Department of Health

Performers List Regulations 2013

Response to Consultation Document

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Performers List Regulations 2013

Response to the consultation on draft Performers List Regulations

Prepared by the Clinical Governance Team

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Executive Summary

Medical, dental and ophthalmic performers may not perform NHS primary care services in England unless they are included on a performers list held by a Primary Care Trust (PCT). The Performers List system provides primary care organisations – in England, PCTs – with powers to manage admission, suspension and removal from their lists. The legislative framework in England is set out in the National Health Service (Performers Lists) Regulations 2004 and subsequent amendments.[1]

The Health and Social Care Act 2012 received Royal Assent on 27 March 2012. The Act abolishes PCTs from April 2013 and creates the NHS Commissioning Board (NHS CB) and Clinical Commissioning Groups (CCGs). It transfers the duties and powers of PCTs in relation to performers lists to the NHS CB. The Secretary of State has decided that national performers lists held by the NHS CB will replace the current system of separate PCT lists. This will ensure alignment with the NHS CB's responsibility for commissioning primary care services.

The link between the medical performers list system and the role of the responsible officer is an important one. In England, responsible officers in the NHS CB will continue to manage admission to the medical performers list.

The consultation sought views on proposed changes to the performers list system and on a set of draft Regulations. The key changes to the Regulations are:

- the NHS CB will become responsible for the performers list and their management;
- national lists will be introduced to help facilitate information sharing and reduce bureaucracy;
- the current provisions of "conditional inclusion" and "contingent removal" have been merged and simplified to provide for conditions on inclusion in the list in certain circumstances;
- changes have been made to the power to suspend performers on the list. This includes an ability to immediately suspend a performer from the list where it is necessary to do so for the protection of patients or the public;
- performers will need to demonstrate that they have appropriate indemnity or insurance arrangements relating to their professional practice;
- performers will need to provide appraisal information (if it is available), ensuring the Board has all relevant information on applicants when they apply to join a list;

[1] The National Health Services (Performers Lists) Regulations 2004 (as amended) (SI 2004 No.585), http://www.legislation.gov.uk/uksi/2004/585/contents/made

- performers will be required to inform the Board when they are called before an inquest which is likely to be critical of their conduct;
- introducing discretion as to whether to refuse entry to the list or remove a performer from the list in the case of practitioners who have been subject to imprisonment of over 6 months; and
- changes related to GP Registrars, including a longer period to make enhanced Disclosure and Barring Service checks (now 3 months) and making clear that they do not have to reapply to join the performers list following completion of their training.

The proposals were generally acceptable to the majority of the 107 respondents. The most controversial was the introduction of the minimum practice provision. While the majority thought the idea has merit, there are considerable practical challenges in implementing it that had not been resolved. Therefore, the proposal will not be implemented at this stage but the NHS CB will lead further work to consider the proposal further.

Chapter one

Introduction

Chapter one provides an outline of the document and a background to the consultation and to the performers list system. It sets out why the Performers List Regulations are being amended and provides an overview of those that responded.

The document

1.1 This document and the draft regulations apply to England only.

1.2 Chapter two summarises the responses to the changes set out in the questionnaire and what we have decided to do in the draft regulations that will be laid before Parliament.

1.3 Annex A provides the draft 2013 Regulations that are to be laid before Parliament.

The consultation

1.4 On 19 October 2012, we published a consultation entitled, *Performers Lists Regulations 2013: Consultation Document*,[2] and accompanying documentation, on the proposed changes to the National Health Services (Performers Lists) Regulations 2004. The consultation remained open for 8 weeks and closed on 14 December. This document forms the response to that consultation.

1.5 The consultation considered the three options available to the Department in considering amendments to the Performers Lists Regulations. The available options were:

- Option 1: do nothing;
- Option 2: make amendments to the 2004 Regulations to reflect the changes made by the Health and Social Care Act 2012 only; or
- Option 3: (the preferred option) to build upon option 2, but include changes reflecting recommendations made by previous reviews.

1.6 We argued that Option 3 should be pursued. In assessing the costs of the option, we determined that there was no impact on the private sector or to civil society organisations. The impact on the public sector is also minimal and mainly consequential to the Health and Social Care Act 2012. Therefore, no impact assessment has been produced.

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[2] Clinical Governance Team, Performers Lists 2013: Consultation Document, Department of Health, 2012, http://www.dh.gov.uk/health/2012/10/consultation-national-performers/.

1.7 The consultation considered changes arising out of the Health and Social Care Act 2012.[3] These changes include the forthcoming abolition of Primary Care Trusts and Strategic Health Authorities, and the establishment of new bodies; such as the NHS CB and CCGs. The background to these changes are discussed further below in *Background.*

1.8 The proposals also included the incorporation of recommendations made by two reviews. The Performers List Review formed part of the Department of Health's Tackling Concern Locally working group.[4] It looked at the effectiveness of the performers list system, making a number of recommendations for improvement. A second review was conducted by Dr David Colin-Thomé and Professor Steve Field.[5] This review considered Out of Hours GP services following concerns raised over the safety of those services. These reviews are discussed further in *Background,* below.

1.9 The consultation contained a number of proposals and questions. It included discussion on the following areas:

- the establishment of national performers lists;
- the introduction of a minimum service requirement;
- changes to the suspension of performers;
- new requirements for indemnity and insurance;
- further changes arising from the Performers List Review; and
- a requirement to report involvement in inquests.

1.10 Chapter two provides further detail on the responses we received to the consultation on these areas, and others. It also sets out the changes we are going to make to the Regulations in light of the information received.

1.11 The consultation was guided by the Cabinet Office's principles on consultation and the accompanying guidance that has been issued. The principles inform Government departments of the considerations that should be made during consultation. These include consideration of the subjects of consultation, the timing of consultation, making information useful and accessible, and transparency and feedback. The consultation principles can be found on the Cabinet Office's website at: http://www.cabinetoffice.gov.uk/resource-library/consultation-principles-guidance.

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[3] Health and Social Care Act 2012 (2012 c.7), http://www.legislation.gov.uk/ukpga/2012/7/contents

[4] Clinical Governance Team, Tackling Concerns Locally: the Performers List System – A review of current arrangements and recommendations for the future, Department of Health, 2009 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_096487.pdf

[5] Colin-Thomé, D and Field, S, General Practice Out-of-Hours Services: Project to consider and assess current arrangements, Department of Health, 2010, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111892

Background

1.12 The current Performers List Regulations came into force on 1 April 2004 and provides PCTs with a framework for managing medical, dental and ophthalmic performers undertaking clinical services in their area.

1.13 Performers are required to be named on a list in order to perform NHS primary care services. The performers list framework provides PCTs with powers over admission, suspension and removal from its lists. The powers are used to ensure that performers are suitable to undertake clinical services and protect patients from any performers who are not suitable, or whose efficiency to perform those services may be impaired. The framework enables PCTs to intervene at an early stage and provide support and remediation for practitioners whose performance is beginning to fall away from the required standards.

The NHS Commissioning Board and National Lists

1.14 The White Paper, *Equity and Excellence: Liberating the NHS,*[6] set out the Government's vision for health services. It described a new commissioning architecture for the NHS. Responsibility for local commissioning of the majority of secondary care services will rest with CCGs supported and overseen by the NHS CB. The NHS CB will hold CCGs to account.

1.15 The Health and Social Care Act 2012 implements this new structure. The Act abolishes PCTs and Strategic Health Authorities from April 2013. These bodies have already been clustered together into larger geographical groups to provide more cost effective services and stability through the transition to the new structure. At the heart of the new commissioning structure are CCGs that will build on the role GPs and other front line professionals play in ensuring quality care for their patients. CCGs will have the power and responsibility for commissioning secondary care medical services and other local services required to contribute to integrated patient care.

1.16 The NHS CB's central role is to ensure that the NHS delivers better outcomes for patients within its available resources. The NHS CB will also commission primary care and some other services. The publication, *Design of the NHS Commissioning Board,*[7] sets out a structure for the NHS CB with a workforce of about 3,500, with approximately two thirds of staff working locally. It describes an organisation that has a medical director and a number of clinical and professional leads supported by small clinical advisory teams. A subsequent paper[8] set out a structure with 27 Local Area Teams. These teams, now referred to as Area Teams, will have a clinical lead and will work closely with local Clinical Senates, local Health and Wellbeing Boards and

[6] Equality and excellence: Liberating the NHS, Department of Health, July 2010 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf

[7] Design of the NHS Commissioning Board, NHS Commissioning Board, February 2012 https://www.wp.dh.gov.uk/commissioningboard/files/2012/01/NHSCBA-02-2012-5-Organisational-Design-Recommendations-Final.pdf

[8] NHS Commissioning Board: Local Area Teams and Clinical Senates, NHS Commissioning Board SpHA, June 2012; https://www.wp.dh.gov.uk/commissioningboard/files/2012/06/lat-senates-pack.pdf

local CCGs. They will be grouped into four regions, each headed by a regional director. The clinical leads for the area teams will report to the regional director. It is now clear that Area Teams will undertake the day-to-day management of the national performers lists under the oversight and direction of Responsible Officers.

1.17 The current performers lists also provides assurance that the primary care services commissioned by PCTs are safe and effective. As the new commissioner of primary care services, the NHS CB will need to assure itself that the services it is commissioning are safe and effective in order to comply with its own statutory duty to seek continuous improvement in the quality of services The NHS CB is developing the administrative systems required to manage the lists (medical, dental and optical) as one organisation with 27 Area Teams.

1.18 The Performers List Regulations will be amended to ensure that duties on PCTs are transferred to the NHS CB. This will ensure that the framework is able to function from April 2013.

The Performers List Review

1.19 The Performers List Review was conducted by a 'Tackling Concerns Locally' Working Group. The Working Group was one of seven working groups tasked with carrying forward implementation of the programme of reform of professional regulation proposed in the White Paper, *Trust, Assurance and Safety,*[9] in 2007. The Working Group's remit was *'…to advise on how local systems could be strengthened to enable healthcare organisations to identify and deal with those healthcare professionals whose performance, conduct or health could put patients at risk.'*[10]

1.20 The establishment of the Working Group followed a recommendation made by the then Chief Medical Officer (CMO) in the report, *Good doctors, safer patients,*[11] that the performers list framework should be reviewed. Both the CMO and the Shipman Inquiry[12] raised concerns over whether PCTs were using their powers under the Performers Lists Regulations effectively. The Performers List Review Report[13] also noted that there had been criticism in the courts over the manner in which PCTs had managed their lists.

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[9] Trust, Assurance and Safety – the Regulation of Health Professionals in the 21st Century, HMSO, 2007, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946

[10] NHS Medical Directorate, Tackling Concerns Locally: Report of the Working Group, Department of Health, 2009, page 1

[11] Chief Medical Officer, Good doctors, safer patients, Department of Health, 2006, http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4137232

[12] Shipman Inquiry 5th report Safeguarding patients: lessons from the past – proposals for the future, TSO, December 2004

[13] Tackling Concerns Locally: the Performers List system – A review of current arrangements and recommendations for the future (see n4, above)

1.21 The report concluded that the performers list system should continue for the foreseeable future. However, it made a number of recommendations as to how the system could be improved. Implementation of many of the recommendations has been overtaken by the creation of the NHS CB and the decision that it will hold national lists. Some of the remaining recommendations are incorporated in these Regulations.

The GP Out-of-Hours Service Review

1.22 In late 2009, Ministers asked Dr David Colin-Thomé, formerly the Department of Health's National Director for Primary Care, and Professor Steve Field, Immediate Past Chair of Council, Royal College of General Practitioners (RCGP), to perform a review of GP out-of-hours services. This followed the release of an interim statement in October 2009 by the Care Quality Commission relating to their investigation into the unlawful death of Mr David Gray. Mr Gray died in February 2008 as a result of being administered 100mg of diamorphine by Dr Daniel Ubani, who was working as a locum for a GP out-of-hours services provider.

1.23 The Review made a number of recommendations and observations on good practice in their report,[14] released in January 2010, some of which are relevant to the Performers List Regulations. The majority related to the operation of lists locally. The outstanding recommendation, to ensure that the requirements within the Regulations are suitable for GP Registrars, has been incorporated into the proposed draft Regulations (see Annex A).

Responses to the consultation

1.24 The consultation received 107 responses which are summarised in figure 1, below. Respondents were able to submit responses via our online system, by e-mail or by hardcopy.

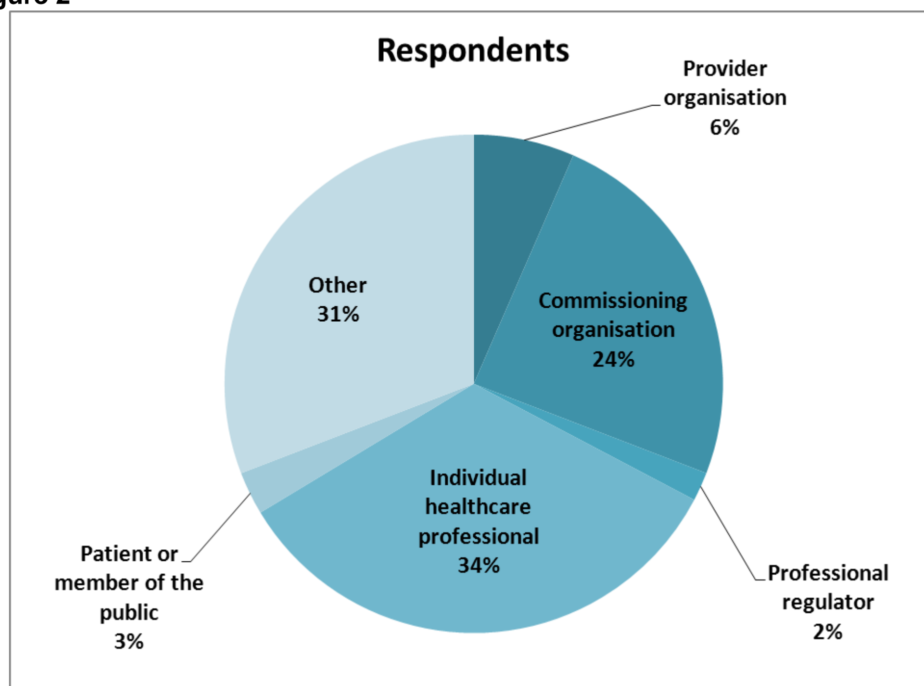
Figure 1

Option	Total
Provider organisation	7
Commissioning organisation	26
Professional regulator	2
Individual healthcare professional	36
Patient or member of the public	3
Other	33
Total	**107**

1.25 A large proportion of respondents classified themselves as 'other'. This includes the Royal College of GPs, the British Medical Association, medical defence organisations, law firms and the NHS Business Services Authority. The percentage breakdown of the type of responses is provided below at figure 2.

[14] Colin-Thomé and Field, see n5, above.

Figure 2



1.26 The largest number of responses (34%) were from those that identified themselves as an 'individual healthcare professional'. We also received responses from a number of large organisations which either represent others, or the professions, such as the General Medical Council and General Dental Council. We received responses from Royal Colleges, such as the Royal College of General Practitioners and Royal College of Ophthalmologists, and also private companies. Approximately a quarter of the responses were from commissioning organisations, including PCTs, and CCGs.

Chapter two

Our response to the consultation

Chapter two sets out a summary of the responses for each question asked in the consultation and the impact that has had on the draft regulations.

National Lists

2.1 We set out the implications of moving to national performers lists and asked:

We consider that it is appropriate to set up national performers lists for England. Do you agree?

2.2 There was overwhelming support for the creation of national lists with 90% of respondents agreeing with the proposal. We agree with the commentator who said, *"…a national list is a welcome development, offering standardisation, countering parochialism, and enabling the ready availability of information concerning relevant areas of clinicians' performance and behaviour."*

2.3 Only 7% expressed concerns about national lists. We think that those concerns are reflected in the words of one commentator who said, *"I believe that when a Performer moves from one area to another and switches lists it prompts [a] number of vital checks. Local knowledge of where performers are working is key and this would be lost under a national system."*

2.4 We think that national lists maintained by the NHS CB with standardised applications and procedures will brings advantages in information sharing and reductions in bureaucracy. However, decisions on admission, removal, suspension and conditions will be taken locally by the area teams of the NHS CB. This will retain the local knowledge and links to contracting, addressing the major concerns of those that did not agree with national lists.

Minimum service to remain on a performers list

2.5 Currently performers on a PCT list may provide primary care services anywhere in England. They do not have to apply to every PCT where they work. However, PCTs may remove performers from their lists where they have not provided services within the PCT's area of responsibility for 12 months. This power enables PCTs to be reasonably confident about the performers that are providing services in their area. A system of national performers lists will enable performers to move around the country without the NHS CB being able to know who is practising in which area.

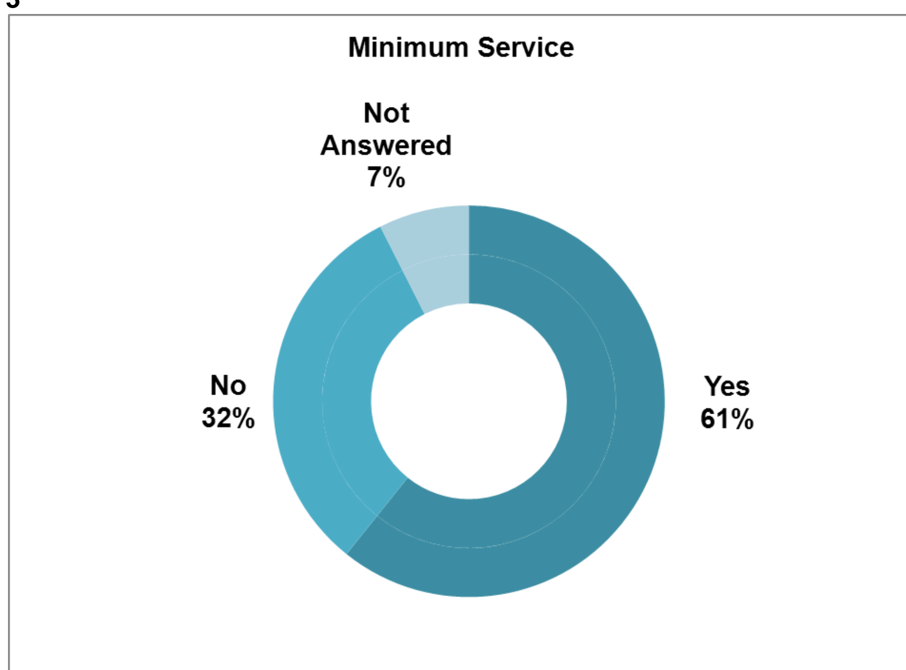
2.6 We therefore considered whether the existing power should be replaced by one that allows the NHS CB to remove performers that have not undertaken a minimum service in twelve months. We asked:

Do you think that the power to remove a performer where they have not provided a minimum service should replace the existing power to remove a performer where they have not provided services within 12 months?

If you agree that this power should be provided, do you think that: a) it should apply the same to all groups of performers (medical, dental and ophthalmic); or b) different measures should be in place for each group of performers?

2.7 61% (see figure 3) that responded agreed with the proposal to provide a power that would enable the NHS CB to remove performers who do not provide a minimum service.

Figure 3



2.8 Even amongst those who agreed that we should provide this power, the comments showed that there were still some reservations about the proposals. Respondents were concerned about what power should be provided and how it would be applied in practice. For example, the Patients Association said:

> *"While we do agree, we note that the Department of Health has itself noted that GPwSI,* forensic medical examiners and prison doctors (2.12) who do not strictly speaking provide primary care services but work in related areas. We know of examples where such professionals are also providing out of hours services or locum services. ….. The Department of Health needs to be sure to avoid unintended consequence of these measures, such as reducing the number of GPs willing and able to provide out of hours services or locum services."*
>
> **Patients Association**

*GP with Special Interest

> *"I think that the PCT should have an 'either / or' option. I do agree that there is a minimum level of practice for safety. However I think that the process of appraisal should be adequately controlling for this. There is clear scope within this for appraisers to see where a doctor has been out of practice for a while, or is due to be out for a while - and why. They can then agree with the doctor concerned how they can ensure that they are practicing safely."*
>
> **Healthcare professional**

2.9 Responses to the question about the application of the power to different groups were less decisive. 31% of respondents did not answer this question, 37% thought that the same measures should be applied to all groups and the remaining 32% were of the view that different measures should be in place for each group of performers.

2.10 We also asked you to explain what the minimum levels of service might be:

Please explain what you think are appropriate minimum level(s) of primary care services.

The answers reflected the range of responses we received. As one commentator said:

> *"This is the key issue and is very difficult to quantify. It is not quantity that counts, but quality, and this should and is measured and recorded in the present appraisal systems (including forthcoming revalidation) and in clinical governance systems."*
>
> **Healthcare professional**

2.11 A number of respondents thought that 200 sessions over five years was reasonable. However, it was clear that many of these were from a medical background. It was also clear from the comments that there is a difference for medical performers, who are subject to annual appraisals where they have to set out the full breadth of their practice as part of revalidation, and the dental and ophthalmic practitioners, where appraisal is not as well embedded.

2.12 It also seemed possible to us that the proposal might impact differently on different groups and we wished to understand how the issue would be perceived by our respondents. So we asked:

What groups do you consider should be subject to an exemption and what other measures do you think should be taken to ensure that this proposal does not impact unequally on specific groups?

2.13 In addition to the groups we identified, respondents identified further groups including those working for overseas aid agencies, the armed forces and members of CCGs, that they thought would be worthy of exemptions. It was clear from the responses that commentators wished to see a system that was

responsive to individual circumstances and not rigidly set in legislation. As one healthcare professional put it:

> *"Exemption may be problematic, and should not be a substitute for a flexible responsive system. If the system is about maintaining competence to practice, then should anyone be exempt from this?"*
>
> **Healthcare professional**

2.14 It is clear from the responses that further work is needed to explore what is a complex issue. Further work will need to ensure that both patients and performers are protected from any unintended consequences in introducing a power to remove performers who have not undertaken a minimum practice. It has been agreed that the Quality Team in the NHS CB will lead this work to develop the proposal and determine whether minimum service can be sensibly introduced into the Performers Lists Regulations.

2.15 In the meantime, the existing power to remove a performer from the list who has not provided any services within the previous 12 months will be retained.

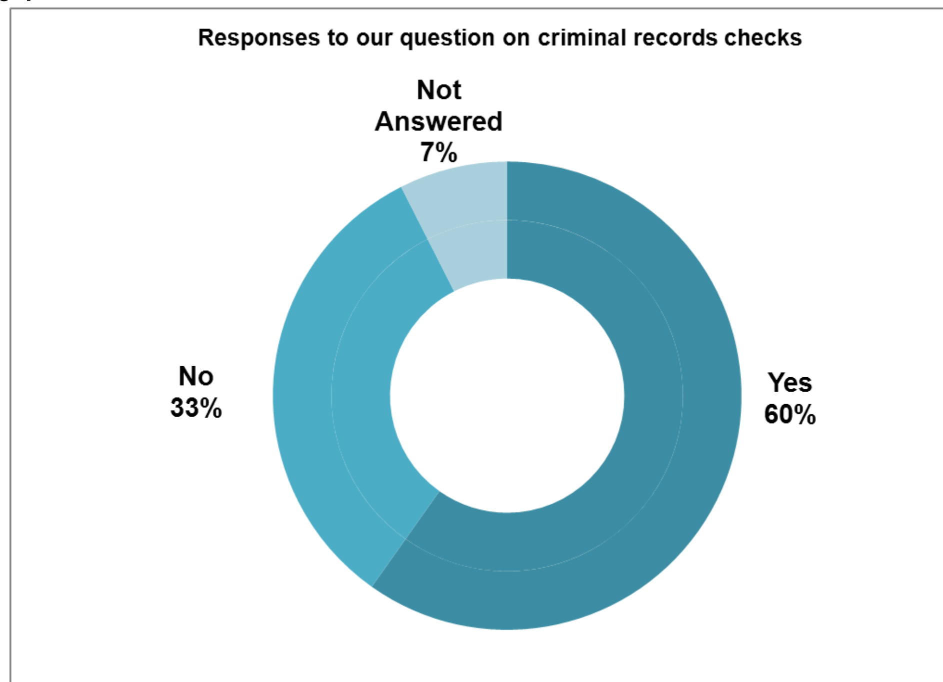
Establishment of the Disclosure and Barring Service

2.16 In the light of the Coalition commitment to scale back the Vetting and Barring Scheme to common sense levels and the introduction of the criminal records certificate 'Update Service' in early 2013, we proposed to remove the requirement on the NHS CB to require performers to submit an Enhanced Criminal Records Check with each application for admission to a list.

2.17 The Update Service, due to be available in 2013, will mean that criminal records checks can be updated. This will give the NHS CB greater flexibility in how it accesses criminal records and barring list information. We were concerned that the existing requirement may not give the flexibility to use the Update Service. So we asked:

Do you agree that the requirement to undertake a criminal records check in every case should be removed from the Performers List Regulations? This would mean that the NHS CB could undertake these checks but would not be under a blanket duty to do so in every case.

Figure 4



2.18 The majority of commentators (60%) agreed with the proposal, with one-third (33%) disagreeing. Difficulties with the existing system were highlighted by one commentator who said:

> *"It is clearly inadequate and repetitious resulting in a costly system not fit-for-purpose. For example GP Registrars end up having 3 CRB checks at the start of their first post and then subsequent ones for other posts."*
>
> **Healthcare professional**

2.19 However, of the 16 responses from commissioning organisations (i.e. those currently responsible for performers lists) ten disagreed with the proposal. One of the ten said:

> *"CRB checks need to stay as they do provide some direction as to the criminal offences status of that individual"*

Another commentator said:

> *"There must be a facility for the NChB to be able to check up to date information on a practitioner at any time especially when apply to join the list for the first time, it does not have to be the traditional CRB but an online check."*

2.20 We have considered the proposal in the light of the comments. We agree that a check on the criminal record status of those seeking to work in the NHS is an important protection for patients and the public.

2.21 We wish to ensure that the most appropriate checks are carried out and we think that the update service will provide a less bureaucratic, more cost

effective and most importantly a service that provides the most up to date information available. However, the draft Regulations cannot refer to the Update service as it has not yet been introduced. Furthermore, it is clear that even with the Update Service, applicants will still have to produce an enhanced criminal records check certificate. In light of the concerns raised in the consultation and the status of the Update Service, we have decided to retain the existing requirement that applicants **must** provide a certificate.

Suspension

2.22 The Performers List Review recommended that PCTs should be able to suspend a performer immediately without having to give 24 hours' notice where it appears that a performer's conduct creates a serious risk to the public. Where a performer is suspended in such circumstances, the Review recommended that the PCT should confirm the decision at a hearing within 24 or 48 hours. We asked:

Do you agree with our proposal to implement the recommendation to enable immediate suspension where it appears that a performer's conduct creates a serious risk to the public?

2.23 The overwhelming majority of responses (81%) agreed that we should proceed with implementing this. Of the concerns that were expressed the main one was that this power will be used unfairly. It is clear that appropriate safeguards need to be in place.

2.24 In our view, the need to protect patients is paramount. It cannot be right that a performer who is a threat to patients is allowed to continue seeing patients for at least a further 24 hours (or longer), which is currently the case. We do agree that the process must be fair and equitable and that anyone who is suspended must have a prompt investigation and that suspension continues to be considered as a neutral act rather than a punitive one.

2.25 We have therefore built safeguards into the regulations that will mitigate against the impact on a performer from an immediate suspension. The performer will be notified of the immediate suspension and the NHS CB will need to conduct a review of its decision within two working days, although this review will not be at a formal hearing. After this initial review, the performer will be offered the opportunity to make written or oral representations at a hearing held at a later date. Regardless of the type of suspension, the performer will be able to request that the NHS CB periodically reviews the suspension, that the suspension cannot last for longer than 6 months (except following an application to the First-tier Tribunal or where such an application is pending) and that the performer receives payment during suspension.

2.26 We also asked a question about the provision of support during suspension, which was a recommendation by the Performers List Review. We asked:

Do you agree that guidance is the best way of setting out the range of support that the NHS CB should consider providing to suspended performers?

2.27 The Performers List Review recommended that support needed to be provided to suspended performers. In our view, it is not appropriate to set out in regulations how this support should be provided. The NHS CB will need to consider how best to provide such support, which could be provided on a national or a local basis. Individual performers are likely to need individually tailored support; such as, strengthening interpersonal skills, attending training, or simply helping them through what will be a stressful situation.

2.28 In the consultation, we asked whether guidance for the NHS CB would be the best approach when considering support for suspended performers. 83% of respondents agreed with the proposal for guidance to be issued. Recognising the new relationship between the NHS and the Department of Health established in the Health and Social Care Act 2012, we think that it is right that the NHS CB issue the guidance rather than the Department.

2.29 We also asked whether additional options should be available to the NHS CB at suspension hearings. We asked:

Do you agree with our proposal to implement the recommendation to have additional options at suspension hearings?

2.30 Respondents were supportive of the proposal to provide additional options at suspension hearings (87%). The draft Regulations included a proposed power that would allow the NHS CB to confirm or impose suspension or to allow the performer to resume practice subject to interim conditions at a suspension hearing. This power was proposed following a recommendation by the Performers Lists Review that extra powers should be available at a suspension hearing. **We propose to implement this proposal in the 2013 Regulations.**

2.31 The Performers List Review recommended that a performer should be able to make an appeal to the Secretary of State where they have been suspended. As we indicated in the consultation document, we consider that the current system for reviews of decisions is sufficient. Suspension is an interim act to ensure public protection on a temporary basis and is not a final determination of the NHS CB on the performer's practise. In light of this discussion we asked:

Do you agree that the current arrangements for reviewing suspensions (modified to provide for reviews to be held by the NHS CB) are an adequate and cost effective measure?

2.32 Respondents were supportive of the current arrangements with 67% agreeing. We do not intend to introduce an appeal against a suspension decision. We think that, as suspension is an interim measure, the practitioner will in any event have the opportunity to be heard before the suspension is imposed or shortly after it (in the case of an immediate suspension) and will have the right to seek a review. Any appeal would only serve to elongate the process and this would further impact on the performer. We therefore intend to retain the current provisions on review and ensure that the NHS CB

develops appropriate guidance on issues relevant to suspension, such as effective and timely investigations.

2.33 The consultation document also considered a further recommendation made by the Performers List Review, which was to introduce suspension without payment where a performer had failed to comply with any undertakings that they had given. In developing the Regulations, stakeholders considered that, were this to be introduced, suspension would have a more substantial and less neutral effect on the practitioner. We therefore proposed not to follow the Review recommendation. We asked:

Do you agree with the proposal not to take forward the recommendation of the Performers List Review to widen the powers to suspend performers. If not, please explain why not.

2.34 Respondents clearly supported not taking the recommendation forward with 78% indicating their agreement. We confirm that we will not introduce a power to suspend performers without payment as recommended by the Performers List Review.

Indemnity/Insurance

2.35 The Performers List Review recommended that performers should be required to demonstrate that they hold appropriate indemnities and insurance relating to their professional practice. We asked:

Do you agree that the requirement to demonstrate adequate indemnity or insurance arrangements should be incorporated into the draft regulations?

2.36 Respondents were strongly in support of the introduction of this recommendation, with 81% agreeing. Respondents did raise a number of concerns which included the following:

i. the requirement to demonstrate was only at the application stage and not on-going;
ii. in order to maintain registration with some of the professional bodies, the performer must hold appropriate indemnity (so the additional check was superfluous, given that the performer would have be registered to be on the performers list);
iii. a general view that adequate should be defined;
iv. that for GPs, their employer will hold the indemnities and that this will be contained within the GMS/PMS contracts.

2.37 Despite the concerns, we consider that this recommendation should nevertheless be implemented. We do not think that the Regulations should require the NHS CB to conduct on-going, regular or annual checks. Upon making an application, the performer is required to undertake that they will continue to maintain indemnity/insurance for their work, and provide evidence of such an arrangement should the NHS CB require it at a later stage.

2.38 The requirement is flexible and only requires the applicant to provide "evidence" of an arrangement. The NHS CB will therefore be able to decide whether registration with any regulator is sufficient evidence in itself. This is, however, a requirement that the NHS CB will need to consider in the course of developing its processes and procedures for applicants.

2.39 A report in the summer of 2010 by Finlay Scott on indemnity and insurance arrangements for healthcare professionals concluded that making insurance or indemnity a statutory condition of registration is the most cost effective and proportionate way of achieving the policy objective. The General Medical Council already requires doctors to "take out adequate insurance or professional indemnity cover for any part of your practice not covered by employer's indemnity scheme, in your patients interests as well as your own."

2.40 All General Dental Council registrants are required to make sure there are adequate and appropriate arrangements in place so that patients can claim any compensation they may be entitled to. The General Optical Council also requires that "individual registrants must also confirm they have professional indemnity insurance" as part of their annual retention process.

2.41 The report also recommended that existing legislation should be harmonised across all regulators in this respect. Although the regulators have requirements relating to indemnity, until the legislation is harmonised we think it is prudent to retain the requirement in performers' and patients' interests**.**

2.42 We did not consider it appropriate to define more precisely what appropriate indemnity or insurance might be in the Regulations. We have however, decided to not use the term "adequate", about which some concerns were expressed The amount of cover will depend on a range of factors including available cover from employers, professional associations and the practice undertaken by the performer. Medicine is a fast moving profession with new treatments introduced daily. It is up to professionals to ensure that they have levels of cover that protect them and their patients.

Reporting Clinical Negligence Claims

2.43 In the consultation we said that we intended to introduce a requirement on performers to report clinical negligence claims that are brought against them at the stage that proceedings are issued or when the claim is settled. This requirement would be to report claims to the NHS CB.

2.44 We did not ask a question in relation to this proposal. However, the consultation responses have led us to reconsider this proposal. We consider that the proposal would require performers to report all claims including those where the claim is withdrawn, vexatious, or shown to be without merit. We now do not think the quality of such information would assist the NHS CB in managing the lists or that it would be efficient or cost effective in identifying poor performers and protecting patients. One respondent to the consultation said:

"There are concerns that this may discourage settlement of claims and is also disproportionate, [as] *practitioners have a very small number of claims in their careers."*

2.45 A second respondent provided further comments on the proposal, as follows:

"We do not believe there should be a requirement to notify the Board of a clinical negligence claim. The regulations clearly have a function to protect the public from risk of harm resulting from a performer whose practice is unsafe, but why a clinical negligence claim should be considered as suitable evidence is unclear. Relatively few claims against medical and dental practitioners succeed as in most cases those who made the allegations do not pursue them. […] Over 70% of claims notified against the [respondent's] medical members are not pursued."

2.46 The respondent provided further comments on concerns relating to: the information to be provided; age of claims; length of time for claims to be concluded; and that a claim investigation is not conducted to determine professional competence, but to determine whether compensation should be paid. The respondent concluded by stating:

"Notifications of claims are not a reliable indicator of a practitioner's performance. They are untested allegations that are generally unlikely to be substantiated and are invariably made some time after the incident. In order to identify and help under-performing practitioners and to protect patients, it would be more constructive to collect and analyse more reliable and current data."

2.47 We agree that the introduction of this power may be disproportionate and have therefore removed this requirement from the draft Regulations to be laid before Parliament.

2.48 The following summarises our proposals relating to the main remaining Performers List Review recommendations.

Changes arising from the performers lists review – questions

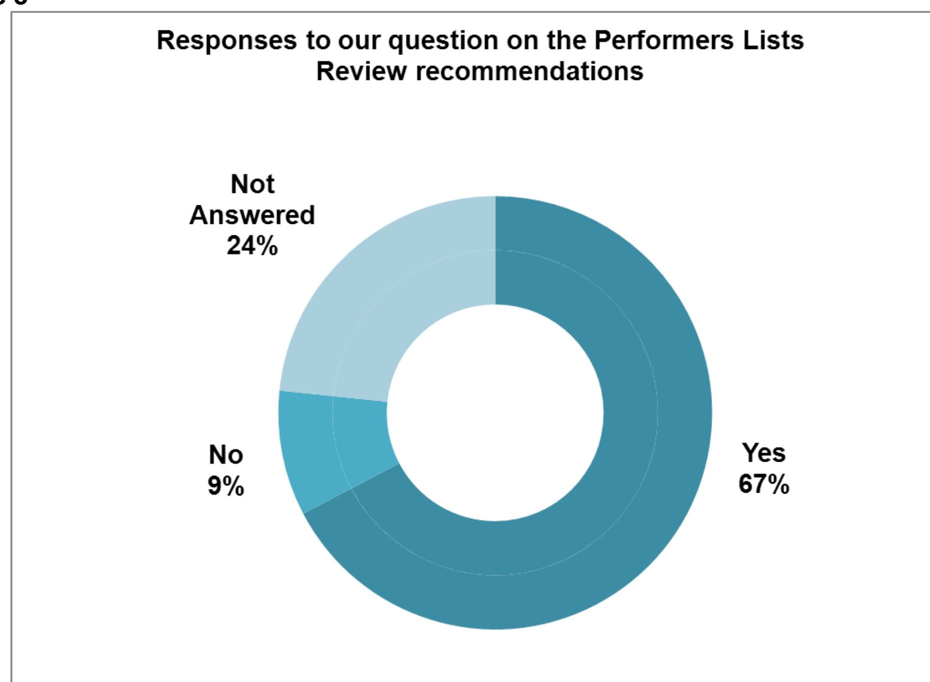
2.49 We included two questions that related to the implementation of the Performers List Review recommendations. Annex C of the consultation provided provisional comments on the recommendations. We asked:

The draft regulations incorporate changes recommended by the Performers List Review (see Annex C). Do you consider that these recommendations have been adequately incorporated into the draft regulations?

If not, please say which recommendations you think have not been adequately addressed.

2.50 The response to the initial question indicated a broad approval, as detailed in figure 5, below.

Figure 5



2.51 We received a range of different responses to the second question and there was no consistent theme. The responses also addressed drafting issues and where we considered the comments appropriate we have taken them into account.

2.52 A number of respondents took the opportunity in response to this question to highlight their disagreement with the proposal to introduce a requirement to report clinical negligence claims. We have addressed these concerns under its own heading entitled *"Reporting Clinical Negligence Claims"*, which is above at paragraph 2.43.

2.53 Some respondents raised concerns about the amount of information to be submitted upon application to the performers lists and the overlap of some of this with information they may have provided to regulators. However, the information needs to be up to date as at the time of the application and the detailed requirements help to ensure that any concerns that might affect the applicant's suitability to be on the list are brought to the attention of the Board. We think these requirements are justified in order to ensure public safety.

2.54 Other respondents stated that they needed more clarification on the NHS CB's processes and procedures, including how the NHS CB would make its decisions and its information sharing procedures and arrangements. While we understand the desire for greater detail it is not possible for the Department to provide it in this document.

2.55 The changes to conditions also featured in respondents' comments. The Regulations maintain a single provision for "conditions" (combining the current

"conditional inclusion" and "contingent removal" provisions.). Having considered the comments we received, where the NHS CB is considering imposing conditions on a performer who is currently on the list, the NHS CB must notify the performer and offer the performer the right to make representations. We think that this will give the performer an important opportunity to determine the outcome of the use of the powers. Performers will also have rights to review, and to appeal against, a decision to impose conditions.

Further amendments concerning the medical, dental or ophthalmic lists

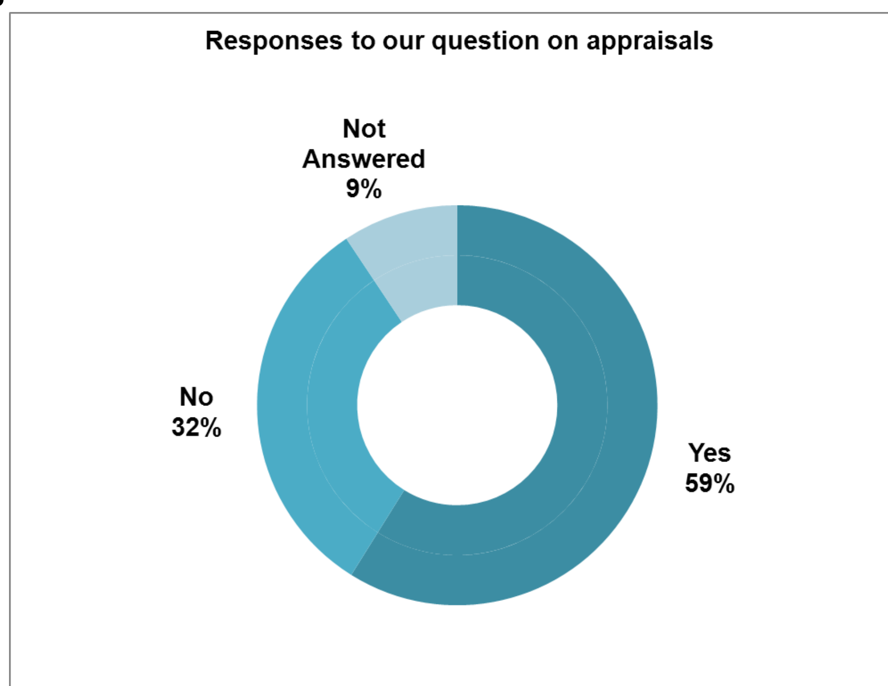
Appraisals

2.56 We introduced a requirement for applicants to provide a copy of their most recent appraisal, where they have one. This was a recommendation made by the Performers List Review. The provision needed flexibility as, although medical appraisal in primary care is well established the same is not true for dental and ophthalmic performers, whilst appraisal reports are unlikely to be accessible for applicants who have not practised in the UK before. We asked:

Do you agree that performers should be required to submit their last appraisal, if they have one, when they apply to join the performers list?

2.57 The responses to this question are represented in the figure below. A clear majority of respondents were in favour of the requirement.

Figure 6



2.58 In their comments, however, respondents expressed concern over the requirement, and raised four important issues:

i. Dentists and ophthalmic practitioners do not currently have a system for appraisals comparable to those of doctors;

ii. Doctors' appraisals are confidential, and only the summary should be provided, if at all;

iii. If there is a disparity between professions and individuals due to the requirement only to provide an appraisal 'if they have one', then it makes the provision redundant;

iv. The introduction could inadvertently discriminate against applicants who have not practised in the UK before, as they will not have appraisals to submit.

2.59 We considered these concerns and accept that, at least for the immediate future, the only performers likely to be able to supply appraisals are doctors, who are taking part in appraisal, as part of revalidation.

2.60 Appraisal information is at the centre of demonstrating that doctors are up to date and fit to practise, as such we think that where appraisal information is available it should be provided as part of the performers list application.

2.61 We think that this will ensure that the NHS CB has access to all the relevant information on applicants when they apply to join the list. Although it will not immediately apply to dentists and ophthalmic practitioners, it provides enough flexibility for the future, should appraisal processes be introduced for these performers.

2.62 We accept that there may be a disparity with some applicants coming from overseas where appraisal is not a common practice. However, we think that where an appraisal is available it should be provided. If an applicant has not taken part in an appraisal system, they will not be able to provide the information, but this would not be grounds for refusal in and of itself.

Inquests

2.63 It was a recommendation of a coroner that performers should have to report where they were an interested person in an inquest. We set out the case for this and asked:

Do you think regulation 9(2)(h), which requires a performer to report when they are a 'properly interested person' at an inquest (subject to the exceptions shown there), achieves the recommendation? If not, please explain why not.

2.64 There was general support for the proposal with 67% of respondents agreeing with the proposal.

2.65 Where commentators did not agree, the concerns were focused on the definition of the term 'properly interested person', which is not defined in the Coroners Rules 1984, or elsewhere. Some respondents considered that the

new provision might lead to performers having to report their involvement in an inquest even where their care is not in question. These are concerns we share and raised in the consultation document. One law firm summarised most of these views when it said:

> *"We strongly disagree with this proposal for the following reasons:*
>
> - *a performer may be classified as a "properly interested person" (PIP) simpl[y] because they were the last practitioner to have provided care, and they will not attract any adverse comments;*
> - *there is an inconsistency between coroners regarding who is declares PIP;*
> - *there are circumstances where a performer's representative will request PIP status to enable that doctor to be represented at the inquest;*
> - *any [concerns] regarding a performer's actions/conduct can be addressed by the coroner in exercising powers under Rule 43 of the Coroner's rules 1984."*

2.66 Whilst we generally agree with these views, we consider that performers should still be required to report their involvement at an inquest in circumstances where there service and quality of care have come into question. Although the Rule 43 mechanism may bring such matters to the attention of the NHS CB following an inquest, we do not consider that this is sufficient to identify concerns earlier in the process.

2.67 The amendment that we have made is to require a performer to notify the NHS CB if the performer is involved in an inquest as a person who falls within one of the two following rules:

- **Rule 20(2)(d) of the Coroners Rules 1984**, which says: *'(d) any person whose act or omission or that of his agent or servant may in the opinion of the coroner have caused, or contributed to, the death of the deceased.'*
- **Rule 24 of the Coroners Rules 1984**, which says: '*Any person whose conduct is likely in the opinion of the coroner to be called in question at an inquest shall, if not duly summoned to give evidence at the inquest, be given reasonable notice of the date, hour and place at which the inquest will be held.*'

General

2.68 In conclusion to the discussion of the proposals for changes to the Regulations we asked the following question:

Do you have any other comments on the draft Regulations or the policy changes described in this consultation document?

2.69 We are very grateful for the time and effort that respondents put into considering the draft Regulations in great detail. Where comments highlighted drafting irregularities we have considered them and where appropriate made changes to the draft Regulations.

2.70 A number of comments focussed on the variations in the way PCTs applied the current regulations and raised concerns about the way the NHS CB would operate them in future. They thought that greater consistency in the application of the Regulations was needed. In contrast, a number of responses highlighted a need for national lists with local decision-making, ensuring that contracting and performers list management are consistent and approached collaboratively.

2.71 Concerns were also raised relating to how performers will know which Area Team is making decisions about them and how information about performers who work across team boundaries will be captured to provide a complete picture. The detailed operational management of the lists will be for the NHS CB, but we would expect them to ensure that they do so effectively and efficiently and to take account of these concerns.

2.72 Other issues that related to the operation of the lists by the NHS CB included outsourcing of list administration; resourcing; checking language skills; and the involvement of decision-making panels. These are also matters for the NHS CB to appropriately address.

2.73 Access to and resourcing of remediation was also raised. This has been the subject of a number of separate pieces of work and is outside the scope of the consultation.

2.74 Other matters raised that lay outside the scope of the changes encompassed by the regulations under the consultation included the extension of the lists to cover other direct service providers; pharmacists lists, and application of the Working Time Directive by individual performers.

Equality

2.75 The Department of Health has obligations and duties under the Equality Act 2010. We asked two questions to help us to consider the draft Regulations in accordance with these principles. We asked:

Do you consider that the proposed regulations will impact differently for different groups in relation to any of the protected characteristics under the Equality Act 2010?

If you have answered 'yes' to question 4.1 [above], are there any measures you would suggest that would address this?

2.76 Many respondents chose **not** to answer the first question (30%). Of those that did, 39% were of the view that the proposed draft Regulations would not

impact differently for different groups. 31 % of the respondents believed that they would impact differently.

2.77 Respondents' primary concern centred on the proposals for minimum service. Many respondents highlighted the concern that introducing minimum service requirements would serve against part time workers, senior doctors (who may be more involved in managerial roles in the health service, or elsewhere), older doctors, those with disabilities or those who have to take a period of leave due to ill health or as carers.

2.78 Respondents considered that the impact on part time workers would have a greater impact on women; for example, as they are more likely to be the primary carer for children and there were also concerns that the proposal would have a negative impact on women in respect of their rights to maternity leave. However, for reasons already discussed above, we are not now introducing the proposals for minimum service in the Regulations. We will be retaining the existing power for the NHS CB to remove a performer where they have not provided services within the last 12 months but this is a discretionary power which we would expect to be exercised by the NHS CB fairly on a case by case basis and in accordance with relevant legislation such as the Equality Act 2010.

2.79 By way of further protection to such individuals, those who are subject to such a removal will continue to have rights to a hearing and an appeal against such a decision. Furthermore, if a practitioner is removed on this basis and subsequently does intend to provide such services, the practitioner would be able to reapply for entry onto the list. We think that this provides adequate protection for performers.

2.80 One respondent raised concerns over the English language assurance. In particular, that current standards are insufficient and that there needs to be in place a standard national process. From April 2013, there will be one organisation responsible for the performers lists. The NHS CB will issue guidance and procedures to its Area Teams that will be responsible for managing the list. We consider that the NHS CB's national list backed by consistent procedures and guidance, rather than the numerous lists held by PCTs, will improve the consistency in processes and decision making and improve language assurance.

Annex A – Draft Regulations

Annex A provides the latest draft of the Performers List Regulations 2013. The draft Regulations include the changes that have been discussed in this document.

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