13 July 2005

Council

General Medical Council

Regulating doctors
Ensuring good medical practice

5a

To consider

Fitness to Practise: Referring Complaints to Local Procedures

Issue

1. Referring cases to local procedures.

Recommendations

2. To agree:

   a. That we should refer cases directly to local procedures for consideration where the allegations as presented, if proven, would not call into question a doctor's fitness to practise.

   b. That we should develop appropriate systems to ensure that cases referred to local procedures are returned to the GMC where there is further information that calls into question a doctor's fitness to practise and that we receive written confirmation that there is no such evidence where the case has been concluded locally.

Further information

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Background

4. A theme running through all our recent work on reforming fitness to practise procedures is the importance of ensuring that we work in partnership with the NHS and other healthcare organisations. We are clearly part of a wider framework involved in the regulation of doctors. This involves a number of strands:

a. A proper shared understanding, on the part of the various agencies including the GMC, employers and other organisations, of their respective roles.

b. Arrangements for sharing information among those bodies, in order to ensure patients are protected.

c. Arrangements for directing cases to the appropriate body, if they have been mis-directed.

d. An understanding that very serious cases where patients are at risk must be referred to the GMC immediately, because only the GMC has legal powers to constrain or prevent a doctor from practising in all four countries of the UK, both in the NHS and independent sectors.

5. The GMC, the NHS, and other major healthcare providers, each have the authority to investigate concerns and to determine what action, if any, should be taken. Our powers and sanctions are linked to our responsibilities for the medical register. We are mainly limited to taking action on serious concerns which call into question the doctor's fitness to practise and suitability to retain unrestricted registration. However, most of the complaints that we receive do not fall into that category; as, even if the allegations were proven, they would not be sufficiently serious to warrant action on registration. The majority would be best dealt with locally, at least initially.

6. In contrast, local procedures are mainly aimed at complaint resolution, albeit with the option of disciplinary action if necessary. Local NHS complaints procedures offer a variety of resolutions that the GMC, as the regulatory body, will not be in a position to offer. Very often, patients pursue a complaint because they want one or more of the following outcomes:

a. An explanation of what happened to themselves or to a relative.

b. An understanding of what, if anything, went wrong in their case.

c. An apology where appropriate.

d. A guarantee that matters will be put right in the future.

7. Local procedures and the Healthcare Commission (and its equivalent elsewhere in the UK) are often best placed to look at the patient's experience and identify systemic problems. For some complaints, it is immediately clear that we will need to investigate. We refer to such complaints as Stream 1. But many complaints that we receive do not fall into this category; and while they could justify action by us if part of a wider pattern of concern about a doctor, they would not do so by themselves. We refer to such complaints as Stream 2.

8. Until May 2004, we advised complainants to pursue Stream 2 complaints through local procedures, in the first instance, where the doctor was employed by a hospital trust or under contract with a Primary Care Trust. We did not redirect Stream 2 matters to the doctor's employer or contracting authority. Instead, the complainant was encouraged to take up the issue through the local complaints procedure.

9. We changed how we handled Stream 2 complaints in May 2004 when we ceased referring cases back to the complainant where we felt that the complaint or concern would not justify action by us, in and of itself. We were concerned that our previous procedures did not ensure that issues about a doctor's performance or conduct would necessarily be followed up, as the onus was placed on the complainant to pursue the matter locally. There was a danger that concerns raised by the complainant would not be investigated either by the GMC or by local procedures and that any pattern of poor performance would simply not be tracked and identified.

10. With Stream 2 cases, we now disclose the complaint to the doctor and to the doctor's employers. We invite the doctor's employers to help us to put the complaint in context, to establish whether there is a broader picture that needs to be taken into account. Following the employers' response, most Stream 2 cases are concluded without further investigation, because the response is reassuring. A proportion of Stream 2 cases will be re-categorised as Stream 1, where information from employers highlights further concerns. Experience thus far has shown that only a small proportion of Stream 2 cases are reclassified as Stream 1.

11. These recent changes in our procedures reflect our commitment to working collaboratively with other organisations with clinical governance responsibilities. However, this new approach also has its drawbacks and we need to consider whether there is a better way for our fitness to practise procedures to dovetail more effectively with local complaints procedures.

Discussion

12. The purpose of the GMC is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We are the only organisation that has powers to permit doctors to practise and to remove or

restrict the right to practise if they fail to meet the standards it has set. Our powers apply to both the NHS and the private sector throughout the UK.

13. The GMC must continue to focus on investigating those cases where the concerns raised about a doctor's fitness to practise, by patients or employers, are sufficiently serious to require restrictions on the doctor's registration or removal from the register.

14. The GMC's core statutory role means that there will be many categories of case where it is immediately clear that we will need to investigate. These cases include:

a. Those where it is necessary for the protection of patients (or is otherwise in the public interest) to take immediate action to restrict a doctor's registration (by way of an interim order).

b. Police investigation, conviction and caution cases.

c. Determinations by other regulatory bodies.

d. Referrals from the coroner's office.

e. Cases involving peripatetic locums.

f. Cases involving doctors working exclusively in the private sector.

g. Any cases which raise issues of patient safety or public confidence, notwithstanding that the matters have not been investigated locally.

15. But many cases that we receive do not fall within these categories, and while they could justify action by us if party of a wider pattern of concern about a doctor, they will not do so by themselves. Therefore, we disclose these complaints (Stream 2 cases) to the doctor's employer(s) and request any further information that might help to determine whether there are wider concerns that we need to consider.

16. The problems with the current approach are three-fold. Firstly, we will continue to handle a substantial number of concerns about doctors where a limited investigation will disclose no need for action on registration by the GMC. This will require us to continue to have an early dialogue with employers on a large number of cases that the GMC will conclude with no action. It also means that substantial resources, both at the GMC and at Hospital Trusts and PCTs, will be devoted to responding to the same concerns and trying to discover, on a case-by-case basis, which organisation is best placed to deal with the concern. In addition, this can cause considerable delay in resolving the issues and reaching a timely conclusion for both the complainant and the doctor.

17. Secondly, while there has been considerable support for the changes we introduced in May of last year, there has been concern too, from some parties, that by carrying out an early investigation into some cases, we risk placing the doctor at the receiving end of parallel investigations, both locally and at the GMC. In response to last year's consultation on disclosure, the British Medical Association commented:

> 'We are supportive of the idea of a single gateway for complaints so that doctors are clear about how complaints against them will be explored and resolved, and which body will investigate. The worst-case scenario is that different bodies concurrently investigate a doctor, looking at various aspects of a complaint'

18. Although our processes must work effectively with local processes to ensure that legitimate concerns do not slip through the net, we must also ensure that the investigation of complaints (by the GMC and others) is appropriate and proportionate and conducted in a timely manner.

19. Finally, by investigating all complaints and concerns that are referred directly to the GMC, we will find ourselves dealing with a substantially increased caseload with the risk that our attention is diverted from the more serious Stream 1 cases that clearly warrant rigorous and thorough investigation and, potentially, immediate and swift action.

20. In our response to the CMO's Call for Ideas, we made it clear that, except where a complaint falls within one or more of the categories identified in paragraph 16, there should be a presumption that the complaint should be handled locally in the first instance and only passed to the GMC if that becomes justified by further, additional evidence. We went on to say that such a presumption would need to be developed collaboratively and that there may be advantages in amending our legislation to give the Registrar the discretion to decide that the GMC would not investigate a complaint until a local process had been exhausted, notwithstanding that the matter could potentially raise a question whether the doctor's fitness to practise was impaired.

21. Amending legislation and developing a presumption that the majority of complaints and concerns should be dealt with by local processes in the first instance may take some time. In the meantime, the GMC will continue to receive cases which do not fall into the categories outlined at paragraph 16. Substantial time and effort will continue to be devoted to investigating cases and liaising with employers locally on Stream 2 cases where there is little possibility that any GMC action is required.

22. In the interim, we should explore the possibility of referring Stream 2 cases directly to local NHS procedures for investigation in circumstances where the allegations, if proven, would not be sufficiently serious to warrant action on registration. Of course, we would need to ensure that employers referred the matter

back to us where any further information they hold, or investigation they undertake, changed the complexion or complexity of the original complaint and called into question the doctor's fitness to practise.

> **Recommendation:** To agree that we should refer cases directly to local NHS procedures for consideration where the allegations as presented, if proven, would not call into question a doctor's fitness to practise.

23. We also need to consider how we can best ensure that cases are referred back to the GMC where appropriate. We need to be satisfied that there are appropriate systems in place to deliver an adequate backstop to guarantee protection of patients where an investigation locally leads to evidence that a doctor's fitness to practise may be impaired to a degree justifying action on registration.

24. In our response to the CMO's Call for Ideas, we emphasised the need for joined up regulation. We suggested that the GMC's role in setting professional values and standards at national level - and in working to protect patients and the public in cases where those values and standards are not met – cannot happen in isolation. We argued that the crucial challenge is to ensure the maintenance of standards at local level through effective appraisal and clinical governance and to establish a more effective interface between the respective responsibilities of employers and the GMC. This would be essential for the early identification and reporting of poor performance and to underpin revalidation.

25. In this context, we mentioned the concept of the 'GMC approved environment' which has come into being as part of our proposals for registration and revalidation. We have said that an approved environment is characterised by a number of attributes, including:

a. Clear lines of responsibility and accountability for the overall quality of clinical care.

b. Procedures for all professional groups to identify and remedy poor performance.

c. Appropriate supervision arrangements for doctors.

d. Annual appraisal or assessment based on *Good Medical Practice.*

e. Arrangements for independent quality assurance (for example, in the case of organisations in England, by the Healthcare Commission).

26. In an approved environment the GMC will, for the purposes of revalidation, be able to rely substantially on local certification of doctors' fitness to practise, subject to

effective audit and quality assurance of local processes. Where local systems do not exist, or are not sufficiently robust, the level of GMC scrutiny will be greater.

27. We have suggested that the concept has more general application. For example, we have argued that all doctors who are new to UK medical practice should work within an approved environment prior to their first revalidation and, in some circumstances, following restoration to the register after a period out of practice.

28. Most importantly, for the purposes of this paper, we explained the relevance of the concept of the approved environment to the handling of complaints locally. We have suggested that we would only refer complaints for local handling to GMC approved environments.

29. The recent report by the Health Service Ombudsman for England has recommended the need for the Department of Health to set core standards to deliver key outcomes consistently. The Ombudsman also recommended that the Healthcare Commission should have a pivotal role in assessing complaints handling as a core standard. We have strongly endorsed those proposals.

30. In the longer term, therefore, we have expressed our intention to refer certain categories of case to local GMC approved environments. We have suggested that it cannot be right that we have or maintain ownership of complaints by accident – simply because the complaint was directed to us in the first instance.

31. However, it is unlikely that we will be in a position to begin to identify GMC approved environments before 2006. In the meantime, if we want to move ahead to begin referring Stream 2 case to local procedures, we need to put systems in place to ensure that we can follow-up on these cases.

32. There are likely to be a number of trigger points during the handling of the complaint locally, where we will need the doctor's employer to contact us with further information. We are suggesting that employers should be asked to contact us in the following circumstances:

a. To confirm receipt of the complaint and that the matter is being reviewed locally.

b. To refer the case back to the GMC where a further investigation locally leads to evidence that a doctor's fitness to practise may be impaired to a degree justifying action on registration.

c. To confirm that a case has been concluded or is now being handled by the Healthcare Commission or equivalent organisation in Scotland and Northern Ireland.

33. Of course, we will need to put systems in place to ensure that we follow up on those cases that are referred to local procedures. At the very least, we will need written confirmation from the employer that they have received the complaint and are investigating it. However, we also intend to follow up cases thereafter to ensure that we receive written confirmation from the Medical Director, Chief Executive or Clinical Governance Lead that they are satisfied that the doctor‘s fitness to practise is not impaired to a degree justifying action on registration.

> **Recommendation:** To agree that we should develop appropriate systems to ensure that cases referred to local procedures are returned to the GMC where there is further information that calls into question a doctor’s fitness to practise and to receive written confirmation that there is no such evidence where the case has been concluded locally.

Resource implications

34. The proposals in this paper are likely to have a significant impact on resources in the short term. Monitoring and following-up on all cases that are referred to local procedures for consideration will require continuing interaction between the GMC and NHS employers for the duration of the case. Any local investigation may take some time to conclude and a continuing commitment to chasing employers on some individual cases may be required.

Equality

35. The proposals in this paper do not disproportionately affect any group of doctors or patients.