

Agenda item:	11
Report title:	Developing the List of Registered Medical Practitioners and an update on the Data Strategy
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Action:	To consider

Executive summary

We are reporting on a number of strands of work which support our aim of becoming a more proportionate, risk based professional regulator. We are seeking to use the information and data we hold to develop a more intelligent way of regulating. We aim to help others protect patients by reflecting what we know back to the medical profession and the healthcare system.

We have completed the work to add additional information to our online register, the List of Registered Medical Practitioners (LRMP). It now better reflects our regulatory responsibilities. We will now consult on a proposal for developing a two tiered approach to the register with additional information about a doctor's practice. We have limited power to require doctors to provide new information for publication.

We continue to progress our Data Strategy with a new database which brings together much of the data we hold. This provides the infrastructure to support a simple interactive reporting system; the UK Medical Education Database (UKMED), delivered in partnership with a range of medical education partners; and a new common data set for the environments that doctors work in. We are developing an intelligence model to help us use our data to understand better the risks in medical practice.

Recommendations

Council is asked to:

- a** Note the progress on adding new information to the List of Registered Medical Practitioners.
- b** Note progress on the Data Strategy.
- c** Consider the draft consultation document on the future of the List of Registered Medical Practitioners ([Annex A](#)).

Better use of our data

- 1 Our Corporate Strategy sets out a clear aim for us to make better use of our data. Over the last 18 months our Data Strategy programme has helped put in place a more corporate approach to the development, analysis and use of the information and data we hold. Council members have seen elements of this work including an opportunity to use the new Agora reporting system.
- 2 Council has also made the development of our online register (LRMP) a priority. At its meeting on 23 April 2015, Council considered some of the initial issues with [developing the online register](#), the outcome of research we undertook to explore how the register is being used and how it needs to evolve to meet the needs of doctors, patients, employers and educators. Council agreed that we should put some additional limited information on the register and that we would develop a more extensive paper for discussion.

Making our online register more useful

- 3 The online register now better reflects our regulatory functions and responsibilities. The following information now appears:
 - a Which doctors are in an approved training programme, including their programme speciality and their deanery or local education and training board (LETB).
 - b For doctors with a licence to practise, the name of their Responsible Officer and designated body (or Suitable Person if they have one).
 - c Which doctors are recognised as GP trainers.
- 4 This work has been supported by a comprehensive communication programme. We have received a very small number of complaints regarding the changes as well as a number of positive comments.

Discussion paper on the future of the register

- 5 Before developing our online register further we are committed to engaging with key interest groups. The draft discussion document is at [Annex A](#).
- 6 The discussion document proposes a two tier approach. The first is a core data set for all doctors which the GMC will validate. The second tier is a broader, voluntary, data set which doctors can choose to opt into. This information would not undergo the same level of validation as the core data set. We would expect to work with key interests to agree how the information is presented, the relevant typologies and appropriate third party sources. We will also make improvements to make it easier to use and integrate.

- 7 The pace of change is partly limited by the current legal framework, which limits the published information we can make a requirement. Given the lack of progress on legal reform we are unlikely to get such a power in the lifetime of this Corporate Strategy. We intend to adopt a voluntary approach for much of the new information we might wish to be added.
- 8 Subject to Council's view, we will consult key interests and report back to Council on 14 December 2016.

Progress on developing our data strategy

- 9 Over the last 18 months we have been working to bring our data together to provide a clearer picture of key characteristics of the medical profession and the environments in which doctors work. At this stage our aim is to ensure that we have a clear, easily manageable picture of the data we have in a way which makes it easy to analyse and share, and that we are exploring ways of using and sharing that data in a way which manages the complex risks inherent in large databases. This is an important foundation to support our aim to be a more proportionate, risk based regulator.
- 10 The Agora database is now live. It enables us to co-ordinate, manage and interrogate our data more effectively across our functions. It provides the foundation for the:
 - a Interactive Tableau Agora reporting system – providing access to our data in a simple interface.
 - b UK Medical Education Database (UKMED).
 - c Data for a common and core data set and dashboard for environments.
 - d Development of an intelligence model.
- 11 We are preparing our data in the reporting system for an external release. Much of our focus has been on ensuring we have the right approach to anonymisation to ensure that an individual doctor cannot be identified by removing non-public domain data and suppressing data.
- 12 We have developed, in consultation with users, a common and core data set and dashboard which provide a single point for reviewing the data we hold about designated bodies. As our formal data sharing agreements grow the product can form the basis for regular, routine data sharing with the potential for automation where need be. We will continue to develop this product over the coming year.
- 13 This year we will also develop a better approach to qualitative data, exploring how we use it to support our developing intelligence model.

UK Medical Education Database

- 14** In partnership with a large number of colleges and other organisations, we have played a key role in helping to develop and launch a new UK Medical Education database (UKMED). The database brings together, for the first time, different undergraduate and postgraduate data relating to UK medical education. It provides a platform for collating data on the performance of UK medical students and trainee doctors across their education and future career. By linking data such as assessment results, UKMED aims to highlight the paths of doctors through school, university and their career. The [website](#) is now live inviting applications for UKMED data from researchers.
- 15** A full update on the Data Strategy is available [here](#).

M11 - Developing the List of Registered Medical Practitioners and an update on the data strategy

M11 – Annex A

DRAFT: February 2016

Developing the List of Registered Medical Practitioners: towards a more useful online register

Introduction

- 1** When the General Medical Council was established in 1858, the rationale was to enable patients and the public searching for a doctor to distinguish between qualified and unqualified practitioners. The regulation of medical practice has developed and evolved substantially over the intervening 158 years yet the function of enabling employers, the public and others to check if someone is registered as a doctor and holds a licence and is fit to practise, is still core to the GMC's work.
- 2** The register* is the GMC's defining contribution to the safety of patients in the UK's health system. It is a unique national resource. No other organisation has details of all those who are registered and licensed to practise. Its integrity and robustness are vital to maintaining public confidence in the UK's approach to the regulation of doctors and, in turn, ensure good medical practice.
- 3** The register has evolved slowly and in many ways it is still recognisable in the form first published as a hardback document all those years ago. Today the information contained on the register is published as an online resource – the List of Registered Medical Practitioners (LRMP) – and is no longer published in paper form. Anyone

** In law there are three registers. In addition to the medical register there is also the specialist register and the GP register. LRMP is a complete list of medical practitioners which takes some of the data available on the three registers and presents it as if one register.*

wishing to check a doctor's registration does so through our website (www.gmc-uk.org) or by calling our contact centre, where our staff will check the LRMP for them. We also share our data with the NHS Electronic Staff record to help employers and provide a download service to a number of commercial customers. The GMC has recently added new information to reflect its increased responsibilities over the past few years including the introduction of revalidation and taking on responsibility for postgraduate medical education and training. A list of the information available on LRMP can be found in the annexes.

- 4 We believe there is a public interest in developing and expanding the information presented on the LRMP and improving its functionality. Our view is that it should be more open, relevant and useful to our key interest groups in their work and interaction with doctors. We are committed to this work in our [current corporate strategy](#). Over the past year the GMC has started a conversation about how to develop the register, what the pitfalls and problems of doing so are and what the role of the regulator is in this regard.
- 5 This paper brings together the issues and opportunities in one document to support a broad discussion about how we might progress. We are committed to ensuring a wide ranging debate about the topic and will consult further on any proposed, significant changes.

Who uses the LRMP?

- 6 There were nearly seven million searches made of our online register last year and 6000 calls were made to our contact centre to ask about a doctor's registration. Independent research* found the majority of people using the online register are professional stakeholders (68%) (comprising employers (23%), health service providers (21%), Professional Bodies (6%) and doctors (18%)). Professional stakeholders tend to be repeat users who visit the site on a regular basis, 94% of employers and 90% of doctors and healthcare professionals had visited the site before.
- 7 Professional stakeholders use the LRMP to check a doctor's identity and status on the register. For example, the main reason that employers use the online register is to check a doctor's status and whether they hold a licence to practise. Other reasons

* [Reviewing the LRMP: Options for Development](#) (2015) Trajectory

include checking a doctor's reference number, whether a doctor is currently under investigation or has received sanctions or warnings in the past and the date of the doctor's registration. The GMC's data download facility allows organisations to import the entire LRMP into their existing systems as a means of checking a doctor's GMC status. This may be particularly helpful to employers outside the NHS that deal with large numbers of doctors. The service provides a daily update file with all changes to the register.

- 8 Patients and carers make up a small proportion of LRMP visits - just 12%. Unlike professional stakeholders, patients and carers are more likely to be visiting the online register for the first time (60%) and are using the register to gain assurances about a doctor's status, qualification and skills, including where a doctor studied for their medical degree and the year of graduation.
- 9 While professional stakeholders are generally satisfied with the information provided, patients and carers find the current register considerably less useful and research suggests that they are unlikely to have heard of the LRMP or know what type of information is available.
- 10 The research found the usability, design and functionality of the LRMP could be improved. In particular, a more detailed and responsive search function is needed. Making it easier to interpret the information, better sign posting around the site and clear categorisation of information would improve the usability. Mobile customisation for smartphone and tablets users is also needed.

Our vision

The GMC's vision for our online register

- 11 Our ambition is to have the most advanced, transparent register in the world. We believe that our register should keep pace with public expectations and with social and technological changes.
- 12 We want to ensure that our model of regulation stays relevant by providing trusted and useful information about a doctor's medical practice to those who require it. Our register should provide a more meaningful reflection of a doctor's past attainment and current capabilities. Further, the non-expert user should be able to use and interpret it as easily as the expert.
- 13 Of paramount importance to us is that the register retains its fundamental integrity. The public must trust in the information provided and be very clear about its validity.

Do you agree with this vision for our register? Do you have any comments to help us develop our vision?

The demand for change

14 Our register has not kept pace with developments in the regulation of doctors. Over the past 10 years the GMC has taken on responsibility for postgraduate medical education and training and introduced revalidation. Both these functions provide important safeguards for patients and extend the scope of information available about a doctor's practice. These recent changes to the online register are a step towards making more of the data public.

An out of date picture

15 Some of the information on the register is not as useful as it might first appear – particularly for those who do not have a good understanding of medical career pathways. For those more senior doctors who are on the specialist or general practice registers, LRMP, doesn't show a doctor's current practice area only the specialty on which they entered the register. This could be many years out of date because, as doctors develop their careers, they may move between specialisms or focus on one narrow area of practice. Doctors are not legally constrained to work only within their recorded specialty. The GMC has previously estimated that up to 14% of doctors on the specialist register were practising outside of their registered speciality.

16 There are a number of different routes to specialist and general practice registration. Typically doctors enter the register by completing a programme of postgraduate education and training leading to the award of a certificate of completion of training. But not all do. Doctors from EU and the European Economic Area countries are unlikely to have completed their training in the UK but under EU rules their training is recognised and registered by the GMC. Recognition does not mean their education and training is equivalent to the education and training undertaken by a UK doctor, only that certain common minimum EU standards have been met. Beyond that, it may well differ in content or duration or both, for example. So what inclusion in the register signifies is likely to be different for different audiences depending on their level of expertise.

17 And the value of this information is becoming less clear. Historically doctors were required to be listed on the specialist register in order to take up a post as a substantive, fixed term or honorary consultant in the health service in the UK. That requirement no longer exists for all hospitals, notably foundation trusts – although it is still used by the vast majority of employers when making appointments to consultant posts.

Box 1 Case study: an incomplete picture

If you look up the LRMP entry for the GMC's responsible officer and senior medical adviser – and currently acting Director of Education and Standards – Dr Judith Hulf, it tells you where and when she qualified as a doctor – Royal Free Hospital School of Medicine and which body awarded her qualification – the University of London.

It also tells you that she has additional qualifications from the Royal College of Physicians of London and Royal College of Surgeons of England, the old 'conjoint examination'. The register also tells you that she is on the specialist register as an Anaesthetist, that she continues to hold a licence to practise and is revalidated by NHS England (Regional Team – London).

But there is nothing about Dr Hulf's current work or her experience in the intervening years. Much of the information is at least twenty years out of date. It does not tell you if she is currently working as an anaesthetist or where she is employed. It makes no mention of her training, qualifications and experience after medical school up to and beyond her specialist registration.

You would not know from the online register that she developed her practice as a general and cardiothoracic anaesthetist and held a consultant post at The Middlesex Hospital (later UCLH) for 32 years. It does not record that she was President of the Royal College of Anaesthetists or that she now works for the regulator.

- 18** The introduction of revalidation and licensing has changed the information landscape. Credentialing^{*}, if introduced, will provide significant new information about that field of specialism. Information to describe a doctor's scope of practice is now increasingly available.

Box 2 Scope of Practice

Scope of practice is a way of describing what a doctor is trained and competent to do. It describes the areas in which they have the knowledge, skills and experience to practise safely and effectively in the best interests of patients.

** Credentialing is a process that provides formal accreditation of attainment of competences (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area. The GMC recently concluded a consultation on a framework for recognising credentials.*

Changing expectations

- 19** Dramatic changes have taken place over the past 50 years in the availability and use of data in every sphere of life. Modern technology provides a quick and convenient way of checking on everything from bank balances to hotel reviews. Increasingly people are using data to help them make choices and inform themselves about the services they use. The public now expects data and information that in the past was limited to experts to be available to them. And they expect that data to be provided in an easily accessible and understandable format. The UK open government network has described data as the raw material that drives transparency, accountability and responsiveness*
- 20** Across the UK healthcare system there are a wide range of initiatives and examples of the medical profession and healthcare providers responding to changing expectations. In many cases the profession is leading on providing easily accessible new information. Twelve specialities now publish consultant outcome data. It shows how many times a consultant has performed a particular procedure and, in many instances, includes other quality measures such as length of hospital stay, re-admission rate, complication rate, adverse events and mortality rate. Professionally led, this work aims to help spread best practice and identify issues that need investigating.
- 21** Other examples of doctors providing more information include doctors already publishing on their own webpages details of their clinical outcomes and other data such as measures of patient experience. They are also providing CVs and details of their training and learning.
- 22** Other services such as [iWantGreatCare.org](http://www.iWantGreatCare.org) are seeking to provide a more organised way of collecting, publishing and accessing patient reviews of individual doctors to help patient choose and assist in raising standards. Hospitals and GP practices are making more data available about the doctors they employ. And NHS services, such as NHS Choices in England, are making more information about doctors available.
- 23** And there are calls for better regulation of doctors' financial and commercial interests, for example a call for a public register of UK doctors' financial interests† and for the GMC to act in this regard. The Association of the British Pharmaceutical Industry now publishes aggregate payments to health care professionals and is expected to launch this year a publically accessible database recording payments to individual health care professionals.

* <http://www.opengovernment.org.uk/>

† <http://www.bmj.com/content/350/bmj.h506>

- 24** The GMC needs to respond to changes underway in medicine and society. One way we can ensure professional regulation stays relevant, and plays a greater part in protecting patients, is to help meet the need for trusted and robust information about medical practice and to build on our unique position as the holders of the register.

Adding to the online register – some views

Our recent research found that user groups have a clear need and appetite for a broader range of information on the online register.

There was consensus about what some of that additional content should be, notably information on the doctor's scope of practice, revalidation and location of work at a regional level. Languages spoken and qualifications were also generally met with approval.

Additionally, the research suggested some information categories would be met with disapproval – notably public reviews, official ratings and outcome or performance data.

Beyond that, different user groups have different views on what additional information should be included.

Patients and the public require the online register to carry much more information for it to be useful to them, particularly on a doctor's skills, practices, location of work and qualifications.

GPs want less additional information to be included than other user groups, for example they are less keen on including age/date of birth, employment history, working practices and listing place of work or contact information.

Secondary care doctors, employers and educators tend to be in the middle – broadly they would like more additional information but have mixed views on the inclusion of some categories such as place of work and contact information.

A more detailed summary of views can be found as an annex to this document.

Is there a case for adding further information to the online register? What else should we be taking into account when considering the argument for and against adding more information?

Practical issues with extending the scope of information on the LRMP

- 25** We have found a strong case for increasing the amount of information we publish on the online register and our research and experience suggest that there is some consensus amongst those surveyed for the inclusion of certain additional information. But there is far from universal agreement on what should be added.
- 26** Over the past year we have been exploring the issues associated with adding more information with key stakeholders through research, conferences, our regular engagement programme and social media.

What is the role of the regulator in publishing this information?

- 27** As the regulator we have a duty to publish some specified information about a doctor's practice and qualifications and a power to publish certain other information. The GMC is a trusted source of information and we have an interest in providing information that might help improve standards and protect patients in line with our overarching statutory objective of the protection of the public.
- 28** The regulator faces a number of issues. First is the issue of utility. Not all the information that could be linked to a doctor's registration is particularly helpful. And the effort in publishing is not necessarily proportionate to its usefulness. We need to be clear that the benefits of publication outweigh the costs.
- 29** These costs are not limited to the financial resources required but also the effort to collect, check and maintain the information. Doctors and their employers could have to bear the burden of this process. We also have concerns about any unintended consequences of publication. For example we know that whilst welcoming the information recently added to the register, some Responsible Officers, with large groups of doctors associated with them, have expressed concern that by linking their name to an individual doctor, complaints or concerns about that doctor may be misdirected in the first instance.
- 30** Second is the issue of relevance to our audiences. As we develop the online register we need to establish whether we should seek to support the needs of all of our key interests groups or prioritise development where we know we have – or can get – information that might be directly relevant to a particular group. We know from our research that employers are the greatest users of the LRMP and that they have a particular need for the information we publish. Patients and the public are not significant users, probably because there is little information they can use in their day to day interactions with doctors. Therefore, should we focus our development on those who already use the LRMP or work to develop and support those currently not accessing it due to its limited utility to them?
- 31** Third is the issue of whether the regulator is best placed to publish the information or whether others are better able to do it. On the one hand the GMC is uniquely

positioned to take this work forward. It has significant advantages as the only holder of a complete list of doctors registered in the UK, having a mandate across the whole of the UK and being a trusted authority with a statutory objective of the protection of the public. On the other, the profession is already taking the lead in publishing information such as outcome data and whilst the GMC might wish to sign-post robust some data it is unlikely that we are the appropriate organisation to lead on its development. The recent debate on registering and publicising conflicts of interest data has touched on whether there is value in the regulator taking the lead or whether it is better to build on the existing registers. It is not clear a consensus exists for either option.

- 32** The final issues focus on the legal powers the regulator has to publish more information. The GMC must publish certain specified information. We hold information on the registers which is not publically available on LRMP, such as registered addresses. We have quite broad legal powers to decide what additional information to publish on the LRMP.
- 33** The more substantive issue is the extent to which we can collect more information to support the development of the online register. In this regard our powers are much more limited. We do not have the power to simply collect information for the purposes of publication.
- 34** It is unlikely that, within a short time, we will achieve a broader power to require doctors to provide us with further information. This is a significant stumbling block in the short term to the GMC adopting a compulsory approach to collecting new information for the register. But it does not prevent us exploring a voluntary approach, which will build on the support within the profession for using the online register as a vehicle for greater transparency. Whichever approach is adopted we will need to consider the possible impact on different groups of doctors before we proceed to ensure we are not treating any groups unfairly.

What is the regulator's role in providing more information to our key interest groups through the register?

Should we focus our efforts on one particular group of users or seek to broaden the usage?

What are your views on the issues raised here?

The quality and comprehensiveness of the information and data we hold

- 35** Whilst the GMC holds significant amounts of information and data as a result of exercising its statutory powers, such material is not a comprehensive record of a

doctor's medical practice nor, in many cases is it up to date. Much of it is a historical record rather than an updated record of a doctor's current practice.

- 36** The data and information we hold, either collected by us or from third parties, is not complete in every respect. For example it may cover one sector such as the NHS but not the private sector. And the amount of information can vary by UK nation, for example, as different nations within the UK take different approaches to recording and sharing data on a doctor's employment.
- 37** In some cases the information that might be included on the register is currently not collected or held by the GMC.
- 38** Therefore, to develop the LRMP the GMC will likely need to collect further information from doctors or to enter into partnerships with other bodies to share information and agree that it can be used.

Maintaining the integrity of the register

- 39** New information will present a range of operational and organisational challenges to publication. A significant issue will be how the information is validated. Given the fundamental integrity of the information available on the online register, it is of paramount importance that the LRMP continues to be an honest representation of the facts, and that users are able to easily understand and weigh up any caveats that might exist.
- 40** For example the GMC does not currently publish on the LRMP the full education and training record of doctors in the UK. A doctor's professional development is a career long activity and they continue to develop their knowledge and skills, completing academic courses and becoming members of professional bodies such as the medical Royal Colleges. Some of this information will be comparatively easy to validate but in other cases, for example qualifications gained overseas, the problems are significant.
- 41** Other information may prove much harder to validate or require checking over the course of a doctor's career. For example adding a photo of the doctors to their LRMP record may require the likeness to be checked and then to be updated over the course of that doctor's career, a situation similar to the UK driving licence.
- 42** The GMC could incur significant costs and operational challenges to validation and checking – particularly if we take a compulsory as opposed to voluntary route to publication.

What else should we be concerned about when considering the integrity of the register?

A doctor's privacy

- 43** Personal privacy and their safety are significant concerns for doctors. Whilst a requirement to be open and honest about their practice is inherent in the medical profession, doctors have a right to a private life and for their data to be protected.
- 44** A doctor's employment history could be very useful to both future employers and patients. Many doctors already choose to publish their career history on personal websites or services such as LinkedIn. But not all do. Individual doctors might be seeking to keep their present location private for good personal reasons and may have legitimate reasons for why they do not wish certain information to be displayed.
- 45** We need to debate how we manage the tension between privacy and openness, recognising that for many doctors there is already a huge amount of information available about them in the public domain. We will consult on any specific proposals.

How do we strike the right balance between privacy and openness?

An approach to developing the LRMP

- 46** Given the above, the GMC is proposing to develop the online register by splitting it into two tiers. The first tier will contain core information for all doctors reflecting their training and registration status including relevant fitness to practise history, which is broadly what currently exists. The second will contain additional information supplied by the doctor on a voluntary basis. Whilst we are working on that we will make changes to improve the user experience of interacting with the online register.

Improving the user experience

- 47** We also know there is more to do to improve the user experience and improve accessibility. In the short term we plan to make some changes to the look, feel and usability of the LRMP to present better the information that is available. We will also look to move away from the current name – the List of Registered Medical Practitioners – to a simpler and more easily understandable title. We will also do more to promote the online register.
- 48** In the longer term we have embarked on a four-year programme of work to overhaul how we provide our services in a digital age. We aim to provide more personalised services to our stakeholders and to use digital technology to deliver the GMC's functions in a more efficient and effective way, reflecting how the user wishes to receive it - for example delivered over 'apps' as well as websites. We will use audience insights and analytics to continuously improve our content, and will choose

topics and formats for content that our customers will find engaging, based on audience feedback.

Do you have any thoughts on how we can improve the usability of the LRMP?

Tier one - core information

49 As mentioned above the first tier will be the core set of information which is currently available on the register. We will explore what further information about revalidation and training can be added within our current powers. For example the training stage for a doctor in training.

Tier two - additional voluntary information

50 The second tier will be information voluntarily supplied by the doctor probably through the mechanism of an annual return with the option to update the record throughout the year. This data will provide a much richer description of a doctor's professional life.

51 We will ask licensed doctors to provide us with the name of their current employer, or if they agree, directly from the NHS in most cases.

52 We will look to the medical profession to help us draw up an agreed typology for us to use in reporting a doctor's practice. The Academy of Medical Royal Colleges has already published a list of types of consultant posts advertised in the UK.

53 The GMC will consult on the final proposals for the type of information to be displayed, and how it is maintained and validated.

54 We propose allowing doctors to link to other sources of data – for example NHS Choices and specialist societies and associations such as the Society for Cardiothoracic Surgery. We think that it is right that the GMC should set out criteria for that data and its presentation, while doctors take responsibility for ensuring they comply with those requirements.

55 We will work with key interest groups to agree the possible categories for inclusion on the LRMP. We could include the following:

- a** Contact details such as work address, phone number, email and social media details
- b** A doctor's photograph
- c** Work history

- d** Languages spoken
 - e** Link to work and professional websites
 - f** Details of qualifications not listed in the core information
 - g** Details of medical Royal College membership exam passed when the doctor gained entry to the College
 - h** Honorary qualifications/awards
 - i** Professional interests
 - j** Conflicts of interest
 - k** Links to other registers, third party feedback websites and providers of data
 - l** Links to employer such as NHS trusts and boards, feedback websites
- 56** Doctors could choose which additional fields of information they could add to their LRMP record but will be expected to maintain the information on a regular basis.
- 57** Our belief is that many doctors will want to make additional information about themselves available and that, as it becomes more common, professional and patient expectations will encourage greater use. Over time and as opportunities to change legislation become available we may wish to make some of this voluntary information mandatory. Any development in our registers, and the online register, will need to be informed by an assessment of the impact on doctors to ensure that we understand the possible effects on doctors or groups of doctors to ensure we are treating registrants fairly.

Given the discussion and the constraints identified do you agree with a two tier approach to developing the online register with a core compulsory data set and a voluntary approach to additional information?

What principles do you think should be applied when deciding on what categories of information should be included or not?

What are the equality and fairness issues we should be considering as we develop this approach?

In principle do you agree that for doctors with a licence to practise we should collect and publish details of their scope of practice?

How might we go about developing a typology to help classify scope of practice?

What should information should we consider as part of the additional voluntary information section of the register?

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Annex A

The LRMP includes information about doctors and doctors in training and is publically available. This information includes:

- a** GMC reference number
- b** Given Names
- c** Surname
- d** Gender
- e** Register status - such as, registered with a license to practise

Also included is further information on the doctor's registration and where they qualified. This may include:

- a** Year of qualification
- b** Primary Medical Qualification, stating the qualifications and name of the awarding body
- c** Provisional Registration Date
- d** Full Registration Date
- e** Specialist Register entry date including the name of speciality
- f** GP register entry date
- g** Information for employers:
 - Employment check requirement details
 - Annual retention fee due date

In a recent update to the LRMP we have included additional information which will appear when applicable. This information includes:

- a** If a doctor is a recognised GP trainer
- b** Information for those subject to revalidation:
 - Designated body

- Responsible officer
- c Information for those in training:
 - Deanery/ LETB
 - Programme Specialty

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Annex B



Reviewing the LRMP: Options for Development

Views on additional information categories

	Primary Care Doctors	Secondary Care Doctors	Employers	Educators	Patients/Public
Scope of practice	✓	✓	✓	✓	✓
Revalidation dates	✓	✓	✓	✓	✓
Sub speciality	✓	✓	✓	✓	✓
Location of work (region)	✓	✓	✓	✓	✓
Languages spoken	Mixed	Mixed		✓	✓
Membership of professional bodies		✓		✓	
Conflicts of interests			✓		
Qualifications	Mixed	✓	✓	✓	✓
Age/date of birth	X	✓	✓	Mixed	✓
Former/other names	Mixed		✓	✓	✓
Employment history	X	✓	✓	✓	
Nationality/birth nation	X			✓	
Working practices	X	✓	X		✓
Qualification country		Mixed	✓	✓	

Photos	Mixed	✓	✓	✓	Mixed
Public reviews	X	X	X	X	X
Official' ratings	X	Mixed	X	X	Mixed
Outcome data	X	X	X	X	Mixed
Place of work	X	✓	Mixed	Mixed	✓
Contact details	X	Mixed	Mixed	Mixed	✓

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