CHAPTER FIVE

Developments in the Arrangements for Monitoring General Practitioners since 1998

Introduction

5.1 In May 1997, a new Government came into office. These were difficult times for the NHS. Concerns about the high mortality rate among children undergoing complex heart surgery at the Bristol Royal Infirmary had become public knowledge by 1995. It was known too that senior staff at the hospital had been aware of problems for some time and had taken no action. Three doctors were charged by the General Medical Council (GMC) with serious professional misconduct (SPM). Hearings began in October 1997 and ended with all three being found guilty of SPM in June 1998.

5.2 In December 1996, Rodney Ledward, a consultant gynaecologist, whose lack of skill had caused injury to many of his patients over a period of 15 years or so, had been dismissed from the hospital at which he worked. His case came before the GMC in September 1998. He too was found guilty of SPM. There had been complaints and concerns about his conduct and competence over a long period, yet he had been allowed to continue in practice. Also in September 1998, Shipman was arrested and it soon became clear that he might well have killed a large number of his patients over many years.

5.3 These events, and other less high profile incidents, focussed public attention on the adequacy of the arrangements then in place for identifying and eliminating incompetent or aberrant clinical practice. Those arrangements had patently failed to protect the patients of Ledward and Shipman, and the children who had undergone surgery at Bristol. It was evident that change was urgently needed.

5.4 The subsequent years have been a period of great change for the medical profession and the NHS. In the field of general practice, there have been significant developments in the role of primary care organisations (PCOs). They have been given additional powers which should enable them to exercise a far greater degree of control than before over the general practitioners (GPs) on their lists. In addition, they have been developing ways to improve the quality of care and to deal with doctors who are not providing an acceptable standard of care. In this Chapter, I shall describe the developments that have occurred and consider how they are working in practice.

The Devolution of Power to the Primary Care Trusts

5.5 The publication of a White Paper, 'The New NHS', in December 1997 heralded a fundamental re-organisation of the NHS. There was to be a greater emphasis on quality of care. Clearly defined standards of care were to be produced, against which the performance of NHS organisations would be measured. Responsibility for meeting those standards was to be devolved locally, with doctors and nurses playing a key role in making decisions about the services to be provided in their areas.

5.6 GP fundholding had encouraged some GP practices to extend the range of their services and to develop different ways of commissioning services so as to benefit patients. In the

White Paper, the Government signalled its intention to do away with fundholding by individual GP practices. However, the intention was to build on, and develop further, the work which had already been started by local clinicians.

5.7 Practice-based fundholding was abolished by the Health Act 1999. In July 2001, in a publication entitled 'Shifting the Balance of Power within the NHS', the Government announced that responsibility for the management, development and integration of all primary care services (medical, dental, pharmaceutical and optical) in England was to pass from the health authorities (HAs) to a network of newly created primary care trusts (PCTs), covering the whole of the country.

5.8 From 1st April 2002, the 95 existing HAs were abolished and 28 new HAs were created in their place. The area covered by the former West Pennine Health Authority (WPHA) became part of the new Greater Manchester HA. Shortly afterwards, HAs were renamed strategic health authorities (SHAs).

5.9 Also in April 2002, 302 (now increased to 303) new PCTs were created. From that time, the PCTs have had responsibility for improving the health of the community in their areas and for commissioning secondary (i.e. hospital) care, as well as for the provision of primary care services. Meanwhile, the SHAs have been made responsible for creating a coherent strategic framework for the development of NHS services in their areas. They are also responsible for managing the performance of PCTs and NHS trusts against agreed business plans and a national set of priorities. In turn, SHAs account to the Secretary of State for Health (SoS) for the performance of the NHS in their areas.

Quality

5.10 I have already mentioned that the 1997 White Paper promised that greater emphasis would be placed in the future on quality of care. One manifestation of this new emphasis was to be a new statutory duty of quality.

The Duty of Quality

5.11 Section 18 of the Health Act 1999 imposed a duty upon every HA, PCT and NHS trust:

> **'... to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care which it provides to individuals'**.

The words 'health care' were defined by the Act (as amended) as:

> **'... services for or in connection with the prevention, diagnosis or treatment of illness and the environment in which such services are provided'**.

5.12 It was intended that the 'duty of quality' should have the effect of focussing the attention of PCTs on devising ways in which to monitor and improve the quality of care provided by GPs in their areas.

Clinical Governance

5.13 The means by which the duty of quality was to be discharged was 'clinical governance', a new concept which essentially involved the setting up of structures and systems designed to secure and improve the quality of care. It was to apply to all NHS bodies. I shall discuss the concept of clinical governance at greater length in Chapter 12.

5.14 As part of their clinical governance arrangements, PCTs continue to monitor GPs' prescribing and continue also to encourage and facilitate audit by GP practices. In addition, all GPs practising in the NHS are now required to participate in annual appraisals. These are organised by their PCTs and conducted in the main by fellow GPs, usually practising within the same PCT. I shall deal with the monitoring of prescribing, audit and appraisal, together with other steps that have been taken by PCTs to implement clinical governance, in Chapter 12.

Standards and Guidelines

5.15 Following the publication of the 1997 White Paper, there was for the first time an attempt to define national clinical standards, by means of National Service Frameworks (NSFs) and by the establishment, in 1999, of the National Institute for Clinical Excellence (NICE). NSFs were developed with the aim of identifying the essential ingredients of good clinical service provision for certain disease groups and patient populations (e.g. for cancer, mental health, coronary heart disease, etc.). The aim was to reduce unacceptable variations in care and standards of treatment across the country. The role of NICE was to develop evidence-based clinical guidelines for the care and treatment of patients with specific diseases or conditions, and to assess and evaluate new and existing medicines, treatment and interventional procedures by reference to cost and clinical effectiveness.

5.16 More recently, in February 2004, the Department of Health (DoH) published a Consultation Paper, 'Standards for Better Health', seeking views on a set of proposed core standards governing the quality of health care provided by all NHS bodies in England. The paper also set out proposed developmental standards designed to encourage a rise in the overall quality of health care in the long term. In July 2004, the DoH published its proposals in a document entitled 'National Standards, Local Action: Health and Social Care Standards and Planning'. This document is aimed primarily at those who have responsibility for planning and commissioning the delivery of services in the years 2005–2008. It sets out the standards that must be achieved immediately as 'core standards' and the 'developmental standards' which should be achieved during the coming years.

The Commission for Health Improvement

5.17 The Health Act 1999 also established the Commission for Health Improvement (CHI), a non-departmental public body, independent of the NHS. CHI assumed full powers in April 2000. It was given responsibility for reviewing and reporting on the clinical governance arrangements made by NHS trusts and PCTs. It was also given the task of monitoring arrangements for national services, including compliance with NSFs. CHI was abolished

by the Health and Social Care (Community Health and Standards) Act 2003 and, with effect from April 2004, its functions have been subsumed into those of its successor the Commission for Healthcare Audit and Inspection (now known as the Healthcare Commission). I shall describe the role of CHI and of the Healthcare Commission in Chapter 12.

Changes in the Arrangements for General Practice

5.18 In the past, GPs have usually practised as principals (i.e. with their own lists of patients) within group practices or single-handed. They have been independent contractors, providing general medical services (GMS) in accordance with a standard national contract. A new GMS Contract came into force in April 2004. There have, of course, always been GP non-principals, who have provided locum services on a full-time or a part-time basis. In addition, over recent years, many GPs have been employed (again on both a full-time and a part-time basis) by deputising services to provide care outside the usual GP surgery hours.

5.19 As a result of provisions contained in the National Health Service (Primary Care) Act 1997, it has become possible for GPs to work within a variety of more flexible arrangements. Now, a significant proportion – approximately 40% – of all GPs provide services under contracts for personal medical services (PMS). The advantage of PMS contracts is that they are individually negotiated and can be tailored to suit the GP practice concerned, as well as the needs of the PCT. It is open to a PCT (subject, of course, to negotiation with the practice) to insert terms into a PMS contract, setting quality standards and giving the PCT additional control over the way in which services are provided.

5.20 Many GPs who do not wish to take on the risks, responsibilities and/or commitment of partnership or single-handed practice are now employed by GP practices or by PCTs. The latter arrangement has advantages for a PCT, which is able to deploy a GP in its employment to practices or areas in need of an additional doctor on a temporary or long-term basis. PCTs have a greater degree of control over the activities and quality of practice of a directly employed doctor than they can exert upon a doctor providing GMS.

The Primary Care Trusts

Organisation

5.21 Each PCT is governed by a board, which has responsibility for the statutory functions of the PCT. It takes decisions on committing financial resources, on policy and strategy and on human resources issues. The board consists of the chairman of the PCT and between ten and fourteen members, not more than seven of whom may be officers of the PCT. The number of officer members of the board may never exceed the number of non-officer members. The non-officer members are lay people, in the sense that they are not practising healthcare professionals or employees of certain specified NHS bodies. The non-officer members are drawn from the locality and are appointed by the SoS, as advised by the NHS Appointments Commission. The officer members must include:

(a) the chief executive, the director of finance and the director of public health of the PCT

(b) the chairman of the professional executive committee (PEC) of the PCT: see paragraph 5.23. He or she is deemed to be an 'officer' of the PCT for these purposes

(c) between one and three persons (at least two of whom must be members of the PEC) appointed by the chairman of the PEC following nomination by the PEC. All such persons are deemed to be 'officers' of the PCT for these purposes.

5.22 At least one of the officer members in categories (b) or (c) must be a GP and one (from the same categories) must be a nurse. The officer members may include officers other than those specified at (a) above. The chairman must be a lay member of the board.

5.23 The PEC is responsible for driving the activities of the PCT. Sir Nigel Crisp, Permanent Secretary of the DoH and Chief Executive of the NHS in England, observed in his statement to the Inquiry that the PEC is the 'engine room' of the PCT. It is dominated by clinicians, the objective being that professionals providing services locally should play a real part in shaping policy and developing services for their area. The PEC sets policy for the implementation of the functions of the PCT and exercises a management function. It has between seven and eighteen members, including the chief executive and director of finance of the PCT. Membership of the PEC also includes local professionals (including at least one GP and one nurse, together with such other professional members as reflect the functions carried out by the PCT), one or two representatives from Social Services and one member with particular expertise in public health. GPs usually form the majority of the PEC and the chairman of the PEC is almost invariably a GP.

5.24 PCTs vary in size. An average-sized PCT will be responsible for about 100 GPs. That is significantly fewer than were covered by the former HAs. The size of the PCTs should mean that their staff are in a good position to acquire a real knowledge of the GPs and other professionals responsible for providing health care in their areas. However, the size of the PCTs also has its disadvantages. It is not practicable for an individual PCT to employ staff who possess all the specialist skills that it will at times require. Many do not have a medical director. This is, no doubt, one of the reasons why PCTs were given the power to join together in order to discharge some of their functions. Many PCTs are making use of this power and are developing ways of increasing the range of skills open to them by sharing services. The Inquiry heard from Dr Robert Queenborough, Medical Director, Trafford North and Trafford South PCTs. His PCTs share a single management team while retaining separate boards, PECs and finances. As time goes on, it may be that the pooling of resources between PCTs will become more widespread.

Operation

5.25 The functions of the PCTs are wide-ranging. Like their predecessors, they have responsibility, not only for the provision of primary medical services, but also for pharmaceutical, ophthalmic (now termed 'optical') and dental services. They also have responsibilities for such matters as the improvement of health in their community, the commissioning of secondary care, and co-ordination with other organisations to provide integrated health and social services. As I shall describe, their management powers in relation to their lists of GPs have now been extended considerably. This places additional responsibilities upon them. The PCTs must also act on concerns about doctors who are

providing an unacceptable standard of practice. A number of witnesses and participants at the Inquiry's seminars drew attention to the considerable determination and resources (both human and financial) required of a PCT when dealing with a doctor who is performing poorly or who is otherwise giving cause for concern. The administrative work associated with the new GMS Contract also represents a formidable challenge for PCTs. All these various functions and responsibilities place a heavy burden on what are, as I have said, small organisations. Not surprisingly, the evidence shows that their efforts to cope with the demands made upon them are meeting with variable degrees of success.

5.26 Another set of problems faced by PCTs arises as a result of their newness. The disbanding of the former HAs and the creation of the 303 new PCTs resulted in the dispersal of a large number of staff with considerable expertise in the field of primary care. In particular, many medical advisers, with an intimate knowledge of the doctors in their areas, have been lost. A number of witnesses have spoken of the loss of 'corporate knowledge' or 'corporate memory' in some areas. It will take time to accumulate that knowledge (or memory) once again. It is to be hoped that the present structures will be left in place long enough for the PCTs' members and staff to develop that knowledge and memory.

5.27 I have already observed that one of the perceived strengths of the new PCTs is that they are led by local professionals. While this has obvious benefits, there are also potential drawbacks. Most PEC chairmen (who are automatically on the board of the PCT) are local GPs. They may also be officers (e.g. secretary or chairman) of the local medical committee (LMC). PCTs are still obliged to consult with LMCs on a wide range of issues. It is easy to imagine circumstances (e.g. when a PCT is in discussions with a LMC about a controversial issue affecting the interests of local GPs) where a conflict of interest may arise. Even when no actual conflict exists, it may be difficult for the doctor concerned to adopt the objective approach that might be expected of a governing member of a public organisation. Mr William Greenwood, formerly Assistant Director of Primary Care at the WPHA, now Director in Chief, Manchester Shared Services Agency (employed by the Central Manchester PCT), mentioned potential tensions about budget management and priorities which might arise. The position becomes even more difficult when a complaint is made or a concern is expressed about the professional practice or conduct of a close professional colleague of a PEC member or chairman or, as has already happened in some areas, the member or chairman him/herself.

5.28 Dr Queenborough said that there was a degree of confusion about the role of the PECs and, in particular, about the accountability of individual members of PECs. He would like to see members of the PEC independent of the LMC. However, he said that, in his area, there were just not enough GPs prepared to take an active role in local medical affairs to make that possible. Mrs Chris Page, Head of Service Redesign, Bebington and West Wirral PCT, told the Inquiry that her PCT had come to an agreement with the LMC that any officer of the LMC who was appointed to the PEC would stand down from his/her position on the LMC. Dr John Chisholm, Chairman of the General Practitioners Committee of the British Medical Association, said that similar agreements had been reached in only a minority of PCTs. He did not support such a division of roles. It was his view that any potential conflict of interest could be managed. He, like Dr Queenborough, was conscious that there was only a small number of doctors willing to take on an active role and to work

on behalf of PCTs. Also, he believed that an overlap of membership between the two organisations could be positively advantageous. He did not, however, regard it as 'ideal' for the chairman of a PEC to be an officer of the LMC.

5.29 Despite the strong professional presence on PCTs, the PCTs do not always enjoy a good relationship with local GPs. Professor Martin Roland, Director, National Primary Care Research and Development Centre and Professor of General Practice, University of Manchester, himself a practising GP, told the Inquiry that it would be wrong to assume that GPs, as a body, regarded PCTs in a positive light as friendly, helpful and supportive towards the profession. On the contrary, some view their PCTs very negatively. Dr Michael Taylor, Chairman of the Small Practices Association, said that the perception of single-handed practices tended to be that PCTs were hostile, rather than supportive, towards them. There is no doubt a good deal of concern and suspicion about how the PCTs will choose to exercise their recently acquired powers to manage their lists. There is also a continuing tension between independent contractor GPs and the PCTs who are seeking to 'manage' them.

The Ability of Primary Care Trusts to Manage Their Lists

5.30 PCTs do not, in general, employ GPs. They do not, therefore, have the usual power of an employer to 'hire and fire'. In the past, they had little say over who was admitted to their lists and no power to remove a doctor who was performing unsatisfactorily. This has now changed.

The Lists

The Medical List

5.31 In Chapter 3, I explained that PCOs were required to maintain a medical list of doctors in their areas who had undertaken to perform GMS. The medical list related to GP principals only. There was no requirement for non-principals, or those providing medical services under PMS contracts, to be included on a PCO's list. In practice, some PCOs maintained lists of non-principals. They did this as a service to GP practices, which were seeking to employ locums or deputies. This was an informal, local arrangement. If no list of non-principals was kept, PCOs had little idea of who was practising in their areas. This remained the position until comparatively recently.

The Medical Supplementary List

5.32 From June 2002, all GP non-principals (except those working under PMS contracts) were required to be included on the medical supplementary list of a PCT. The term 'non-principals' covers locums, deputies, associates, retainers and GP registrars (i.e. trainees). Some non-principals (e.g. locums) may operate in an area covered by several different PCTs. They are required to be on the list of only one of the PCTs in whose area they work. A non-principal must maintain a connection with the area of the PCT on whose list s/he appears. If s/he does not, the PCT is entitled to remove him/her from its list.

5.33 As from April 2002, GP principals were prohibited from engaging as a deputy or employing any doctor (save for a doctor performing PMS) who was not included on (or the subject of an outstanding application for inclusion on) a medical supplementary or medical list. The requirement for non-principals to be on the PCT's list is now covered by the new GMS Contract. DoH guidance makes it clear that any person employing or engaging a non-principal who is included on a PCT's list bears responsibility for satisfying him/herself that the non-principal has the necessary clinical skills and experience to undertake the tasks s/he is recruited to perform. The non-principals must provide clinical references, which should be checked. Inclusion on the PCT's list is no warranty. Once again, this is covered by the new GMS Contract.

5.34 From the time of the introduction of supplementary lists, PCTs have had the same powers relating to admission to and suspension or removal from the supplementary list as for the medical list.

The Services List

5.35 Until recently, doctors performing PMS were not, in general, included on a PCT list. Some might be on the medical supplementary list. However, as from February 2004, all doctors performing PMS (other than those already included on a supplementary list) were required to be on a PCT services list. Applicants had to produce satisfactory evidence of their intention to provide PMS in the area of the relevant PCT.

The Medical Performers List

5.36 Since April 2004, a new medical performers list has replaced the three types of list described above. All GPs performing medical services, whether under GMS or PMS contracts, must appear on the list. The Health and Social Care (Community Health and Standards) Act 2003 provides for regulations to be made in the future prohibiting certain healthcare professionals (e.g. practice nurses) from working in a GP practice unless they are on a PCT list. If such regulations are made, and lists of nurses and other healthcare professionals are created, this will enable PCTs to apply the same rules for inclusion and continuance on the list to other healthcare professionals as are currently applicable to GPs.

Admission to a List

5.37 I have described in Chapter 3 the procedure, as it was in 1977, for the appointment of a replacement member of an existing GP practice and the very limited part played in the process by the PCO (then the family practitioner committee (FPC)). I explained also that the FPC played a greater role in the selection and appointment of a doctor to fill a single-handed practice vacancy or where a vacancy arose for an additional GP in its area.

5.38 Between 1977 and 1998, there were changes to the arrangements for dealing with applications for inclusion on the medical list and to fill vacancies. It is not necessary for me to enumerate the various changes in detail. In essence, however, the powers of the PCO remained much the same. There was still no requirement for applicants for inclusion on the list to provide information about previous disciplinary proceedings or criminal convictions.

The Introduction of Statutory Criteria

5.39 In December 1998, the National Health Service (General Medical Services) Amendment (No. 2) Regulations 1998 made significant changes to the arrangements. Again, there is no need for me to describe these in detail. However, an important development was that the Regulations introduced statutory criteria to be applied by PCOs (then the HAs) when deciding whether to approve for inclusion on their lists a candidate who had been selected by an existing practice and when itself selecting a candidate to fill a vacancy. The Regulations also gave HAs power to determine (within certain limits) their own criteria, against which applicants would be judged. This power gave HAs more flexibility in planning for the future. For example, they could require that applicants for a vacancy should have specific language skills or a particular expertise in caring for children. Despite these changes, the power of a HA to influence a practice in its selection of a replacement doctor remained limited. DoH guidance at the time stated that, if the selected candidate did not meet the criteria set out by the HA, the HA should have discussions with the practice with a view to reaching an **'acceptable compromise'**. If no agreement could be reached, the HA should consider whether to appoint the practice's selected candidate or to decline to do so and require the practice to select another candidate. The guidance warned:

> **'Refusal to appoint a doctor in these circumstances should be an exception and HAs will need to have strong reasons for doing so.'**

5.40 This guidance was not likely to encourage HAs to raise opposition to a candidate selected by a practice. Moreover, there was still no requirement for applicants to declare – or HAs to seek – information about previous disciplinary proceedings or criminal convictions.

Declarations by Applicants

5.41 That changed on 4th February 2000, four days after Shipman's conviction for murder. The National Health Service (General Medical Services) Regulations 1992 (the 1992 Regulations) were amended to require applicants to declare whether they had been convicted of any criminal offence or had been bound over or cautioned and whether they were or had been the subject of any disciplinary proceedings by their professional or regulatory body, in the UK or elsewhere. HAs were given the power to reject an application if, having considered the content of his/her declaration, they regarded the applicant as unsuitable for inclusion on their medical list.

The Abolition of the Medical Practices Committee

5.42 The Health and Social Care Act 2001 abolished the Medical Practices Committee (MPC). From that time, PCOs were given the power to decide whether there was a need for a replacement or additional GP in their area.

Pre-Admission Checks

5.43 The National Health Service (General Medical Services) Amendment (No. 4) Regulations 2001 (the 2001 Amendment Regulations) made it obligatory for a PCO (then the HA) to

carry out certain checks before admitting a doctor to its list. HAs were required to check, as far as practicable:

- the references provided by the applicant
- the information given by the applicant relating to his/her medical qualifications and his/her registration
- the contents of his/her declaration about any past criminal or disciplinary record. This declaration was now required to be significantly fuller than previously: see paragraph 5.60
- whether there was any past or ongoing fraud investigation involving the doctor.

5.44 The HA was also required to take up and consider two references.

5.45 These checks are now carried out by PCTs. At present, there is no requirement that a PCT should carry out checks with the Criminal Records Bureau (CRB) before taking a decision as to whether to admit a doctor to its list. The DoH has left this to the discretion of individual PCTs. Dr Anne Rothery, Medical Director of the Tameside and Glossop PCT, told the Inquiry that her PCT chooses to make such checks. It is a time-consuming operation, taking about half a day for each check. The CRB has, of course, been under considerable pressure since it was established and there have been long delays in completing checks. Since April 2004, all GPs applying to join a PCT's list have been required to provide an enhanced criminal record certificate as part of their application. This should provide information about unproven allegations, criminal charges which were not proceeded with and acquittals. However, the extent of the information contained on the record is dependent upon the applicant giving all relevant addresses and his/her correct names.

5.46 The Family Health Services Appeal Authority (Special Health Authority) (FHSAA (SHA)) (formerly known as the Family Health Services Appeal Authority) is the body which used to hear appeals from the former medical service committees and, after that, the medical disciplinary committees. It maintains, on behalf of the SoS, a record of doctors who have been refused admission or conditionally admitted to, or suspended, removed or contingently removed from, the list of a PCT. The completeness of the information held by the FHSAA (SHA) is entirely dependent upon PCTs notifying it of relevant decisions. Although PCTs are required to do this, it does not always happen. Since November 2003, it has been mandatory for PCTs to make a check with the FHSAA (SHA) before admitting a doctor to their lists. The Government has recently announced its intention to abolish the FHSAA (SHA) and to transfer its functions to the NHS Litigation Authority.

5.47 Dr Sarah Wilson, Director of Public Health and Medical Director, Trent SHA, said at the Inquiry's seminars that the checks which PCTs are required to carry out involve 'a real chase-round'. Their completeness depends on people knowing what checks are to be made and with whom. The clerical staff who carry out the checks do not always have this knowledge. The suggestion was raised during the Inquiry hearings that it might be possible to simplify the process and Sir Nigel Crisp said that the suggestion would be considered.

Non-principals

5.48 Non-principals are required to make the same declarations on their applications to join a PCT's list and have the same ongoing duty to declare criminal and disciplinary proceedings. PCTs are responsible for making checks on their qualifications etc., on an application to join the list. DoH guidance refers to the impracticability of making detailed enquiries about a non-principal's employment history and suggests that attention should be concentrated on any significant breaks in the career history.

Personal Medical Services Providers

5.49 Until the introduction of the new services lists, PCTs did not receive declarations from many doctors working under PMS contracts about criminal or disciplinary proceedings in which they had been involved. Nor could PCTs take action to remove or suspend a doctor performing PMS, a *lacuna* which could cause considerable difficulty. Such action was possible only if appropriate provisions were contained in the local PMS contract. Since February 2004, doctors providing PMS have been obliged to make the same declarations, and are subject to the same sanctions of removal and suspension from the list, as GMS providers.

Refusal to Admit

5.50 The 2001 Amendment Regulations also extended the grounds on which a HA could refuse to admit a doctor to its list. Previously, these had been very limited. A HA had been required to refuse entry to its list if the applicant lacked suitable experience, did not speak the English language sufficiently well, was 70 or over or had been disqualified by the NHS Tribunal. In addition, HAs had discretion to refuse admission to a doctor who had had conditions imposed on his/her registration by the GMC or who did not fulfil the criteria for the post. HAs could also refuse admission if they considered that, in the light of his/her declaration about past or ongoing criminal or disciplinary proceedings, a doctor was unsuitable: see paragraph 5.41

5.51 The 2001 Amendment Regulations made it mandatory for a HA to refuse to admit a doctor to its list in certain circumstances, the most important of which were:

- where s/he had been convicted in the UK of murder
- where s/he had (after 13th December 2001) been convicted of a criminal offence and sentenced to a term of imprisonment of over six months
- where s/he was the subject of a national disqualification by the Family Health Services Appeal Authority (FHSAA) in England or a comparable body elsewhere in the UK: see paragraph 5.54.

5.52 In addition, HAs were given discretionary powers to refuse entry to their lists if:

(a) they considered that the doctor was unsuitable for inclusion on the list by reason not only of the contents of his/her declaration about past or ongoing criminal and disciplinary proceedings but also by reason of any other information in the

possession of the HA, or by reason of the results of the checks made on his/her qualifications and/or registration

(b) having contacted referees, they were not satisfied with the doctor's references

(c) the facts relating to past or current fraud investigations by the NHS Counter Fraud Service (now the NHS Counter Fraud and Security Management Service) and any fraud case involving or relating to the doctor justified it

(d) they had grounds for considering that admitting the doctor to the list would be prejudicial to the efficiency of the service that s/he would undertake.

Statutory criteria, to be taken into account before reaching a decision on these issues, were set out. HAs were given the power to defer a decision in certain circumstances or to impose conditions on a doctor's inclusion on the list.

5.53 These powers are now exercised by the PCTs, which are required to notify to the FHSAA (SHA) all decisions to refuse admission or conditionally admit a doctor to their list.

The Family Health Services Appeal Authority

5.54 In December 2001, the NHS Tribunal was abolished and the FHSAA was created. Despite the similarity of name, the FHSAA is a different body from the FHSAA (SHA) (formerly the FHSAA), to which I referred at paragraph 5.46. The FHSAA is an independent tribunal, whose President and members are appointed by the Lord Chancellor. Appeals against the refusal of a PCT to admit a doctor to its list (save when the refusal was on mandatory grounds) are determined by the FHSAA. PCTs which refuse a doctor admission to their lists are advised to consider approaching the FHSAA, with a view to the FHSAA imposing a national disqualification on the doctor. In the past, a national disqualification did not necessarily mean that a doctor was disqualified from inclusion on all PCT lists. It was possible, for example, for the FHSAA to disqualify a doctor from all supplementary lists, but not other lists. In practice, this was rarely (if ever) done. Since the introduction of the medical performers list, the position has changed and any national disqualification (whether imposed before or after April 2004) applies to all medical performers lists.

The Effect of the Changes

5.55 The changes which I have described have enabled the PCOs (now the PCTs) to exercise real control over who is and who is not admitted to their lists. It is now the PCT (not the MPC) which determines whether there is a need for a new doctor or practice in its area. It is the PCT (after consultation with the LMC and any practice involved) which sets the criteria by which applicants for a vacancy are to be judged. These new powers have enabled some PCTs to develop a strategy for recruitment, tailored to the needs of their population and of GP applicants. This can be of particular assistance in deprived areas where recruitment is difficult.

5.56 The new system of declarations by applicants, and the requirement for PCTs to carry out more comprehensive checks on the information provided by applicants, should mean that PCTs are much better informed about any adverse past history of doctors applying for

inclusion on their lists. If a PCT decides to admit to its list a doctor with a criminal or disciplinary record, it can do so conditionally, and can design suitable conditions to be imposed on the doctor for the protection of patients. Where appropriate, it can refuse admission. Had Shipman's application to join the list in Tameside been made now, with these new provisions in place, the PCT would have been fully aware from the first about his criminal convictions. It could have enquired into the circumstances of them and into his progress since leaving Todmorden. It could have made its own decision as to whether it thought it appropriate to admit him to its list. If the PCT had decided to do so, it could have made special arrangements to monitor his prescribing. It could have advised the local police chemist inspection officer to scrutinise with care any relevant entries in pharmacists' controlled drugs registers. Above all, from the very start, it would have known far more about the person with whom it was dealing.

5.57 I described in Chapter 4 how, in 1992, Shipman was able to move easily to single-handed practice. He was already on the medical list, so few formalities were required. If the HA had been wholly opposed to the move, it could have refused the necessary funding. However, it might have had inadequate information about the doctor concerned (in this case, Shipman) on which to base an informed decision. Now, however, it would be open to the PCT to give careful consideration to the need for, and the desirability of, the formation of an additional single-handed practice and to the suitability of the applicant doctor. If the PCT was aware that the doctor concerned had a criminal and/or disciplinary record like Shipman's, it might be unwilling to enter into a contract with him as a single-handed practitioner. It would not be open to him, under the provisions of the new GMS Contract, to take with him his list of patients as Shipman did from the Donneybrook practice. It seems doubtful whether, if the present arrangements had been in place in 1992, Shipman's move to the Market Street Surgery would have taken place.

Doctors Already Included on a Primary Care Trust's List

5.58 The new provisions governing declarations by applicants for inclusion on PCOs' lists about any past criminal or disciplinary proceedings did not, of course, cover doctors who were already on the lists. It was evident that there might be doctors who, like Shipman, had criminal convictions or disciplinary findings against them of which the PCO was unaware. Therefore, the 2001 Amendment Regulations also contained a 'catch-up provision', requiring every doctor on a medical list to supply to the relevant HA by 31st March 2002 written information as to whether s/he:

(a) had any criminal convictions in the UK

(b) had been bound over following a criminal conviction in the UK

(c) had accepted a police caution in the UK

(d) had been convicted elsewhere of an offence, or what would have constituted a criminal offence if committed in England and Wales, or was subject to a penalty which would be the equivalent of being bound over or cautioned

(e) was currently the subject of any proceedings which might lead to such a conviction, and which had not yet been notified to the HA

(f) had been the subject of any investigation into his/her professional conduct by any licensing, regulatory or other body anywhere in the world, the outcome of which was adverse

(g) was currently the subject of any investigation into his/her professional conduct by any licensing, regulatory or other body anywhere in the world

(h) was, to his/her knowledge, or had been where the outcome was adverse, the subject of any investigation by the NHS Counter Fraud Service in relation to any fraud case

(i) was the subject of any investigation by another HA, or equivalent body, which might lead to his/her removal from any of that HA's lists, or any equivalent lists

(j) was, or had been where the outcome was adverse, subjected to an investigation into his/her professional conduct in respect of any current or previous employment

(k) had been removed from, contingently removed from, refused admission to, or conditionally included in any list or equivalent list kept by another HA, or equivalent body, or was currently suspended from such a list.

5.59 It will be appreciated that this declaration was more comprehensive than that which had been required since February 2000 to be made by applicants for inclusion on a list. In particular, it included action taken by a previous employer or PCO. At the same time, the declarations to be made before admission to the list were extended. If any of the above circumstances were declared, the applicant had to give details of the relevant investigation or proceedings. Doctors already on the medical list and new applicants to the list were required to give similar details in respect of any body corporate of which they were directors. The 2001 Amendment Regulations also required doctors to consent to the HA seeking information from third parties about any investigations into their conduct where the outcome had been adverse.

5.60 In addition, the 2001 Amendment Regulations imposed an ongoing requirement on doctors to inform the HA within seven days of a conviction, caution or binding over, or of the start of any proceedings or investigations of the type specified in paragraph 5.58(e)–(j) and any action by a HA of the type specified at paragraph 5.58(k).

5.61 Such declarations are now made to PCTs. There is to be a 'catch-up exercise', requiring all GPs already on a PCT's list to provide an enhanced criminal record certificate, unless one has already been provided. PCTs will require all GPs on their lists to apply to the CRB by 1st February 2005. Any GP who fails to comply with the requirement will be removed from the PCT's list. However, as it is expected that there may be some delay in processing the large number of applications, PCTs may allow an extension of time. At present, PCTs may require a GP to provide such a certificate if they have reason to believe that his/her declaration was not complete, but it is not a general requirement.

5.62 As from November 2003, GPs were required by their terms of service to report to the PCT any death occurring on their surgery premises. This duty is now placed on practices entering into the new GMS Contract. Since March 2004, GP practices have been required to keep registers of gifts with a value in excess of £100 given to members of the practice and doctors and other persons employed in the practice, together with their spouses or

partners, by patients, patients' families and business associates or potential business associates. Both these provisions were plainly designed with Shipman in mind.

Removal, Suspension and Contingent Removal from a List

5.63 I have already mentioned in Chapter 3 that, in 1977, the powers of a FPC to remove a GP from its list were very limited. That remained the position until 4th February 2000 when the 1992 Regulations were amended to make it mandatory for a PCO (then the HA) to remove from its list a doctor who had been convicted in the UK of murder, or had been convicted of a criminal offence and sentenced to a term of imprisonment of at least six months. This latter provision was later changed to a period of more than six months. In his supplementary statement to the Inquiry, Sir Nigel Crisp said that the original intention had been to limit mandatory removal from the list to those cases in which a sentence was passed exceeding the maximum sentence for an individual offence which could be imposed by a Magistrates' Court, i.e. to reflect the view taken by the judicial system of the seriousness of a particular offence. These provisions for mandatory removal were similar to those referred to in paragraph 5.51, governing the admission of doctors to the list.

5.64 The Health and Social Care Act 2001 conferred powers (and, in some circumstances, an obligation) upon HAs to remove a doctor from their list on the grounds that:

- the doctor's continued presence on the list would be prejudicial to the efficiency of the medical services which doctors on the list undertook to provide (an 'efficiency case')
- the doctor had been involved in an incident of fraud or attempted fraud (a 'fraud case')
- the doctor was unsuitable to remain on the list (an 'unsuitability case').

5.65 In an efficiency case or a fraud case (but not an unsuitability case), HAs were also given power to impose conditions on a doctor's continued inclusion on the list. If the conditions were subsequently breached, the doctor could be removed from the list. Thus, the imposition of conditions was termed 'contingent removal'. Conditions could be subject to a review. HAs were also given power to suspend doctors in certain limited circumstances, namely when it was necessary to do so for the protection of members of the public or was otherwise in the public interest.

5.66 A decision to remove a doctor from the list, or to impose conditions on his/her continued inclusion on the list, might be taken for a number of reasons. Those reasons might relate to prejudice to efficiency arising from the doctor's poor performance. They might relate to financial dishonesty or addiction to drink or drugs. A PCO might also decide to remove a doctor from its list by reason of information about a recent involvement in criminal or disciplinary proceedings which had been disclosed pursuant to the provisions described at paragraph 5.58. The 2001 Amendment Regulations set out criteria to be applied when removal was being considered on the grounds of unsuitability, fraud or prejudice to efficiency. One of the criteria to be applied in all cases is **'the likely risk to patients'** posed by the doctor's past conduct.

5.67 Appeal against a removal from a list went to the FHSAA. HAs were advised, if they took a decision to remove a doctor from their list, to consider approaching the FHSAA with a view to the imposition of a national disqualification. A provision was introduced whereby a doctor could not, except with the consent of the SoS, have his/her name removed from a medical list until any action by the HA on whose list his/her name appeared had been determined. This was to prevent a doctor from evading action by a HA by voluntarily removing his/her name from its list.

5.68 These powers have now devolved to the PCTs. They are now required to report to the FHSAA (SHA) (soon, the NHS Litigation Authority) decisions to remove, suspend or contingently remove a doctor from their lists.

The Effect of the Changes

5.69 The new powers available to control their lists represented a considerable advance in the ability of the PCOs (now the PCTs) to deal with problem doctors. No longer do they have to rely on other bodies (in particular, the GMC) to take action. If the protection of patients requires it, they can take urgent steps to suspend a doctor. If the problem is less acute, they can place conditions on his/her continued inclusion on the list, so as to secure patient safety and ensure the efficient delivery of services. Mr Greenwood said that the new provisions had 'transformed the system'. They had equipped PCTs with new powers and new sources of information. He believed these were essential if PCTs were to increase their ability to monitor GPs in the future.

5.70 Use of these new powers can, however, lead to the loss or restriction of a doctor's livelihood, and can damage his/her professional and personal reputation. They must be used responsibly and any action taken by a PCT must be based on sound and reliable evidence obtained in the course of a thorough and objective investigation. Otherwise, injustice may be done and decisions taken under the powers will be constantly subject to appeal and to challenge in the courts. That said, it is vital that PCTs develop the confidence and the skills to use the new powers when the situation demands it.

5.71 DoH figures show that, between 14th December 2001 (when GP list management was first introduced) and March 2003, PCTs reported to the FHSAA (SHA) 37 suspensions and nine removals from their lists, together with 16 contingent removals. Three of these removals followed the conviction of the GP concerned for criminal offences. No reasons for the action taken were available in the other cases. In addition, PCTs reported that they had refused 33 doctors inclusion on their lists and imposed conditions on inclusion in 49 cases. One refusal related to the fact that the doctor concerned had served a sentence of imprisonment. Other than in that case, no information is available about the circumstances giving rise to the refusals or the imposition of conditions.

5.72 Between 1st April 2003 and 31st March 2004, a further 22 suspensions were notified to the FHSAA (SHA). Including those extant from previous periods, there were 25 suspensions still in force as at 31st March 2004. In addition, there had been 25 removals from PCT lists and two contingent removals. Doctors had been refused admission to a PCT list on 21 occasions and had been included conditionally in 28 cases. There had been five successful appeals against PCT action and a further seven appeals remained

outstanding. No information is available to the Inquiry about the reasons for the actions taken by PCTs during the year to 31st March 2004. PCTs are not required to notify this level of detail to the FHSAA (SHA). It seems to me unfortunate that this information is not collected and analysed. It would assist in providing guidance to PCTs about the sorts of circumstances in which they should exercise their management powers. It would also enable evaluations to be carried out to discover whether PCTs are making adequate and appropriate use of their new powers. As of 31st March 2004, there were nine national disqualifications in force.

5.73 Unverified figures supplied by the FHSAA(SHA) for the six-month period to 30th September 2004 reveal that there were a further 27 suspensions during that period with 46 suspensions extant on 30th September.

Gaps Remaining in the Information Available to the Primary Care Trusts

5.74 There are still significant gaps in the information available to a PCT about GPs applying to, or already included on, its list. In particular, a PCT will not usually be aware of:

- complaints (even complaints of a serious nature) made by patients or others about a GP while s/he was on the list of another PCT or in employment elsewhere in the NHS or in the private sector. A PCT would be aware of such complaints only if they had been determined and had resulted in list management action by the PCT, or disciplinary action by the GMC or an employer. For example, an applicant GP who had been the subject of a series of unproven complaints of indecently assaulting patients would not have to declare that fact. The only circumstances in which the PCT might learn of his/her history would be if it were told informally, or if the police had investigated and a CRB check revealed that information.
- concerns about the doctor's performance expressed by colleagues, healthcare professionals or others. A PCT would be aware of such concerns only if they had resulted in list management action by another PCT, or disciplinary action by the GMC or an employer.
- under the GMC's 'old' fitness to practise procedures complaints made to the GMC about the doctor, unless the GMC took a decision to proceed with the complaint beyond the screening stage. Since August 2000, the GMC has been required to inform employers and PCOs about such complaints once that decision has been taken; that decision may be taken some time after the complaint is received by the GMC. If the complaint is not pursued, no notification will be given. The arrangements under the 'new' procedures should result in earlier notification of allegations made to the GMC. In addition, since May 2004, the GMC has adopted the practice of having early discussions with a doctor's PCO in some cases. Thus, the gap here is now not as great as it was.
- the past or ongoing involvement of the doctor in clinical negligence proceedings, whatever the outcome.
- complaints made to the GP's practice. Until April 2004, a practice was obliged only to inform a PCT of the numbers of complaints made. Under the draft Complaints

Regulations to be implemented shortly (see Chapter 7), there will be an obligation to inform the PCT of the subject matter of complaints. However, the PCT will not see the complaint itself and is reliant upon the honesty of practices in reporting complaints to it.

5.75 These gaps mean that PCTs may be unaware of information about GPs which is highly relevant to the protection of patients. If PCTs are to comply with their duty of quality and provide safe and effective local medical services, it is imperative that they be placed in possession of all available information about the GPs on their lists. In future, if and when PCTs are required to participate in the process of revalidation, by signing a certificate warranting that there are no unresolved significant concerns about the doctor, it may become even more important for PCTs to have full information about the GPs on their list. I shall describe the proposals for revalidation in Chapter 26.

Dealing with Poor Performance

The Development of Local Performance Procedures

5.76 I mentioned in Chapter 4 the introduction, in July 1997, of the GMC's performance procedures and the power which the GMC then acquired to suspend or impose conditions upon the registration of a doctor whose professional performance was found to be seriously deficient. The GMC would take action only in respect of those doctors whose performance was so seriously deficient as to call into question the doctor's registration. This was a very high threshold. It was recognised from the first that there would be doctors performing at an unacceptable standard who would not reach the GMC threshold but who nevertheless represented a real risk to patients. Local procedures had to be developed, therefore, to enable PCOs (then the HAs) to deal with such doctors.

5.77 In addition, the GMC would invoke its performance procedures only in respect of performance after 1st July 1997. Evidence of performance before that date, however unacceptable, could not be relied upon. The effect of this provision was that HAs were unable to refer to the GMC those GPs whose performance had been causing problems for years. Instead, they had to wait until sufficient post-July 1997 evidence could be accumulated. In the meantime, they were left to deal with poor standards of care by means of their own local procedures.

5.78 In 1997, the DoH commissioned the School of Health and Related Research at Sheffield University (ScHARR) to formulate guidance to assist HAs in developing arrangements for supporting GPs whose performance was giving cause for concern. The ScHARR guidance was published in September 1997. It was directed primarily at assisting HAs in tackling performance which was giving rise to some concerns, but not to concerns of such magnitude that a referral to the GMC was obviously appropriate. Unlike the GMC procedures, the guidance covered concerns about the performance of GP practices, as well as about that of individual GPs. The guidance recognised that there would be a few GPs whose performance was so poor that referral to the GMC would be necessary. However, it stressed that a HA making a referral to the GMC would have to demonstrate that it had first done all in its power to improve performance through the giving of appropriate support.

5.79 The ScHARR guidance gave advice about how, once a GP had been identified as under-performing, a HA could best support and assist him/her to raise his/her standard of performance to an acceptable level. The guidance emphasised, *inter alia*, the need:

- properly to diagnose the underlying problems which were causing the GP to perform poorly, and to address them
- to consider a wide range of possible interventions. These might include remedial or additional education and/or training, mentoring, measures to improve practice infrastructure (e.g. the provision of additional support staff, staff training or improved facilities), together with measures to address any health problems the doctor might have.
- to set up a clear management process, led by a senior manager, for responding to concerns about possible under-performance and for co-ordinating the response to those concerns, together with any necessary intervention or other action.

5.80 With the assistance of the ScHARR, pilot procedures for identifying and managing poor performance among GPs were developed and tested at six sites in the North West of England. One of these pilots was established by what was then the Manchester HA. A 'performance panel' was set up, comprising representatives from the HA, the LMC, the local community health councils and the local postgraduate education department. The panel considered cases where the HA had received expressions of concern about a GP from a minimum of three sources. The panel defined a 'concern' as a statement made by or on behalf of a patient, or by a professional, which suggested that a doctor's performance might fall below acceptable standards. Concerns might also come from HA staff as a result of information which was in their possession. The panel would then consider the concerns alongside background information about the doctor held by the HA. It would decide whether the evidence satisfied its criteria for poor performance. If the criteria were satisfied, two members of the panel would visit the GP by prior arrangement to discuss the concerns. The visiting team would then report back to the panel and a decision would be taken as to what, if any, action was necessary.

5.81 Action, if taken, would usually involve the preparation of a 'contract', incorporating a practice development plan and a timetable for implementation. The HA would arrange and fund a trained GP mentor to give support to the doctor if s/he wanted it. The HA might also provide administrative support and assistance if this were required. If a serious deficiency were identified, if the doctor failed to co-operate or if no improvement were effected, the doctor would be referred to the GMC.

5.82 From 1998, in the wake of the pilot projects, HAs began to set up similar arrangements. They approached their task in different ways. For example, some HAs responded (like the Manchester panel) to concerns brought to them by third parties. Others sought to identify doctors who might be performing poorly from the data routinely available to them. Not surprisingly, HAs experienced problems in investigating and assessing concerns about poor performance and in devising and implementing remedial measures once poor performance had been identified. This was new territory for the PCOs and there was uncertainty about how to operate the new procedures.

The National Clinical Assessment Authority

5.83 These problems were addressed in a Consultation Paper, 'Supporting doctors, protecting patients', published by the DoH in 1999. The paper proposed the establishment of a number of assessment and support centres, run jointly by the NHS and the profession. The centres would provide advice to NHS bodies on handling concerns about doctors (both hospital doctors and GPs), would carry out assessments with a view to identifying the nature and seriousness of any problem and would make recommendations for action. It would then be for the local employer (or the HA, in the case of a GP) to implement the recommendations and to provide any support and take any remedial action required. It was hoped that the development of assessment and support centres would allow specialist expertise to be developed and would replace the need for individual NHS bodies to carry out their own assessments of performance. In the past, these local assessments (mainly performed by NHS trusts) had proved very variable in quality.

5.84 The National Clinical Assessment Authority (NCAA) was set up in April 2001. Its form was different in some respects from the model described in 'Supporting doctors, protecting patients'. In particular, the proposal for local centres (which had been opposed by the profession on the grounds that they would resemble 'boot camps') was dropped. Instead, there was to be an administrative centre in London (there is now also one in Wales), with personnel located around the country. The NCAA is at present a special health authority, covering England and Wales, but not Scotland or (currently at least) Northern Ireland. It now deals with dental, as well as medical, practice in the NHS and in the prison and defence medical services. It does not cover the private sector. Under new arrangements, announced by the Government in the summer of 2004, the NCAA is to be subsumed into the National Patient Safety Agency, of which it will be a separate division.

5.85 Although its form was not as planned, the purpose of the NCAA remained similar to that originally envisaged. It was to provide a performance assessment and support service to assist NHS employers and HAs in resolving problems of poor performance. It receives referrals from a variety of sources, mainly NHS trusts and PCTs. As at the end of September 2004, the NCAA had received 1438 referrals. Since 2001, many PCOs have sought the advice of the NCAA. That advice is provided by a team of advisers. The advisers are senior clinicians or managers, located around the country, each covering certain SHA areas. The advisers liaise directly with the PCO and advise on the management of individual cases. If local resolution of the concerns cannot be achieved, the NCAA may agree to undertake an assessment of the doctor's performance. The decision whether or not to undertake such an assessment is for the NCAA to make. A PCO cannot compel the NCAA to intervene. From December 2001, GPs' terms of service were amended to impose a duty on a doctor to co-operate with an assessment by the NCAA when requested to do so by his/her PCO (now the PCT). Under the National Health Service (General Medical Services Contracts) Regulations 2004 (the 2004 Regulations), it is the duty of a practice entering into a GMS Contract to ensure that a doctor working in the practice co-operates with an assessment by the NCAA when requested to do so by the PCT.

5.86 The NCAA assessment is formative (i.e. educational), not summative (i.e. 'pass or fail'). Assessments are directed at ascertaining whether the doctor is 'fit for purpose', i.e. fit for

work in the setting in which s/he is currently working. If a doctor is not 'fit for purpose', s/he may nevertheless be competent to work in a different setting. The problem may, for example, be that s/he does not fit into the team at his/her place of work. Professor Alastair Scotland, Chief Executive and Medical Director of the NCAA, emphasised that 'fitness for purpose' is a very different concept from that of 'fitness to practise', i.e. fitness to practise as a doctor in any setting. Performance assessments carried out by the GMC are directed at fitness to practise, not fitness to practise in a specific setting. NCAA assessments are carried out by trained medical and lay assessors. The Inquiry has been provided with a report of a specimen assessment for information purposes. The first element of every assessment is an occupational health assessment. Its purpose is to ensure that the doctor is fit to go through the rest of the assessment. It also addresses the question of whether there are any features of the doctor's health which might impact on his/her ability to practise effectively in his/her current setting, or which might have an effect on his/her general wellbeing. The second element is an occupational psychology assessment, directed at exploring the doctor's preferred behaviours at work. Professor Scotland said that this was a particularly valuable exercise. It is his experience that, when a doctor is performing poorly, there is invariably a behavioural element which is playing a part. The assessment for GPs includes an assessment of basic knowledge, using a test developed by the Royal College of General Practitioners (RCGP). There is also a day's practice visit, which includes inspection of a sample of medical records and observation of the doctor in consultation.

5.87 A full report of the assessment, with recommendations, is sent to the doctor and the referring PCT. The NCAA will then work with both to assist in the development of a practical action plan to address the assessors' findings. The NCAA cannot compel compliance with its recommendations but, if a PCT neglects to implement them, the NCAA can raise the matter with the relevant SHA or with the DoH. It can also refer a doctor to the GMC if his/her performance appears to be putting patients at risk. Occasionally, the NCAA has felt it necessary to suspend an assessment in order to make an urgent referral to the GMC.

5.88 The PCT retains responsibility for resolving the problem and for putting in place any necessary remedial or supportive measures. This is usually done in conjunction with the postgraduate deans who are responsible for the provision of postgraduate medical education in their areas. Funding for such measures can be a problem, especially given the small size of PCTs. Professor Scotland told the Inquiry about steps which were being taken in an attempt to obtain funding from other sources to assist the PCTs in discharging this responsibility.

Current Local Procedures

5.89 Since PCTs replaced the HAs, responsibility for local performance procedures has devolved upon them. It is now customary for PCTs to adopt a two-stage process. The first stage is usually conducted by a committee or group of persons, including officers, managers and board members of the PCT and at least one representative of the LMC. Other people with appropriate expertise (e.g. a pharmaceutical adviser) may be co-opted as necessary. In Tameside and Glossop PCT, the relevant body is known as the Contractor Monitoring Group. The Group's function has been to discuss and consider the

reports of independent review panels (which were abolished in July 2004), together with complaints and expressions of concern about GPs and GP practices, and to consider these against a background of 'hard' information available to the PCT. Dr Jeffery Moysey, one of Shipman's former colleagues at the Donneybrook practice and vice-chairman of the LMC which serves Tameside, is a member of the Contractor Monitoring Group. He described how the Group discussed 'often rather intuitive, and often subjective concerns' about the performance of practitioners. He felt this was important as, in the future, this information might fit together and 'build up a jigsaw puzzle' which would alert the Group to aberrant behaviour by a GP. Having considered all the relevant information, the Group will then devise local action plans to support the GP and to assist him/her in achieving a higher standard of performance. If these efforts prove unsuccessful, or if there is a history of poor performance which has not been addressed, the doctor will be referred to a performance panel. Tameside and Glossop PCT also has a 'fast track' procedure for use when there are immediate and urgent issues of concern.

5.90 A PCT will either have its own performance panel or will share a panel with one or more other PCTs. Tameside and Glossop PCT has a panel comprising its Chief Executive, Clinical Governance Lead and Medical Director, three LMC representatives and a lay board member. The PEC Chairman also chairs the performance panel. The panel makes a preliminary visit to a doctor about whom concerns have been raised. Following that visit, the panel will decide whether an assessment is necessary. If an assessment takes place, it will result in a report and recommendations. The panel will then seek the doctor's co-operation in complying with the recommendations. If that co-operation is not forthcoming or if the remedial action recommended has no effect, the doctor will be referred to the NCAA or the GMC.

Problems with the Current System

5.91 Concerns have been expressed (for example, by Professor Roland and his colleagues in their report to the Inquiry) that panels serving only one PCT may see performance cases only rarely and may, therefore, be unable to accumulate sufficient expertise in dealing with such cases. There is also the problem of lack of independence and potential conflict of interest. Professor Roland advocates that performance panels should cover a larger area than that of one PCT or that there should be cross-cover between PCTs. There is also scope for inconsistency between panels in different areas of the country. Mr Michael Newton, Head of Performance Management, South Yorkshire SHA, and a NCAA adviser, told the Inquiry that the quality of local assessors and assessments was variable. There are no common standards against which local assessments are carried out. He believes that issues of performance are better and more quickly dealt with by small groups than by large performance panels. He favoured the establishment of teams of properly trained assessors who would carry out assessments on behalf of a number of PCTs. They would carry out assessments to a common protocol to ensure consistency. Mr Newton has been involved in the establishment of a local assessment service available to PCTs in South Yorkshire. A protocol has been produced and the scheme has been adopted in other areas. Mr Newton emphasised that an assessment team should provide a technical, professional service, which identifies concerns and makes recommendations for remedial

action. It is then for the PCT to decide what action should follow. Moreover, he said that it was essential for a PCT to satisfy itself about the evidence of poor performance. It might, at some future date, have to take a decision to remove or contingently remove a doctor from its list on the basis of that evidence. It is essential, therefore, that it has confidence in the evidence on which it is to rely.

5.92 The NCAA has carried out work with the aim of developing a method for local assessment of a doctor about whom there is a concern. In doing so, the NCAA has responded to requests from PCTs for guidance on how to set about conducting assessments themselves or in conjunction with other PCTs. The NCAA has reservations about whether it is practical for PCTs to carry out such assessments. It points out that the process of evidence gathering is complex and time-consuming. Assessors must be of a high calibre, carefully selected and well trained. There must be a system of quality assurance. If an assessment is not done to a high standard, it may not achieve its objective and may be open to challenge. The NCAA believes that the process of setting up and managing local assessments **'poses formidable and perhaps insurmountable challenges for a single PCT, or small groupings of PCTs, undertaking an assessment only very rarely'**. It advises that any PCT considering undertaking local assessment should seek advice from the NCAA before proceeding. It may be that an assessment is inappropriate and that a local investigation, or referral to the GMC, is required.

5.93 An alternative to a local assessment is an assessment by the NCAA. In fact, the NCAA has carried out relatively few assessments during the period of its existence. In the three and a half years between April 2001 and September 2004, the NCAA carried out 87 full assessments. Of those, 36 were assessments of GPs. Much of the NCAA's activity during this period was focussed on problems with hospital doctors, particularly those under suspension. Most requests for help from PCTs have been dealt with by giving advice, by supporting PCTs in the use of their local procedures and by assisting in resolving disputes. I have no doubt that the NCAA is a valuable source of advice and assistance to PCTs. One of its real strengths is its independence from PCTs and other NHS bodies, as well as from the doctor about whom concerns have been raised. Another is the enthusiasm and commitment of its Medical Director, Professor Scotland.

5.94 There has been disappointment on the part of some that the NCAA has not carried out more assessments. However, Professor Scotland said that the fact that comparatively few assessments had been carried out was not related to lack of time or resources. He said that the NCAA had carried out assessments in all those cases in which it considered that an assessment would be useful and appropriate. In the vast majority of cases, it had been possible to deal with the problem without the need for a full assessment.

5.95 It is theoretically possible for a GP who is eventually referred to the GMC to undergo three separate assessments – one conducted locally, one by the NCAA and a third by the GMC. This may not occur frequently, but it is certainly not unusual for a doctor to be assessed twice. This is wasteful of resources, as well as being unduly demanding and stressful for the doctor. Moreover, it can lead to very substantial delays, during which the doctor may continue in practice, with consequent risk to patient safety. Professor Dame Lesley Southgate, Professor of Primary Care and Medical Education, University College London,

drew attention to this problem. She emphasised the need for systematic collection of evidence locally. She said that local assessments should be carried out with the assistance of the deaneries and a decision taken as to whether remedial action seemed possible. She felt that the NCAA could assist with these local processes and could set national standards for the way evidence was gathered. If a judgement were taken that remedial action was likely to be unsuccessful, the GMC or some other body with the requisite experience could undertake a full assessment.

5.96 I shall deal with the potential for duplication between assessments by the NCAA and the GMC later in this Report. As for duplication with local procedures, there seems to be a move towards supporting and improving local performance procedures in order to enable PCTs to resolve their problems themselves, with advice – but not necessarily intervention – from the NCAA. Whether that move will produce assessments of a sufficiently high and consistent standard remains to be seen.

5.97 Particular problems arise with locum doctors. They may operate in the area of more than one PCT. They may not work in one place long enough for a pattern of substandard practice to be recognised and acted upon. The results of substandard practice may not be discovered until after their departure. If problems are experienced with a locum, a practice may not be inclined to employ him/her again. Having taken that decision, members of the practice may be inclined not to bring the locum's performance to the attention of the PCT. Even if they do, the PCT may be unwilling to take on the difficult task of investigating the doctor's poor performance. It may have little evidence on which to do so, especially if the locum has moved on to another area. If the matter is investigated and a need for remedial action is identified, it may be difficult for the PCT to arrange the necessary action. Problems of funding may also arise.

Maintaining Quality

5.98 The recent emphasis on quality of care has given rise to a corresponding increase of interest in ways of securing and maintaining good standards of medical practice. This has resulted in a number of initiatives aimed at assuring the quality of services provided by individual doctors and GP practices.

Individual Mechanisms

Summative Assessment

5.99 In the past, GPs underwent no specific training to equip them for their work in general practice. Qualification for inclusion on the medical register was considered sufficient preparation for their future role. Over time, some individuals began to undertake voluntary vocational training. However, it was not until 1981 that vocational training, consisting of at least a year spent as a GP trainee in an approved training practice, together with up to two years in educationally approved posts within a number of defined specialties, became mandatory.

5.100 Even after 1981, there was no formal assessment at the conclusion of vocational training by which the competence of the trainee could be tested and a decision taken as to

whether s/he was suitable to enter general practice. A certificate of satisfactory completion of training was all that was required. Between 1989 and 1992, only 0.26% of trainees failed to obtain such certificates. Entry to general practice was more or less guaranteed, therefore, upon completion of vocational training. Some doctors elected to take the RCGP's Membership examination within a short time of starting in practice. However, there was no obligation to do so.

5.101 For training purposes, the UK is divided on a regional basis into 22 deaneries. The deaneries are responsible for commissioning postgraduate medical education. They are based around each UK medical school. Responsibility for the provision and organisation of training within each deanery rests with the director of postgraduate general practice education. The organisation of training includes the accreditation of training practices which are subjected to detailed assessment visits every three years, together with continuous monitoring of the quality of the training provided. In England, just under 25% of GP practices have at least one approved trainer. Nearly 4000 GPs are approved trainers. Responsibility for overseeing the training of GPs currently lies with the Joint Committee on Postgraduate Training for General Practice, which conducts three-yearly monitoring visits to the deaneries. These visits include detailed assessments of training practices (conducted jointly with the RCGP) to ensure that standards of accreditation are being maintained. In the future (currently expected to be September 2005), responsibility for overseeing the training of GPs will be transferred to the Postgraduate Medical Educational and Training Board (PMETB), which also has responsibility for the training of hospital doctors.

5.102 In 1996, summative assessment for all GP trainees (now known as GP registrars) was introduced throughout the UK. This became mandatory on 30th January 1998 for all GPs practising in the NHS. There is no requirement that a GP practising in the private sector should have undergone vocational training or summative assessment. The components on which candidates for summative assessment are judged are:

(a) an assessment of knowledge and problem solving

(b) an assessment of consultation skills, judged by means of a videotape or simulated surgery

(c) a written submission of practical work, usually an audit

(d) a trainer's report.

The four components of the assessment are designed to reflect tasks which any independent principal in general practice should be able to perform competently. If a candidate fails one or more components of the assessment, s/he is given extra training to assist him/her to pass on the next occasion. There is no limit on the number of attempts a candidate can make, although funding may not be available for indefinite further training.

5.103 The knowledge and problem solving tests are administered and marked nationally. The trainer's report is compiled within the training practice. The other two components of the assessment are judged by trained assessors and calibrated by the deaneries. The National Summative Assessment Office carries out quality control of assessment results.

A recent review of summative assessments carried out between 1996 and 2001 revealed a disparity in the failure rates between deaneries, with rates varying between 1.1% and 10.1%. The system of summative assessment was designed to give patients the protection of knowing that all GPs completing vocational training would have had their competence assessed to a national standard. The disparity demonstrated in the review is worrying since it suggests that standards differ significantly from area to area. The authors of the review (representatives of two deaneries and of the National Summative Assessment Office) calculated that, if the failure rate in the deaneries with the lowest failure rates had been in line with the average, a further 40 GP registrars would have failed. That suggested that there might be 40 GPs from that period currently in practice who should not have been assessed as competent. The authors suggested that action was required to make standards more consistent.

5.104 At the Inquiry seminars, Dame Lesley Southgate, who is a member of the PMETB and the chair of its Statutory Assessment Committee, expressed the view that summative assessment in its present form was very likely to be abolished in future and that entry to a new GPs' specialist register would be governed by an assessment similar to that required for Membership of the RCGP: see below. She expected that this would lead to a raising of standards but also expressed the concern that the change might lead to tensions between the PMETB and the Government as the latter would be concerned about the provision of sufficient numbers of GPs to staff the NHS.

Membership of the Royal College of General Practitioners

5.105 The RCGP has developed a number of awards to mark excellence in individual doctors. Membership of the College by examination is usually undertaken just before or just after the end of a GP's vocational training. I have already explained that a GP registrar must undergo a summative assessment at the conclusion of his/her vocational training. Dr William Reith of the RCGP said that it was widely accepted that the level of attainment needed to pass the summative assessment was less than that required to secure Membership of the College. He attributed this primarily to the fact that the Membership examiners are a small group of well-trained individuals who impose consistent standards. He drew attention to particular differences between the two procedures in the assessment of the video recording of a candidate's consulting skills, an element common to both summative assessment and the Membership examination. The criteria applied by the RCGP are different from those for summative assessment. In addition, for the Membership examination, assessment of the video recording is carried out by trained individuals who specialise in that part of the examination. For the summative assessment, assessment of the video recording is carried out in the deaneries by a large number of doctors applying less consistent standards.

5.106 It is difficult to establish a precise pass rate for the Membership examination because it is modular in form and candidates can sit modules at different times. Historically, the pass rate was about 90% although, following the recent introduction of the modular format in place of the previous 'all or nothing' approach, one would expect the pass rate to have increased (as it is now possible for a candidate to fail a module and retake it). Also, the introduction of Membership by assessment of performance (see paragraph 5.109) means

that GP principals seeking Membership are likely to opt for that route, rather than for Membership by examination. These more experienced candidates tended to have slightly lower pass rates in the examination than their more junior colleagues, probably as a result of difficulties with examination technique. The fact that fewer of them are taking the examination will have tended to cause the pass rate to increase.

5.107 Of course, in comparing the pass rates for summative assessment and Membership of the RCGP, one is not comparing like with like. Candidates for the Membership examination are self-selecting. It is perhaps unlikely that the weaker recruits to general practice would choose to sit the examination. If all those who underwent summative assessment also sat the Membership examination, the gap between the pass rates for each would no doubt be considerably wider.

5.108 Dame Lesley told the Inquiry that the issue of the difference between the standard for summative assessment and the standard for the Membership examination had been debated over the years. The purpose of the two processes is different. Summative assessment is intended to establish that the candidate has attained a minimum standard for practice. The Membership examination is intended to establish the standard for high quality performance and entry to the RCGP. It is more academic in nature. One element of summative assessment is a report from the GP registrar's trainers, based on his/her observations of the GP registrar or practice. This is not a feature of the Membership examination.

5.109 Membership of the College by assessment of performance was introduced in 1999. It involves a searching assessment of a doctor's clinical abilities and practice. He or she must submit a video recording of consultations and some audit work and undergo a practice visit, including an inspection of medical records. By October 2004, 79 GPs had successfully completed Membership by assessment of performance and 194 were officially registered as working towards the qualification.

Fellowship of the Royal College of General Practitioners

5.110 Fellowship of the RCGP by assessment was introduced about a decade earlier than Membership by assessment. This is a very demanding qualification, requiring the demonstration of extremely high standards of care. Candidates must have been Members of the RCGP for at least five years before embarking upon their Fellowship. By October 2004, 289 GPs had successfully completed the Fellowship, and a further 16 were in the process of doing so. Because the qualification is so demanding, it has not attracted as many applicants as the College initially expected.

Practice-Based Mechanisms

Practice Accreditation

5.111 Practice accreditation is a process by which GP practices submit themselves to assessment of various aspects of their organisation by a visiting team. In England, it is a wholly voluntary process. There is no link between practice accreditation and GP appraisal.

5.112 Methods of practice accreditation began to be developed in the 1990s. Mr Newton told the Inquiry that, in 1998, the Sheffield HA, together with the Leicestershire HA, developed a practice accreditation scheme, the Commitment to Quality Programme (CQP). This scheme has been continued by the PCTs within the area of the South Yorkshire SHA, working in conjunction with PCTs from Leicestershire and Lincolnshire. After wide consultation, a number of standards of good practice were set. GP practices are required to meet these standards in order to secure accreditation. A senior PCT manager works with practices to assist them in preparing for their assessments. The formal assessment is carried out by a team of trained assessors who systematically audit all aspects of a practice's activity against the CQP standards. The teams may consist of two doctors or a nurse and a manager. A representative from the PCT accompanies the team on the assessment visit and has access to the assessment report. The assessment is practice-based and is not directed at assessing the performance of individual doctors. It does, however, include an examination of medical records, protocols and the personal development plans of GPs working in the practice. Reciprocal arrangements between PCTs mean that the assessment team can be drawn from outside the area of the practice being assessed. Accreditation lasts for three years, after which a further assessment is required in order to secure re-accreditation.

5.113 Mr Newton said that good GP practices have found the scheme very helpful. They use the standards as a checklist to ensure that they have proper systems in place. Even more encouraging, however, is the fact that many practices in deprived areas have joined the scheme. The PCTs provide support for practices to assist them in meeting the standards for accreditation and in making any necessary improvements. They operate a website from which practices can obtain *pro formas* for documents needed to comply with the standards (e.g. staff contracts of employment, confidentiality agreements, etc.) and other assistance. Mr Newton said that the CQP provides an excellent opportunity for PCTs to get to know the practices in their areas.

5.114 The RCGP has devised a programme, known as the Quality Team Development Programme, which is used by some PCTs and is similar in some respects to the CQP. Under the programme, PCTs carry out a preliminary audit of GP practices to see whether they meet the required standards. They then assist and support practices to improve in those areas where they fall below standard. There is no final assessment visit and no 'pass or fail'. The programme is intended to promote continuous quality improvement and, once again, is entirely voluntary.

5.115 During the time that the Quality Team Development Programme was being developed in England, the Clinical Standards Board for Scotland (now part of NHS Quality Improvement Scotland) had identified a need for a similar programme in Scotland, but with the added element of a formal assessment in order to secure accreditation. The Quality Team Development Programme was modified for use as a practice accreditation scheme, and the Clinical Standards Board endorsed the scheme as its preferred method of assuring quality in general practices in Scotland. The scheme is operated by RCGP Scotland.

5.116 Like the South Yorkshire scheme, the Scottish practice accreditation scheme is pitched at a level that any reasonable GP practice should be able to achieve. According to

Dr Hugh Whyte, Senior Medical Officer, Directorate of Health Policy and Planning, Scottish Executive Health Department, assessors look for evidence of, *inter alia*, clinical audit, critical incident analysis and clinical effectiveness. Assessors are trained and approved by the RCGP. They may be clinicians, practice managers, nurses or lay people. The assessment includes a random inspection of records and (unlike the South Yorkshire scheme) interviews with the doctors working in the practice. It also examines practice organisation. The assessors produce a report which is submitted to the relevant PCO. The report identifies strengths and weaknesses and makes recommendations for change. PCOs use these reports as part of their clinical governance strategy.

5.117 At present, the Scottish practice accreditation scheme is voluntary. By October 2004, 586 of the 1052 GP practices in Scotland had attained some form of accreditation (or were about to do so), either by means of this scheme or under the system for approving practices as suitable for training GP registrars. The latter system is more demanding than the practice accreditation scheme. All practices approved for training purposes should be able to attain accreditation comfortably under the practice accreditation scheme. The two schemes have now been linked, so that assessments for both are carried out simultaneously. The practice accreditation scheme is also linked with the system of appraisal in Scotland. GPs working in practices which have achieved accreditation will automatically be taken to have completed certain aspects of appraisal. There was a Ministerial commitment in Scotland that all practices would have achieved accreditation by the end of 2004. Whether this will be achieved (albeit later than originally envisaged), and what will happen if some GP practices decline to undergo the accreditation process, is not yet clear. There is no mechanism to compel co-operation. But it does not appear that there was any great resistance to the proposal. I think that this must be attributable to the determination and enthusiasm of the leaders of the profession and at Government level in Scotland. I am sure that there is also real enthusiasm within the RCGP in England but, as yet, this has not resulted in the same commitment by the profession as a whole. It may be that the difference is one of scale and that it is much more difficult to motivate a large body of professional people than a relatively small one. However, it seems to me that it would be very valuable if all GP practices in England could also be encouraged to meet the standards necessary for accreditation.

5.118 The RCGP also operates a Quality Practice Award which was described to the Inquiry as the 'gold standard' for accreditation. It was launched in 1997. As its name suggests, the Award is directed at the achievements of GP practices, not individual doctors. It demands high standards and culminates in a formal assessment to ensure that those standards are met. Dr Reith explained that the Quality Practice Award gives practices more opportunity to be creative. They are able to choose certain aspects of care, or special interests, and to provide more detailed evidence of expertise in those areas. By October 2004, 118 practices had attained it and 31 were working towards it.

5.119 To some extent, practice accreditation may have been overtaken by the terms of the new GMS Contract: see paragraphs 5.123–5.134. Under the Contract, practices will earn 'points' (and therefore additional remuneration) for meeting certain quality standards. Some of those standards are similar to those which must be attained in order to secure practice accreditation. It is possible that the need for separate accreditation schemes will

diminish in the future. For the present, however, the new Contract provides that GP practices accredited under the Quality Practice Award will be excused from providing evidence about certain aspects of their activities. It is intended that, in the future, other organisational quality schemes may be approved for a similar purpose.

The Value of Quality Markers

5.120 As several witnesses pointed out, practice accreditation schemes have limitations. They are directed at practices, not individuals. They focus on organisational factors, on systems of care and on measurable aspects of care. They do not test the skills of the doctor in the consulting room. Nevertheless, accreditation contains some elements relevant to the practice of individual doctors. Records are reviewed and staff are interviewed. Under the Scottish model, doctors are interviewed also. All these aspects may well reveal problems with a doctor's competence or performance, if such problems exist. In single-handed or small practices, the weakness of an individual doctor may be evident. In a large group, it may be more easily obscured. The evidence shows that poor practice organisation can frequently be symptomatic or causative of poor performance. Dr Reith pointed out also that practices and doctors may be performing poorly because they lack resources, are under-staffed or are operating in deprived areas. They may need help and support to provide a proper service. An assessment for the purposes of practice accreditation may reveal these types of problem and result in the necessary support being provided. Perhaps the most valuable aspect of an accreditation scheme, however, is that it provides an opportunity for assessors – whether from the PCT or elsewhere – to go into practices and observe at first hand how they are run and whether there are obvious problems with organisation, facilities or relationships. There are considerable benefits for practices also. Professor Richard Baker, Director, Clinical Governance Research and Development Unit, University of Leicester, observed that even the process of sitting down as a team and working out how to achieve the standard is a useful exercise. The problem is that, in England, participation in practice accreditation is entirely voluntary and has not had the boost of Ministerial commitment as in Scotland. Those practices that do not choose to participate can avoid the close scrutiny to which practices applying for accreditation are subjected.

5.121 Individual markers of quality are of real value in assessing the standard of a doctor's practice. Membership of the RCGP by examination indicates the attainment of a standard higher than that required by the compulsory summative assessment at the conclusion of GP vocational training. Membership by assessment of performance, which can be undertaken at any point in a GP's career, requires evidence of a high standard of clinical care. Fellowship of the RCGP by assessment demands real excellence. There is, however, no requirement for GPs to submit themselves to these examinations or assessments and a sizeable proportion (well over a third) of GPs do not. No financial reward is available for those acquiring these quality markers.

5.122 It is interesting to note that, despite his much-vaunted professional prowess, Shipman did not seek an optional qualification. He did not take the Membership examination. By contrast, he encouraged his practice staff to obtain appropriate qualifications and expressed pride when they did so. There was no practice accreditation scheme in

operation in the Tameside area during the time he practised there. Even if there had been, it seems highly unlikely that he would have participated. I do not think that he could have taken the risk that a random inspection of his records might cause someone to question the care of his patients. His staff, if interviewed, might have spoken about the high level of deaths among patients in the practice or about deaths which had occurred in the surgery. While accreditation is not directed at detecting aberrant behaviour by individual doctors, it is possible that, if accreditation were compulsory, the mere knowledge that their practice would be placed under close scrutiny would serve to some as a deterrent against such behaviour and to others as an incentive to improve.

The 2004 General Medical Services Contract

5.123 The new 2004 GMS Contract was implemented on 1st April 2004. From that date, PCTs were placed under a new duty to secure the provision of primary medical services. These services can be commissioned by four routes: by GMS, by PMS, by alternative providers (e.g. the voluntary sector, commercial providers, NHS trusts or other PCTs) or by direct provision by the PCT itself.

5.124 A contract to provide GMS is made between a PCT and a practice with at least one GP provider of services. A contract is no longer between a PCT and an individual GP. The contracting practice may be a single-handed practice, a partnership or a certain type of limited company. Patients now register with a practice, rather than with an individual GP. At the time of registration, they are asked to name a preferred practitioner within the practice.

5.125 Contracting practices are under an obligation to provide 'essential services' during 'core hours'. They can opt out from providing 'additional services' (i.e. cervical screening, contraceptive services, adult and childhood vaccinations and immunisations, child health surveillance, maternity medical services and minor surgery). From 1st January 2005, practices can also opt out from providing out of hours services. Where a practice chooses not to provide certain additional services, or out of hours services, it is the responsibility of the PCT to commission others to provide those services.

5.126 The new Contract is designed to encourage practices to develop different ways of working, using an increased mix of professional skills. For example, a practice may decide to employ more nurses to carry out some of the functions previously carried out by doctors. Practices might also make greater use of employed (possibly part-time) GPs. It is no doubt hoped that this will ease, to some extent, the problem of inadequate GP numbers. The opportunity to opt out of providing out of hours services is intended to make the job of a GP more attractive and thereby to help GP recruitment and retention.

5.127 From 1st April 2004, the GP terms of service, and the disciplinary mechanisms invoked (rarely) in the event of a breach of those terms of service, ceased to have effect. The new Contract arrangements are governed by the 2004 Regulations. The Schedules to the Regulations set out the obligations on practices that enter into the Contract. Under Schedule 6, such a practice is obliged, *inter alia*:

- to have in place an effective system of clinical governance

- to carry out its obligations under the Contract with 'reasonable skill and care'
- to operate a complaints procedure in accordance with the NHS complaints procedure and to provide the PCT at such intervals as required with information about the number of complaints received
- to co-operate with any investigation of a complaint by a PCT or the Healthcare Commission
- to hold adequate professional indemnity insurance
- to ensure that those performing services within the practice are suitably qualified, are competent, have the necessary clinical experience and training and are registered (where appropriate) on the PCT's list
- to ensure that those performing services within the practice have arrangements in place to maintain and update skills and knowledge
- to ensure that GP performers participate in appraisal
- to ensure compliance with a NCAA assessment when required to do so by the PCT
- to provide suitable premises
- to allow persons authorised by the PCT to enter and inspect the practice premises
- to keep adequate patient records and ensure patient lists are kept up to date
- to have arrangements in place for effective infection control and decontamination.

5.128 The sanctions available to a PCT where a contracting practice fails to discharge its obligations are set out in the 2004 Regulations. In certain circumstances, a PCT can terminate a GMS Contract. If a contracting practice breaches the terms of the Contract and the breach is capable of remedy, the PCT can give notice to the practice, requiring it to remedy the breach within a certain period. Where a breach is not capable of remedy, the PCT may serve a notice, requiring the practice not to repeat the breach. If the breach is repeated, or further breaches occur, the PCT may terminate the Contract. A PCT can do this only if satisfied that the cumulative effect of the breaches is such that it would be prejudicial to the efficiency of the services provided to allow the Contract to continue. Other sanctions (e.g. termination or suspension of specified obligations under the Contract, or the withholding or deducting of monies payable under the Contract) are also available.

5.129 The significant difference under the new mechanism is that such sanctions as the withholding of payments can be applied only to the contracting party and not (unless s/he is a single-handed practitioner) to individual GPs. However, it is perhaps reasonable to suppose that a doctor whose conduct causes, or might cause, the practice as a whole to suffer a financial or other type of penalty may be under a certain amount of pressure from his/her colleagues to mend his/her ways. The DoH points out that, under the GMS Contract, a contractor is fully responsible for any failure to exercise reasonable care and skill by any person performing services under the Contract. Any contractor who does not deal appropriately with a failure by a doctor employed by the practice could therefore

place at risk the entire Contract. PCTs will also retain their powers to remove, contingently remove and suspend practitioners from their lists.

5.130 The new Contract introduced a new quality and outcomes framework (QOF), a system of financial incentives designed to encourage practices to achieve certain quality standards. A significant amount of a practice's remuneration will potentially be linked with the QOF. The Contract contains 146 indicators, which, if attained, carry 'points' which represent additional payments. Practices can select indicators that they will attempt to attain. The indicators relate to:

- the clinical domain (covering such areas as the prevention of coronary heart disease, treatment of diabetes, etc.)
- the organisational domain (covering such areas as patient records and practice management)
- the patient experience domain (covering length of consultations and patient surveys)
- the additional services domain (covering cervical screening, child health surveillance, maternity services and contraceptive services).

5.131 Data on 'quality achievement' is communicated by practices to PCTs by means of computer links. The operation of the QOF is reliant largely on the honesty of the contracting practice. Some checks will be made to prevent fraud, but there will be a large element of trust in the operation of the system. PCTs will undertake annual reviews of all contracting practices, using trained assessors. Among the assessors will be GPs, PCT managers and patient representatives. ScHARR has advised the DoH on the procedures to be followed at such reviews. The DoH has issued preliminary guidance to PCTs on the recruitment of assessors. Practices will be required to submit evidence in advance of the review. Assessors will have access to medical records in order to check achievement against the QOF. Inspection of the records will be subject to a code of practice. It seems likely that the inspection will be limited in extent and purpose, as was the case with post-payment verification, which I referred to in Chapter 4. It is not intended that concerns about a doctor's performance should be dealt with at an annual review.

5.132 The linking of payment to indicators of quality modifies the previous system whereby payment was more closely related to the number of patients on a GP's list. The change will not, however, result in any loss of income (in the short term at least) for practices which retain large lists and do not participate in the QOF. The DoH has guaranteed that no practice will suffer a loss of income as a result of the changes to the GMS Contract.

5.133 The Contract is in its early days and it is impossible to assess with any confidence the impact it is likely to have on the quality of patient care. There is some concern that the fact that practices will be encouraged to concentrate their efforts on meeting the quality indicators identified in the Contract might lead to neglect of important aspects of care (such as continuity of care) that are not included. Moreover, the quality indicators do not cover some of the most important aspects of 'doctoring' such as consultation skills and accuracy of diagnosis. The Contract should have the effect of increasing significantly the amount of data available to PCTs about practices which participate in the QOF. It remains

to be seen whether that data will be of real use in assessing the quality of care given to patients. The annual review will provide an opportunity for PCTs to get inside GP practices and to examine certain aspects of them. The value of this exercise will depend on the precise form the reviews take and on the skills and expertise of the assessors concerned. It is not clear at present how closely practices will be scrutinised. Another unknown factor is the extent, if any, to which practices where the standards of care may be poor will choose to participate in the QOF and the provision of additional services.

5.134 It is expected that PCTs will seek to measure performance on PMS contracts by reference to the same framework as under the new GMS Contract. Since PMS contracts will continue to be negotiated locally, the effect of this remains to be seen.

Conclusions

5.135 In this Chapter, I have described briefly some of the major developments in the arrangements for monitoring GPs that have occurred since Shipman's arrest in September 1998. There have been other changes too, which I shall refer to later in this Report. Some of these developments have occurred as a direct result of Shipman's crimes, although their application extends much further than an attempt to protect patients against a murderous doctor. It is clear that the landscape in which general practice is conducted now is significantly different from that of six years ago. There have also been alterations in the way that many GPs work. The increase in the number of GPs in direct employment with PCTs and working under PMS contracts has given PCTs more ability to 'manage' them. How successfully that will be achieved remains uncertain. In any event, there is still a large population of GPs working as independent contractors and not readily susceptible to the management or control of the PCT. It remains to be seen whether the new GMS Contract will give PCTs greater opportunities for monitoring and regulating the quality of primary medical care and, if it does, whether those opportunities will be used effectively. PCTs now have access to more information about GPs and are more likely to be aware of doctors who are aberrant in some way. In an extreme case, they can remove a doctor from their list. It seems to me that, at least in theory, all these changes are for the good. However, they impose an immense burden upon PCTs, which are, as I have said, small and 'young' organisations. It is likely, in my view, that the success attending these new measures will be variable.

5.136 If these new measures had been in operation during the time when Shipman was practising, would he have been prevented or deterred from killing patients or would he have been detected if he had done so? Certainly, the PCT would have known about his background and could have refused him admission to the list. It could have imposed conditions upon his inclusion which would have allowed close supervision of his practice in respect of controlled drugs. However, I do not think it likely that such arrangements would have deterred Shipman from killing. Nor would the current arrangements have greatly enhanced the prospects of his detection. In subsequent Chapters, I shall consider whether there are other measures which should be taken to monitor GPs. In particular, I shall consider how a complaint or concern about a doctor should be investigated and whether, once an aberrant doctor has been identified, adequate steps are being taken to

restrict his/her professional activities or remove him/her from practice, and thus to prevent unacceptable risk to patients.