to read and understand the British National Formulary (BNF); and be able to arrange referrals to hospitals.

Non-EU Nationals:

9. In contrast, GPs who do not have an enforceable EU right (usually referred to as International Medical Graduates) must satisfactorily complete GMC-determined assessments of their language and clinical skills and be awarded a PMETB Certificate confirming Eligibility for General Practice Registration (CEGPR) before being admitted to the GMC's GP Register.

10. Under Article 14, it is PMETB's role to evaluate the skills, knowledge and experience of each applicant against the curriculum for their specialty and to judge whether it is deemed to be equivalent. If PMETB feels it is equivalent they will issue a CEGPR, if not they will recommend a period of additional training likely to make up the shortfall. In order to undertake additional training, doctors must be registered with the GMC and this entails undertaking Professional and Linguistic Assessments Board (PLAB) and International English Language Testing System (IELTS)³⁹ tests.

11. If a doctor is awarded a CEGPR by PMETB they are eligible to work as a GP in the UK provided that they have GP registration (as above) and are admitted to a PCO Performers List. Obtaining a CEGPR will entitle them to be included in the GMC's GP Register.

RCGP Guidance on Admitting GPs From Outside the UK to Primary Care Lists

12. Speaking on behalf of the RCGP, which I have chaired since 2007, the College feels that most doctors admitted to primary care lists are clinically and linguistically competent. However, the RCGP is concerned by the threat posed by the minority of GPs who may not be.

13. In 2008, the RCGP issued advice to all PCOs on admitting GPs from outside the UK to primary care lists⁴⁰. It advises PCOs that if they cannot be certain that an applicant for a list meets all the following criteria, patient safety could be compromised and further information on the applicant should be sought:

- (a) The applicant can demonstrate a knowledge of English which, in the interests of the applicant and of patients, is necessary for performing primary medical services;
- (b) The applicant is familiar with primary care in the NHS;
- (c) The applicant has worked in a healthcare system which has exposed him/her to the generality of patients and conditions routinely managed by GPs in the NHS.

14. A further recommendation would be that PCOs should conduct face-to-face interviews with all Performers List applicants from outside UK in order to verify language skills.

15. PCOs should ensure that all relevant documentation submitted by applicants is checked for authenticity as well.

³⁸ EEC Directive 2005/36/EC

³⁹ GMC. *English Language Requirements*. http://www.gmc-uk.org/doctors/registration_applications/language_proficiency.asp#.

⁴⁰ RCGP (2008) *Admitting GPs From Outside the UK to Primary Care Lists: Advice to Primary Care Organisations*. http://www.rcgp.org.uk/docs/Admitting_GPs_From_Outside_the_UK_to_Primary_Care_Lists.doc

Training, Selection and Induction of Out-of-Hours GPs

16. PCOs should work with postgraduate deaneries in providing tailored assessment and induction to incoming GPs to ensure that they are competent and safe to practise.

17. The RCGP has accepted the recommendation in the report *General practice out-of-hours services*, to review its guidance on GP Registrars' training in out-of-hours care. This has been discussed at a recent meeting of the College's Postgraduate Training Board. This work will involve engagement with relevant stakeholders, in particular the Committee of General Practice Education Directors (COGPED).

Providers of Out-of-Hours Services

18. Providers need to ensure their doctors are competent to the level of UK trained graduates, have good English skills, are not overly tired after working long shifts, and are orientated to the local conditions. There needs to be safeguards and reviews in place, at both the clinical and strategic level. Longer term, we need more GPs to get involved in commissioning and providing out-of-hours, weekend and emergency services.

19. Providers should ensure that the people they employ have the required knowledge and skills (including language competency) for the posts they are applying.

Professor Steve Field CBE MMed FHEA DUniv FRCP FRCGP
Chairman of Council

March 2010

Memorandum by the General Medical Council (OHS 03)

OVERSEAS DOCTORS' CREDENTIALS

INTRODUCTION

1. The General Medical Council (GMC) is the independent regulator of doctors in the UK. The GMC protects, promotes and maintains the health and safety of the public by ensuring proper standards in the practice of medicine.

2. The law gives the GMC four main functions:

- (a) keeping up-to-date registers of qualified doctors;
- (b) fostering good medical practice;
- (c) promoting high standards of medical education; and
- (d) dealing firmly and fairly with doctors whose fitness to practise is in doubt.

THE MEDICAL REGISTER

3. Doctors must be registered with and hold a licence to practise from the GMC to practise medicine in the UK. Patients entrust doctors with their lives and wellbeing, as such it is essential that doctors are competent and from this patients will have confidence in them. The GMC aims to protect the public interest and one of the ways we do this is by controlling entry to the register by ensuring that only those who are suitably qualified and fit to practise gain registration.

4. The GMC's powers to register and license doctors are specified in the Medical Act 1983. The recognition of professional qualifications held by EEA nationals or those who are entitled to be treated as such is provided for by the EEA Directive 2005/36/EC. The Directive was transposed into UK law by way of amendment to the 1983 Act.

DEFINING THE TERM "OVERSEAS DOCTOR".

5. The legislative framework means that doctors generally fall into one of the following categories:

- (a) those who hold a primary medical qualification from one of the 32 UK medical schools approved by the GMC, regardless of their nationality.
- (b) those doctors who hold a primary medical qualification (that is to say, a first degree in medicine) awarded in a relevant European State and who:
 - (i) are European Economic Area (EEA) or Swiss nationals; or
 - (ii) benefit from an enforceable Community right to be treated as an EEA/Swiss national for the purpose of free movement between relevant European States;
- (c) those, known as International Medical Graduates (IMGs), who are not EEA/Swiss/EC rights doctors and who may be granted registration in the UK at the GMC's discretion by virtue of holding a primary medical qualification awarded outside the UK acceptable to the GMC.

6. There are currently 218,833 doctors with a licence to practise on the register. Of those 139,018 received their primary medical qualification in the UK; 19,710 in the EEA; and 60,098 are IMGs. It is important to note that these are numbers of doctors able to practise in the UK, not the numbers actually practising.

THE REGISTRATION PROCESS.

7. The specific requirements that doctors have to satisfy before being granted entry to the medical register vary depending under which category they fall. We carry out pre-registration identity checks on all doctors and all doctors must sign a fitness to practise declaration as evidence that their fitness to practise is not impaired. We require applicants to provide evidence that they are in 'good standing' with any other medical regulator in whose jurisdiction they have practised in the five years preceding their application (or, in some circumstances, a longer period). Where necessary we seek further information from doctors who are unable to provide such credentials.

8. We can ask for original versions of supporting evidence to confirm qualifications, training and certificates of good standing and require translations of all documents not in English (for EEA applicants this is done at the point of registration rather than as part of the process to recognise their professional qualifications). For all applicants, irrespective of the route to registration we undertake verification of at least one item of information upon which the applicant relies—going directly to the source of that information to confirm its veracity.

UK graduates.

9. The GMC sets the standards for UK medical education and quality assures the 32 UK medical schools to make sure they are delivering those standards. Doctors who hold a primary UK qualification are entitled to be registered (provided their fitness to practise is not impaired), regardless of their nationality.

European doctors.

10. European doctors (as defined in paragraph 5b) must provide evidence that they have a medical qualification as listed in the Directive 2005/36/EC. The GMC cannot by law test the language proficiency of European doctors as defined in paragraph 5b or carry out any assessment of the medical knowledge and skills at the point of registration.

International Medical Graduates.

11. IMGs, on the other hand, must prove at the point of registration that they have the necessary knowledge of English. Most IMGs demonstrate this by achieving the scores that we require in the academic version of the International English Language Testing System test, administered by the British Council and IDP Education Australia. This test is widely used including by the UK Foundation Programme Office and Royal Colleges for entry to their programmes.

12. An IMG doctor must also prove that they have the necessary professional knowledge, skills and—in the case of applicants for full as opposed to provisional registration—the experience required for medical practice in the UK. This is usually demonstrated by passing the two-part Professional and Linguistic Assessments Board (PLAB) test, which we administer. The first part is a written examination and the second part is a practical test, involving simulated medical procedures using actors and manikins.

GMC POSITION.

13. The GMC supports the free movement of doctors in the EU and the principle of recognition of professional qualifications; for decades the UK health system has benefited from EU and overseas qualified doctors practising in the UK. Approximately 36% of those doctors on the register gained their primary medical qualification in countries other than the UK.

Testing knowledge and language skills of European doctors.

14. We believe the current legal framework impedes our statutory obligation towards patient protection and is unacceptable as it does not adequately safeguard patient safety. As the law currently stands it is clear that the GMC is precluded from testing, at the point of registration, the professional and English language skills of doctors who benefit from mutual recognition. This undermines the integrity of our registration processes and the register of medical practitioners which in turn damages confidence in the profession among patients, employers and doctors themselves.

15. We would like to have the discretion to test properly the English language proficiency and clinical knowledge and skills of all potential registrants where we consider it to be in the interests of patient safety. Leading counsel's advice received by the GMC suggests that the language element of this could be achieved through an amendment to the Medical Act 1983.

16. We are also calling for clearer guidance from the European Commission on the Directive to clarify what regulators can do to assure themselves that the doctors they register have the necessary knowledge of language.

Information sharing between regulators.

17. The GMC is also concerned that there is currently no legislation at European level that requires regulators to share information about a doctor when action is taken with regard to their registration. We believe that this creates a risk that a doctor exercising their rights of free movement could be granted registration without fitness to practise information being shared or that a doctor who holds registration in more than one jurisdiction could be barred from practising in one country, while continuing to practise in another.

18. The GMC makes fitness to practise information easily available on our website via the List of Registered Medical Practitioners or LRMP. We also send a monthly 'decisions circular' to all relevant European regulators listing all doctors who have been subject to GMC fitness to practise hearings and the outcome of the hearing. However the information that we receive from other European regulators can be patchy.

19. The GMC works with other European regulators to raise awareness of this issue and holds the secretariat of the informal partnership of European healthcare regulators known as Healthcare Professionals Crossing Borders (HPCB). HPCB has been successful in establishing a number of voluntary agreements. However difficulties remain about data protection and privacy legislation in some countries, which means that compliance with the HPCB agreements is variable and unreliable.

20. The GMC is calling on the European Commission to introduce a legal duty on all medical regulators to share registration and fitness to practise information proactively with other regulators in Europe. We believe that there is an opportunity to establish a legal duty either through the revision of Directive 2005/36/EC due to take place in 2012 or through the Patient's Rights Directive on cross-border healthcare currently under consideration. To date, the European Parliament has supported our position and agreed an amendment to the draft Patient's Right directive at first reading.

Medical qualifications.

21. The legislation that facilitates doctors' freedom of movement within Europe relies on the premise that each Member State will ensure that its doctors are trained and qualified to a minimum standard. The assumption therefore is that, where a competent European authority certifies that a doctor has been granted recognition of a relevant professional title (such as, in the UK, GP), that certificate is capable of being relied on across Europe as evidence that the doctor does indeed have the necessary minimum level of skills and experience.

22. This assumption may or may not be safe, that is not for the GMC to decide, but what is clear is that competent authorities such as the GMC are obliged to accept such certificates at face value, and cannot go behind them to investigate further.

23. With this in mind the GMC is calling on the European Commission, as part of its review of the Directive to insist that medical training is based on competence and skills acquired rather than hours studied. We are also concerned that some of the descriptions of study programmes in the Directive's annexes are over 20 years old and need to be updated if they are to command the confidence of patients and doctors.

CONCLUSION

24. Recent events have highlighted some of the regulatory gaps that have the potential to harm patients and undermine confidence in healthcare. The GMC is committed to working with the Department of Health (England), devolved administrations, employers and the European institutions to ensure that the free movement of doctors in the EU does not compromise patient safety in the UK.

March 2010

Memorandum by the British Medical Association (OHS 04)

THE USE OF OVERSEAS DOCTORS IN PROVIDING OUT-OF-HOURS SERVICES

In response to the Committee's announcement of an evidence session on the use of overseas doctors in providing out-of-hours services (OOHs), I thought that I would use the opportunity to write to you in advance of the session as the General Practitioners Committee of the BMA has also been in close discussion on this issue for almost a year with Government and a number of the other stakeholders that will appear as witnesses for the evidence session. I welcome the Committee's interest in this important matter, as it is timely following both the findings from the David Gray inquest concerning the activities of Dr Daniel Ubani and the Department of Health's own review of OOHs.

Understandably, this is a complex subject area covering fitness to practice and language competency for overseas doctors undertaking OOHs work and the broader issues surrounding OOHs provision. What is clear is that OOHs provision is unacceptably patchy around the country and while there are some OOHs organisations that provide a high-quality service there are others, as has been highlighted by the tragic and avoidable death of David Gray, that fall shockingly short. We believe that the recommendations made in

the report to the Department of Health are sensible and we are pleased that the Government has accepted them in full. In particular, we welcome the report's proposal for greater involvement of local GPs in assessing the quality of services. We hope that this, combined with proposals to improve monitoring of services and the selection of clinicians, will raise the standard of OOHs across the board so that all patients, no matter where they live, receive high-quality care.

In terms of the use of overseas doctors in providing OOHs services, we strongly encourage OOH providers and primary care organisations (PCOs) to be much more careful to ensure that anyone coming from abroad to work in the UK as a GP has relevant clinical training and experience, appropriate for the breadth of UK GP activity, and sufficient English language skills. It is possible that some doctors who have undertaken their training outside of the UK may not offer the range of experience that UK trainees possess and may not be able, in our view, to provide the same quality of service to NHS patients. The BMA is more than willing to help with plans to establish a national database of overseas doctors working as GPs. The Government has already asked the BMA to help in this regard and we have agreed to do so.

With regard to other solutions to improve OOHs services, some commentators have suggested that GPs should return to pre-2004 arrangements where GPs were personally responsible for making the arrangements to deliver OOHs and in the event of not being able to make suitable arrangements, were forced to offer this service personally. With the current pace of general practice and level of demand for OOHs, making the GP liable to being the provider of last resort is unsustainable, dangerous for patients and would return general practice to a time when it struggled with recruitment and retention of doctors. Nonetheless, significant changes must be made to address the current widespread variation in the quality of OOHs provision and the BMA is fully behind such moves.

There is considerable variation in the funding of OOHs services by PCOs. Research by the Primary Care Foundation⁴¹ has indicated that PCO funding ranges from as little as £3 per head to nearly £16 per head, underlining the view that many PCOs have been more concerned with cutting costs rather than ensuring patients receive the best quality care. Proper investment by PCOs will enable the provision of quality services and would also lead to better local recruitment and retention of medical staff.

Standards of OOHs care could also be improved if PCOs were required to involve local GPs in the commissioning of OOHs care so that high-quality, timely and cost-effective services can be developed that are sensitive to local circumstances. GPs must be involved in the commissioning process at a level that does not force them to be providers of last resort, but permits them to raise objections to any PCO plans that offer unacceptably low standards and to have their concerns listened to and acted upon.

Added to this, the application of appropriate monitoring of PCOs will ensure that quality standards are maintained and OOHs services are improved. Clear minimum standards for OOH providers and the GPs they employ are absolutely necessary. Every PCO should have to gain approval for its OOH plans from local commissioning groups and the Local Medical Committee (LMC). Before 1996, it was mandatory for the old commercial deputising services to have an LMC-nominated, PCO-appointed deputising service liaison officer that played a role in undertaking unannounced spot-checks.

I hope that you find this submission useful; should the Committee request it, we are more than happy to expand on any of the points raised.

Dr Laurence Buckman
Chairman
BMA General Practitioners Committee

4 March 2010

Memorandum by the Medical Defence Union (OHS 05)

THE USE OF OVERSEAS DOCTORS IN PROVIDING OUT-OF-HOURS SERVICES

1. The Medical Defence Union (MDU) is the oldest and largest of the UK's medical defence organisations (MDOs). It is a non-profit making mutual membership organisation with members in the UK and Ireland. In the UK it provides a wide range of medico-legal benefits to its members who are over 50% of doctors in hospital and primary care, and over 30% of dentists. Among the benefits of membership, MDU members are provided with an insurance policy providing them with indemnity for clinical negligence claims.

2. The MDU understands that the Health Committee will hold a special evidence session on Thursday 11 March to consider the use of overseas doctor in providing out-of-hours services and wishes to submit evidence about clinical negligence indemnity.

⁴¹ The Department of Health has selected the Primary Care Foundation to support a national benchmark of out-of-hours services. Details can be found here: <http://www.primarycarefoundation.co.uk/page1/page1.html>

EXECUTIVE SUMMARY

3. The MDU suggests that the Committee may wish to consider provision of clinical negligence indemnity as part of its inquiry into the provision of out-of-hours services. First, there is no requirement for mandatory indemnity for doctors practising in the UK. Second, it is possible currently for overseas doctors to practise in the UK and to treat NHS patients while being indemnified by an indemnity provider that is not based in the UK.

4. We believe that this could potentially give rise to two problems:

- (a) First, that it is possible that a doctor from overseas could practise in the UK without adequate or appropriate indemnity.
- (b) Second, UK patients should be able to expect that if they are treated in the NHS and something goes wrong, they can sue in the UK, in a jurisdiction that they and their legal and other advisers can understand. This should apply even if the indemnity provider is based in another country as all indemnity policies covering doctors practising in the UK should be required to allow claims to be brought in the UK.

FACTUAL BACKGROUND

5. There is currently no statutory requirement in operation that requires doctors who are licensed to practise in the UK to have clinical negligence indemnity. The General Medical Council (GMC) has powers under S44C of the Medical Act 1983 to require doctors as a condition of registration to have 'an adequate and appropriate indemnity arrangement' for their work as a doctor. The GMC has not yet exercised these powers and currently the only ethical requirement upon doctors is that set out in the GMC's guidance Good Medical Practice which says at paragraph 34: 'You must take out adequate insurance or professional indemnity cover for any part of your practice not covered by an employer's indemnity scheme, in your patients' interests as well as your own.' The GMC does not define 'adequate insurance or professional indemnity cover' and nor does the Department of Health.

6. Doctors working in NHS hospitals and the community throughout the UK (UK doctors and overseas doctors) are indemnified through NHS indemnity for clinical negligence claims arising from their NHS work and many of them, though not all, seek indemnity from other providers for work they undertake outside of their NHS contracts. Such indemnity is provided in the form of insurance for members of the MDU, or as discretionary indemnity through membership of the two other MDOs. A very few doctors, usually practising in the independent sector, make direct insurance arrangements with an insurer.

7. UK general practitioners as independent contractors are usually required as part of their contractual requirements to hold indemnity, though this is not always the case. The majority are members of an MDO, but there is no way of knowing if all GPs have indemnity.

8. Overseas doctors who provide services in primary care in the UK are generally required through their contracts to have indemnity in place, but there are no stipulations as to what type of indemnity they should hold. Some of them may join an MDO if they are going to practise in the UK for some time but others, who also practise in other EU member states, may prefer to hold indemnity in the state where they live and practise most. There is nothing to prevent them from doing this.

9. There is currently a draft EU directive under active consideration in Brussels with the aim of facilitating cross-border healthcare. One of the provisions of this draft directive (the proposed directive on the application of patients' rights in cross-border healthcare), Art 5 (1) (d) & (e), covers indemnity with the aim of ensuring that patients who travelled to another member state and who were negligently harmed would be able to claim and receive compensation. Currently the draft proposals would require member states to have arrangements in place so that patients were able to and would have the right to seek compensation when they suffered harm and that the mechanisms would guarantee that remedies "which are appropriate to the nature and extent of the risk are in place for treatment provided in their territory". It is currently accepted that this would mean that patients would be able to use the mechanisms of the country in which they received treatment to sue and to gain compensation. A UK patient who was harmed would sue in the UK jurisdiction, as would any patient who came to the UK for treatment. Similarly this would provide that, for example, a Dutch or German doctor who treated patients in the UK must be sued through the UK courts.

10. The MDU believes that such an arrangement has much to commend it. If it were adopted, it would ensure that all UK NHS patients would have equal rights to seek compensation and access to justice in their own jurisdiction, irrespective of whether the doctor who had negligently harmed them came from overseas.

MDU RECOMMENDATION

11. We would like the Committee to consider making a recommendation that, in the interests of protecting NHS patients, any doctor practising in the UK must be covered by adequate and appropriate indemnity. Such indemnity could be either NHS indemnity or a contractual arrangement providing a guarantee that negligently damaged patients will be compensated. This would ensure that any claims arising from treatment provided to NHS patients in the UK would have to be brought and compensation provided through the UK clinical negligence procedure.

12. In the absence of EU approval and adoption of the draft directive on cross-border healthcare, which would require each member state to have such appropriate arrangements in place, the GMC could make this a requirement of all doctors who wish to hold a licence to practise. The GMC has had powers to require registered doctors to hold adequate and appropriate indemnity (which it must define) since 2006 but has not yet exercised these powers.

Dr Christine Tomkins
Chief Executive

5 March 2010

Memorandum by Mike Farrar, NHS North West (OHS 06)

The recent issues raised in respect of GP out of hours services can be tracked back to the early 1990s when GPs were first allowed to delegate their out of hours responsibilities to a third party. This significant change was lamented by many, who believed that “continuity of care by their much loved local family doctor” had been compromised. However, the changes at that time reflected wider concerns about the quality of care which GPs were able to deliver when operating on a 24/7 basis, and the impact which such time and clinical commitments were having on GP recruitment.

Throughout the 90’s, during which time I was Head of Primary Care at the Department of Health (1997–2000), out of hours care, even on a delegated basis, provided a major area for patient complaints and a reported barrier to GP recruitment. Furthermore, with the advent in the late 1990’s of multiple access points for urgent, non-planned care GP out of hours services became increasingly part of a more complex and intricate range of service options. It therefore made sense that as part of the new GMS contract negotiations to address GP out of hours services with a view to requiring PCTs to commission them directly as part of a coherent service response that enabled patients to navigate access to urgent care appropriately and effectively. It was intended that such a move would also potentially herald an increase in the popularity of general practice as a career and also, given the concerns over quality of out of hours services, could lead to its improvement.

The new GMS contract created a platform for improving the quality of out of hours services. The negotiators believed that, whilst the unit costs of GP input would increase (as GPs were no longer obliged to provide out of hours care), a more coherent service based on call-triaging, better patient navigation and reduction in duplication would more than compensate with improved service quality.

The detailed competency of the individual doctors was considered to be manageable through the NHS Performers List arrangements and active contract monitoring by PCTs.

Experience since the introduction of the new arrangements would suggest that robust arrangements are in place to ensure delivery of improved out of hours care but that there is some variation in how PCTs undertake their role. In particular, I believe, some PCTs have yet to commission a coherent out of hours urgent care system although the current QIPP programme and recent rises in non elective activity are driving all PCTs to focus on the effectiveness and efficiency of their current service offer. SHAs have focussed most of their performance management role on this larger urgent care commissioning agenda and the management of demand for acute care. Also SHAs have and do scrutinise the local actions by PCTs to ensure the quality of out of hours service provision as part of their overall performance management role. This has often been brought to the fore at times when out of hours contracts have been tendered and/or where numbers of complaints or untoward incidents have provoked concern.

Mike Farrar
CEO North West
(and ex lead negotiator for NHS Confederation re new GMS Contract)

March 2010

Memorandum by the Patients Association and Stuart and Rory Gray (OHS 07)

OUT OF HOURS CARE

EXECUTIVE SUMMARY

1.1 The Patients Association considers the death of David Gray on 16 February 2008 to be a powerful example of the complete failure of a Primary Care Trust (PCT) to commission a safe, high quality healthcare service for patients. It is also symbolic of the poor performance of out of hours service provision that has been repeatedly highlighted over a number of years.

1.2 The Care Quality Commission publication Care Quality Commission’s Update on enquiry into Take Care Now and out-of-hours services (2009) and review by Steve Field and David Colin-Thomé confirm that provision continues to be a problem nationally.

1.3 Recently completed FOI based research conducted by the Patients Association revealed that at least 4 PCTs still have no record of the complaints being lodged with their contracted provider and at least 5 PCTs were also unable to provide us with information on the numbers of Serious Untoward Incidents (SUIs)

1.4 The Trust that received the lowest patient satisfaction ratings for their out of hours service (according to the unweighted National GP Patient Survey results for Quarters 1 and 2 2009/10) operates an all GP opt in service very similar to the system operating before the reforms, suggesting all GP led services aren't necessarily better than contracted providers

1.5 Cornwall and Isles of Scilly PCT (CIS PCT) in particular were made aware of problems with the out of hours care (OHC) being given to their local patient population but failed to act. In particular concerns were raised about the use of foreign doctors over a year before the death of David Gray.

1.6 Other PCTs have systems (for example assessments of English language skills) that ensure those doctors joining the providers list for the PCT (from whom OHC services will be delivered) are suitably trained. CIS PCT introduced no such test despite concerns being raised about the English language skills of foreign doctors providing care.

THE DEATH OF DAVID GRAY

1.7 The Patients Association considers the death of David Gray on 16 February 2008 to be a matter of serious concern and a powerful example of the complete failure of a Primary Care Trust (PCT) to ensure those professionals authorised to provide care to patients (whether this be to the patient population of this PCT or another) were able to provide safe, high quality healthcare service for patients. In particular it shows a failure to respond to specific concerns raised about poor care being delivered to patients.

1.8 There have been national concerns raised about ensuring PCTs commission safe out of hours care (The Panel Report for the Serious Untoward Incident investigation into the death of Penny Campbell 2007) but there was also a history of concerns about Cornwall and Isles of Scilly PCT (CIS PCT) specifically.

1.9 The Patients Association met with Rory and Stuart Gray and discussed the case, reviewing the significant amount of evidence they have accumulated. We would kindly ask that the Committee consider this memorandum submitted in partnership with them as part of its inquiry.

1.10 Much of the interest around the case has surrounded the issue of eligibility to work as a doctor and be registered with the General Medical Council. As an EU member state, doctors from Germany are not legally required to undertake additional examination/qualification to register with the GMC.

1.11 Whilst this is a valid and important concern we also feel that basic safety assurances should have been sought by CIS PCT as part of their duty to commission safe, high quality OHC on behalf of the local population. As mentioned concerns about PCTs ability to do this nationally in respect to OHC have been raised but in addition concern about the suitability of foreign doctors to provide out of ours care had been raised with CIS PCT by patients, the media and MPs.

1.12 Measures that can be taken include the testing of the English Language skills of those joining the providers list. Dr Ubani failed such a test which prevented him from joining the providers list at another PCT.

PREVIOUS CONCERNS ABOUT CORNWALL AND ISLES OF SCILLY PCT OHC.

1.13 The Hansard record from a Westminster Hall Debate held on 20th February 2007 highlights widespread concerns about the quality of out of ours care being commissioned by CIS PCT. It indicates that local MPs had been concerned for some time and made their concerns known to the Trust. They felt they had received an inadequate response. Matthew Taylor MP states "From the evidence of my own constituents, those of my colleagues, and indeed the PCT's media statements, it is clear that KUCS as it has been operating is unfit for purpose, and as a result patients are potentially at risk".

1.14 Matthew Taylor MP tells of one case of parents who used the service and "their daughter was seen by another overseas agency doctor who not only found it difficult to understand her/this has been an issue with the overseas doctors employed/but relied on an electronic word converter to communicate with the patient. He was also unable to communicate with other doctors. raises the issue of foreign doctors in particular".

1.15 In the same debate Tim Loughton MP states "there have been instances of serious misdiagnosis, and treatment by doctors who have an inadequate grasp of the English language and British medical procedure. Many doctors are drafted in from eastern Europe on a temporary basis"..

1.16 Concerns were also raised in the national press. On 28th March 2007 the Daily Mail published an article titled "Foreign doctor unable to call ambulance". The article detailed the concerns of patients and local MPs and stated that "The NHS has now launched an inquiry after a complaint by St Ives Liberal Democrat MP Andrew George".

1.17 As clearly illustrated by the death of David Gray almost exactly a year after this debate was held, the necessary improvements were not made. In particular the PCT had taken no steps to require those providing OHC had the necessary English language skills despite this being raised as an issue. Whilst Daniel Ubani did not provide care in their locality, his successful registration with them as a provider on 18 July 2007 enabled him to act as a provider elsewhere.

1.18 The Patients Association feels further examination of this case through an independent inquiry (also desired by Stuart and Rory Gray) would serve to illustrate many limitations of PCTs to commission safe high quality services for patients.

RESULTS FROM NATIONAL GP PATIENT SURVEY QUARTER 1–2 2009–10 AND PATIENTS ASSOCIATION FOI BASED RESEARCH

1.19 The National GP Patient Survey questionnaire asks a number of questions about the provision of out of hours services. The unweighted results for 2008–09 and the first two quarters of 2009–10 are publicly available through the House of Commons Library.

1.20 The results for the first two quarters of 2009–10 show that the highest percentage of patients that rate their service as either poor or very poor (21%) reside in NHS Richmond (formerly Richmond & Twickenham PCT).

1.21 According to responses sent to the Patients Association asking for information regarding out of hours services “All GP practise in NHS Richmond are opted into out of hours, which mean they retain their responsibility for the provision of out of hours services”.

1.22 This would support the argument that the “postcode lottery” of the quality of care is not necessarily dependent on whether or not local GPs provide the service.

1.23 The Patients Association has submitted a number of questions to PCTS about out of hours care provision under the Freedom of Information Act and would highlight the following interim findings:

1.24 Four Primary Care Trusts were unable to tell us how many complaints had been received by their contracted provider.

1.25 Five Primary Care Trusts were unable to tell us how many Serious Untoward Incidents had been reported to them relating to the out of hours service.

1.26 Of the 48 PCTS that provided figures to us for the entire period, as a whole spending on out of hours services has increased from £109,618,998 in 2005–06 to £121,028,725 2008–09.

March 2010

Supplementary memorandum by the Department of Health (OHS 01A) ADDITIONAL INFORMATION REQUESTED BY THE COMMITTEE

NHS CORNWALL AND ISLES OF SCILLY PRIMARY CARE TRUST

Statements made by NHS Cornwall and Isles of Scilly Primary Care Trust and the evidence produced to the Coroner indicate that the PCT may have failed to take adequate steps to satisfy itself that Dr Ubani had the knowledge of English necessary to perform services in the PCT’s area. Whether and the extent to which this may have breached the law must be determined by the appropriate legal authorities rather than the Department.

We confirm that the Department’s understanding is that no disciplinary action has been taken by the PCT. The South West Strategic Health Authority, which is responsible for performance managing local NHS bodies, is aware of and is monitoring the situation. We understand that the PCT has since reviewed its procedures and has introduced a number of new safeguards, including arrangements for assuring itself that GPs it admits to its performers list have necessary knowledge of English language.

CLARIFICATION ON ISSUES RELATING TO THE MEDICAL ACT 1983 AND DIRECTIVE 2005/36/EC

1. I understand that the Committee asked for clarification on two points:
 - (i) Precisely what legislation it is that prevents the GMC from assessing language knowledge; and
 - (ii) What changes would we like to see made to the Directive if it were to be amended.

The Directive

2. Article 53 of Directive 2005/36/EC (“the Directive”) makes it clear that persons benefiting from the recognition of professional qualifications shall have a knowledge of languages necessary for practising the profession in the host Member State. However, lack of language knowledge is not a ground for refusing recognition of the qualifications of a national of another Member State—the Commission’s own guidance is clear about this.

3. The UK has therefore transposed the provisions in the Directive that state that migrants shall “have a knowledge of languages necessary for practising the profession in the host Member State”, not at the point of registration, but at the point where a doctor seeks to provide services in the community; both through the National Health Service (Performers List) Regulations 2004,⁴² in primary care, and through separate guidance to NHS employers.

4. During the Committee hearing the situation in France was referred to where a different regulatory model exists. Our understanding is that the “*Conseil National de l’Ordre des Médecins*” is the competent authority in France, but the process of registration occurs not at a national level, but at a regional level (by each *département*), closer to the point of employment. In order to practise in France a doctor must be registered in his or her *département* with the “*conseil départemental de l’Ordre*” and it is at this level that the various checks (carried out in the UK by the GMC) on good standing and so on are undertaken. It is also at this level that language checks, on a case by case basis, are carried out.

Medical Act 1983

5. There is no explicit prohibition in the Medical Act 1983 (the Act), which prevents language testing. However, the Registrar is prevented from requiring such testing because under section 3 of the Act, a person is entitled to be included in the register of medical practitioners if they meet the requirements set out in that section. These requirements relate to the doctor’s primary qualifications, which may either be UK training & qualifications, or recognised European qualifications. Neither involves a requirement for the doctor to demonstrate knowledge of English.

6. The way Parliament has transposed the Directive into UK legislation is in line with the Commission’s own guidance and it is also informed by the history of policy in this area which dates back to 1979. At that time the GMC did have a statutory power to require EEA doctors to demonstrate language knowledge at the point of registration. However, in April 1979 the European Commission issued a reasoned opinion against the UK on the basis that our implementation was in breach of the mutual recognition regime.

7. In 1981, following discussion with the Commission about the infraction proceedings, the Government repealed the English language requirements which had been imposed as a condition of registration in the Medical Act 1956.

8. At the same time, fresh provisions relating to English language knowledge were introduced to NHS legislation in relation to the approval and listing of practitioners of medicine and dentistry to provide NHS primary care services (the precursor to the current Performers List arrangements).

9. This split between professional regulation under the Medical Act 1983 and local level approvals and employment within the NHS have been reviewed but continued in place since then, as the Medical Act 1983, which replaced the 1956 Act, and the National Health Service (Performers List) Regulations 2004, both demonstrate.

Possible future changes to the Directive

10. The Department of Health agrees with the GMC that the current requirements with regard to exchange of information between EEA competent authorities should be strengthened. This might potentially be achieved through amendment to the Directive.

11. Amendment to the Directive to enable checks on language by the UK competent authority at the point where initial registration occurs, as part of the recognition process, may also be desirable to provide the GMC with the maximum possible flexibility, whilst keeping within the principle of proportionality, to assure itself that doctors are fit to practise. This is something we would look at taking account of the existing protections available for NHS patients under the Performers’ List regime and guidance for others providing NHS care.

Department of Health

25 March 2010

⁴² SI 2004/585. These Regulations apply to England only.

Supplementary memorandum by the General Medical Council (OHS 03A)**THE USE OF OVERSEAS DOCTORS IN PROVIDING OUT-OF-HOURS SERVICES**

I would like to thank you and the Committee for the invitation to give evidence on 11 March and discuss important issues related to out of hours care. I would also like to take this opportunity to provide some additional information, which I have set out below.

INDEMNITY AND INSURANCE

I would like to clarify our response to Dr Howard Stoate on indemnity insurance (Question 76). In 2006, the Medical Act 1983 was amended to include a new section 44C which requires doctors to hold “adequate and appropriate” insurance or indemnity to get or maintain GMC registration. This provision has not yet been brought into force.

The Department of Health (England) has established a working group, chaired by the former GMC Chief Executive, Finlay Scott. The group will look at the feasibility and proportionality of making this legislative change, following feedback from a number of interested parties.

Currently, all GMC registered doctors have a professional duty, as set out in the GMC’s guidance *Good Medical Practice*, to hold adequate indemnity cover: “You must take out adequate insurance or professional indemnity cover for any part of your practice not covered by an employer’s indemnity scheme, in your patients’ interests as well as your own.” (Paragraph 34)

CORRESPONDENCE WITH GERMAN AUTHORITIES ON DR UBANI

Responding to Dr Taylor (Question 101), I said that I thought the GMC had written 22 times to the German authorities in relation to the Dr Ubani case and that we had received no response. I would like to clarify that we received no response to our questions or anxieties about Dr Ubani’s fitness to practise, but we did receive replies to acknowledge our correspondence and to confirm they were taking no action against him.

NON-UK GRADUATES AND GMC FITNESS TO PRACTISE STATISTICS

Dr Stoate asked why doctors who qualified outside the UK are disproportionately overrepresented in GMC cases (Question 84). It is very difficult to understand why the GMC receives more fitness to practise queries about non-UK qualified doctors but we continue to develop our methods for understanding the data we have about trends of inquiries coming to the GMC. I would like to add that we have commissioned independent research projects to understand better the unique challenges faced by this category of doctor when they start to practice in the UK.

Niall Dickson
Chief Executive

24 March 2010
