



The Shipman Inquiry – Summary of Recommendations

The Shipman Inquiry Fifth report was released today [9 December 2004]. It is in three volumes and is 1258 pages long. The Report makes 109 recommendations.

Obviously there has not been time for a full analysis of the report or the recommendations and it is not known how the Government is going to respond to the recommendations. Over half of the report's recommendations are for the General Medical Council (GMC) but many of the other recommendations, if accepted, are likely to have significant implications for primary care trusts and NHS employers more generally. The main recommendations of the Report for the service are summarised below around:

- *Handling complaints and concerns*
- *Appraisals*
- *Expectations of PCTs*
- *National database*

In terms of the handling of complaints the proposals are not out of line with the current direction of travel although the practical implications for PCTs need to be clarified.

The call for a single national database to bring together all the information about a doctor may be understandable but certainly poses considerable practical problems not to mention the potential difficulties in securing the support of doctors.

Throughout the recommendations there is an expectation that PCTs will take a far more proactive role in relation to the management and monitoring of GPs. The Confederation would probably recognise merit in many of these recommendations. However this raises real issues about the capacity and resources available in PCTs to undertake this work.

The Confederation will wish to gauge the views of members on the proposals and report them to Government to help shape their response.

NHS Employers, the new employers' organisation for the NHS in England, will be working with NHS organisations and professional bodies to identify the next steps in the areas for which it has responsibility including safer recruitment, whistle-blowing, and electronic smart cards for doctors.

1. Handling Complaints and Concerns

The Lodging of Complaints

Recommendations 1-3

Supports the draft Complaints Regulation in that patients will be able to make a complaint against their GP either with the practice or with the local PCT but wants the time limit for lodging the complaint extended from 6 – 12 months. Steps should be taken to improve the standard of complaints handling by GP practices. GP practices should be required to report all complaints to the PCTs with 2 days of receipt.

The Investigation of Complaints

Recommendation 4

There should be statutory recognition of the importance of proper investigation of complaints about clinical governance and monitoring the quality of care.

The First Triage

Recommendation 5

When the PCT receives a complaint about a GP the first 'triage' should be conducted by an experienced member of PCT staff to assess whether the complaint arises from a purely personal grievance or raises clinical governance issues.

Private Grievance Complaints

Recommendation 6

These should be dealt with by PCT staff, the objective being the satisfaction of the patient and restoration of the patient-doctor relationship.

The Second Triage

Recommendation 7

Clinical governance complaints should be investigated with dual objectives: patient protection and satisfaction and fairness to doctors. They should be referred for the second triage to a small group e.g. a Medical Director of the PCT and lay member of PCT Board who will decide whether the complaint should be investigated by the PCT or referred to another body e.g. police or GMC.

The Investigation of Clinical Governance Complaints

Recommendations 8 and 9

Should not be undertaken by PCT staff but by trained teams of investigators who could be joint between PCTs. The investigation's aim is to reach a conclusion and set out evidence; if a conclusion isn't reached then the report should say so.

Acting on the Investigation Report

Recommendation 10

When it receives the report the PCT which carried out the second triage should consider what actions to take. This could be referring to another body or taking actions directly. If the report is inconclusive it should be reported to the Healthcare Commission.

The Effect of Concurrent Proceedings

Recommendations 11 and 12

Legal processing should not be a bar to investigation by an NHS body of a complaint. Where an NHS body is already taking disciplinary proceedings against the individual being complained about and it is a comparable circumstance the complainant should be able to see the report. If it is necessary for an NHS body to discontinue an investigation, e.g. because a matter is being investigated by the police, it should 'not lose sight of its duty' to find out what happened and provide the information that the patient needs.

The Role of the Healthcare Commission

Recommendation 13

The draft Complaints Regulations should include a power enabling PCTS to reference a complaint to the Healthcare Commission for investigation at any point during the first stage of the complaints procedures. Referral should happen when the inter-PCT investigation team cannot reach a conclusion.

Complaints in the Private Sector

Recommendation 14

Complaints procedures in the private sector should be aligned as closely as possible with those in the NHS so that complainants can proceed to the second stage process conducted by the Healthcare Commission if necessary.

Handling Concerns

Recommendation 15

Concerns about a GP raised by people other than the patient or their representative e.g. a fellow healthcare professional, should be investigated in the same way as patient raised complaints. Consideration should be given to allowing the Healthcare Commission to investigate concerns without needing a reference from the Secretary of State for Health.

Standards

Recommendation 16

Objective standards against which complaints can be judged to be upheld or rejected should be established urgently. These should fit together with the threshold used by the GMC to act on allegations to form a comprehensive framework.

2. Appraisal

Disciplinary Procedures

Recommendation 19

The powers of PCTs should be extended to enable them to issue warnings to GPs and impose financial penalties in respect of misconduct, deficient professional performance or deficient clinical practice.

Appraisal in the Context of Clinical Governance

Recommendations 25 and 26

The purpose of GP appraisal must be made clear. It needs to be decided if appraisal is just an educational process or if appraisal has more than one purpose e.g. part educational, part pass/fail and/or part performance management.

If appraisal is intended to be a clinical governance tool it must be strengthened. Appraisers need to be trained and GPs should be appraised by GPs from other PCTs. The standards by which GPs pass or fail should be specified and all appraisal should be based on a nationally agreed set of verifiable information.

3. Expectations of PCTs

Recommendation 30

PCTs should be willing and able to provide advice to GP practices on good recruitment practice and should also be willing to offer support in drafting job specifications and advertisements. They should be prepared to help sift applications and make the necessary checks on applicants before the interview process to exclude unsuitable applicants.

Recommendation 34

PCTs should ensure through training that GP practice staff understand the importance of reporting concerns and know how to do so.

4. National Database

Information Available to Employers and Primary Care Organisations

Recommendations 40 – 43

The report recommends that there be a central database containing information about every doctor working in the UK. This would be accessible to officers of NHS bodies and accredited employers in the private sector as well as other bodies such as the Healthcare Commission, the GMC, the NCAA and the DoH.

The database would contain information from the GMC, the Criminal Records Bureau and the NHS Counter Fraud and Security Management Service. It would also include records of disciplinary action by employers, adverse reports following investigation of a complaint, adverse findings by the Healthcare Commission panel or Healthcare Ombudsman and details of clinical negligence.

Doctors would be able to access their own entry. Private sector employers would be required to provide relevant information as a condition of registration with the Healthcare Commission. Unsubstantiated allegations would not be included on the database but would be flagged to indicate that confidential information is held by a named body.

Further information to be provided to Primary Care Organisations

Recommendation 44

GPs would be required to disclose to the relevant PCO the fact that a clinical negligence claim has been brought against them.

Information Available to the Public and Patients

Recommendations 45 – 47

The GMC would adopt a policy of tiered disclosure to those seeking information about a doctor. First tier information, relating to doctors current registration status, together with certain information about their past fitness to practice will be posted on the GMC website. Second tier information, on a doctor's current fitness to practice will be available to those who request it.

Information that should be given to patients of a practice

Recommendation 48

If a GP's registration is subject to conditions or where they have resumed after a period of suspension, patients of any practice where the GP works should be told.

Summary of main recommendations to GMC

- There should be a basic change of culture, so that the GMC puts patients first. To do this, the GMC should change its structures to remove the medical majority.
- The GMC's role in both investigating and punishing doctors, its fitness to practice procedures, should be split. Doctors should instead be disciplined by an independent body. This arrangement should be assessed within three to four years with the potential for that role to be taken away from the GMC altogether if it was found to be wanting.
- The GMC should be directly accountable to Parliament.

If you have any questions about the implications the Shipman Report recommendations please contact Alastair Henderson on 020 7959 7234 or alastair.henderson@nhsemployers.org.