



# A quality workforce: ensuring standards, applying fairness

We're working with doctors on the frontline to better understand the risks they face, and to help develop solutions to tackle the pressures of modern medical practice



In medical education we're taking action to support training environments; we're creating a new Medical Licencing Assessment, and have issued new guidance on reflective practice

We are taking steps to ensure groups of doctors with lower attainment, unrelated to ability, are supported

Pressures impact on work environments. In 2018 we joined other regulators to sign the Emerging Concerns Protocol to share concerns about particular places early



We are monitoring the fairness of our fitness to practise processes and reforming them to minimise burden, while ensuring standards and patient safety are maintained



We're working with others on a joint approach to improving exception reporting in England, and rota monitoring in the devolved countries

## Introduction

As the regulator of the medical profession, we set the standards doctors need to follow throughout their careers, and oversee UK medical education and training to ensure a quality workforce that is fit for purpose and capable of adapting to changing environments.

While we can play a pivotal role, ensuring a quality workforce needs to be a collective action by all in the health system. We need collective knowledge on where the risks are in the modern medical profession, particularly given the pressures discussed in the previous two chapters. We are always developing our understanding of these risks so that we can take action wherever there is an identified risk to patient safety. In this chapter we examine the measures we are taking to ensure standards and how we support all groups of doctors to achieve high standards throughout all stages of their career, and particularly how they can realise their potential during training.

The first section of this chapter includes our work in relation to medical education, the development of skills, and training environments. This includes: supporting groups of doctors who have different achievement levels from others, known as differential attainment; enhanced monitoring of training environments; and the development of the Medical Licensing Assessment. This is intended to create an environment where UK medical graduates and IMG doctors can meet a common threshold for safe practice and our new guidance to support reflective practitioners.

The second section of this chapter describes some of the collaborative action we are taking to improve working environments. The environments that doctors work in can have a strong influence on their ability to maintain high

standards, and we are increasingly using the intelligence we gather from engagement with the profession to work jointly with others where problems, in particular workplace problems, have come to light that affect the profession or patient safety.

Finally a culture that allows doctors to raise concerns confidently, and have those concerns acted on, and encourages learning is vital to maintaining and improving standards. The section on raising concerns highlights the importance of having a culture. This is vital to maintaining and improving standards.

We are always aiming to identify risks in a way that allows us to support doctors before problems occur. But when we become aware of situations where doctors may have failed to uphold the standards required, they may face fitness to practise procedures. Our final section provides our latest data on this and an update on the reforms we are making to these procedures.

We are committed to proportionate regulation and have been making strides in this area. We are doing the best we can to reduce pressures on doctors and not put them through the stress of these processes unnecessarily.

This includes our introduction of provisional enquiries – a way of ensuring the facts about a doctor's standards are discovered and dealt with quickly. Other reforms include an emphasis on local first – moving consideration of issues to local level with the hope that that this will enable quicker and more effective learning of any lessons to improve standards. This would bring fitness to practise processes in line with the local approach already being taken in education.

A theme throughout is fairness – fairness in our attempts to make sure that different doctors are treated fairly when they are trying to maintain

high standards, and in the processes they face when their professional standards are brought into question.

## Medical education

Our national training surveys\* (NTS)<sup>13</sup> continues to show that medical education is highly rated by doctors in training, with eight out of 10 (81%) considering the quality of their experience in their current post to be good or excellent. This continuing confidence in the system reflects well on the hard work of trainers and doctors in training, and is to be celebrated. However, this should not prevent us from identifying where issues exist.

In particular, doctors in training face many of the same high work pressures as those identified in chapter 3 – with over 40% working describing their workload as heavy or very heavy, and nearly half (48.5%) stating that they go over their contracted/rostered hours on a weekly or daily basis. In addition, around a third (30.9%) of trainers disagreed or strongly disagreed that they were always able to use the time allocated to them as a trainer specifically for that purpose.

As a regulator we want to ensure quality, fairness and high standards in all aspects of the education of our doctors in training.

Our approaches to addressing this include:

- enhanced monitoring of training locations where training is not meeting our standards
- ensuring good support is in place for all medical students and doctors throughout

their training, informed by our work on differential attainment

- the establishment of our Medical Licensing Assessment (MLA), which will ensure that all those who wish to work as a doctor in the UK can demonstrate that they meet a common threshold before we grant a licence to practise.

### Enhanced monitoring

When postgraduate bodies<sup>†</sup> are concerned about the training of doctors, they work directly with trusts and health boards to make improvements.

If the situation doesn't improve, they tell us. We also receive reports from the medical royal colleges, faculties, and others if they have concerns, so we can see evidence of pressures building from different sources.

We then work with all the organisations involved to address the concerns, improve the quality of training, and develop a sustainable solution through what we refer to as our 'enhanced monitoring' process.

Issues that need enhanced monitoring are those which we believe could adversely affect patient safety, doctors' progress in training, or the quality of the training environment, and which have not shown progress through local management.

\* For further information on the NTS, see research notes on page 139

† Postgraduate bodies include: NHS Education for Scotland and The Northern Ireland Medical & Dental Training Agency, Health Education England, and the recently established Health Education and Improvement Wales.

We then work with healthcare educators to ensure standards are met. We receive updates from postgraduate bodies, and we can provide representatives on a locally led visit to investigate a concern or check on progress. We publish information on enhanced monitoring cases on our website and share information with other healthcare regulators and improvement bodies where appropriate.

When serious concerns persist, we may decide to use our legal powers to place conditions on the approval of postgraduate training posts.

We may attach conditions to any approval that we have already given. If it becomes clear that it is unlikely the conditions will be met, we may decide to withdraw our approval for training, which means that doctors in training are removed from the training environment.

We have now undertaken statutory action at six organisations: North Middlesex University

Hospital NHS Trust (box 5), Weston Area Health NHS Trust, East Kent Hospitals University NHS Foundation Trust, Brighton and Sussex University Hospitals Trust, NHS Ayrshire and Arran, and Isle of Wight NHS Trust. In most of these cases, this was to intervene where there had been a lack of support for foundation doctors. However it has taken other collaborative action to influence care, as at Southampton University NHS Foundation Trust (box 6, see page 112).

On an operational level, there is a significant amount of collaboration involved in the monitoring and oversight required for assurance between the GMC, Health Education England (HEE), NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical & Dental Training Agency (NIMDTA).

### Box 5: North Middlesex University Hospital NHS Trust

#### Background

North Middlesex is a large trust in London which has an extremely busy emergency department. A Health Education England (HEE) and GMC visit in 2016 investigated a steep decline in NTS results, with particularly negative outcomes in the emergency department. We found a culture of bullying, deficient equipment, and competence and supervision issues among doctors.

#### Challenges

North Middlesex has experienced a range of problems. Recruitment and retention of staff

is difficult and this leads to rota gaps and problems with supervising doctors in training. These issues have a detrimental effect on the culture of the department, with service requirements being prioritised over education. We needed to intervene and offer significant support and guidance.

#### Actions

Following the 2016 visit, requirements were immediately set for the trust by HEE. A follow-up check by HEE and the GMC six weeks later showed that, although the equipment issues had been resolved, there was still a lack of appropriate supervision for doctors

in training, and pressure on staff within the department had not been alleviated. We were obliged by the seriousness of the situation to set new conditions, which, if not met, would result in the removal of doctors in training from the department. We took this step after much serious consideration.

Following this, North Middlesex requested help, including a loan of staff, from neighbouring trusts for the emergency department. There were also leadership changes at the trust. Subsequent visits and the NTS results in 2017 were more encouraging, but once loaned staff returned to their home trusts North Middlesex began to deteriorate again. We then set additional conditions, which were more prescriptive, with specific requirements around

how supervision of doctors in training should be structured. This was in order to help guide the trust in its activities, and offer it the benefit of our experience and knowledge by providing guidance through conditions.

A series of visits throughout late 2017 and early 2018 confirmed that the conditions have been enacted, resulting in a safer and more supportive environment.

### Outcomes

Threatening to withdraw doctors in training led directly to improvements at the trust; although it should be noted that we are always careful to balance any risks that this course of action might involve.

## Impact of enhanced monitoring and statutory action

Feedback from our stakeholders tells us that enhanced monitoring is effective. We know that our direct involvement raises the profile of education issues; for example, it ensures Trust and Health Board discussions and monitoring. It also means that local education providers will dedicate resources to education and training. This is important for influencing longer-term cultural change at struggling organisations, and ensures education is given appropriate weight.

Enhanced monitoring cases are complex, and local education providers involved with this process will commonly be struggling with wider system pressures such as workforce issues. These issues are not easily resolved, which is why organisations tend to stay within enhanced monitoring for some time. 22 out of the 43 open concerns (51%) under enhanced monitoring have been open for more

than two years. When a serious issue arises, we work with the postgraduate organisation and the local education provider to ensure an action plan is in place and being delivered, but it can take some time for improvement to be embedded and sustainable so that we can remove the site from the process.

It may be that, in some cases, improvements take longer to materialise. There is also the possibility that some underlying problems may not be solved by enhanced monitoring alone; we are undertaking further work to better understand this. However, it is clear that, in cases where we've taken statutory action, there is evidence of improvement. Where we have set conditions on approval, follow up visits indicate things have got better. The longer-term impact of statutory action is still unclear. We set conditions on approval for the first time in 2016, and as more data become available we will be better able to track the efficacy of our actions.

Enhanced monitoring does not always result in us taking statutory action; there are a number of examples of the process itself being effective

in raising the profile of education issues and influencing progress and improvement (box 6).

### **Box 6: University Hospital Southampton**

#### **Background**

University Hospital Southampton, a large teaching hospital, is the main specialty training hub for the Wessex region. In 2013, the NTS indicated very poor results for this trust, particularly for doctors in training in posts in the trauma and orthopaedics department. An HEE and GMC visit confirmed there were issues affecting doctors in training at all levels across this department. These issues included bullying and undermining, lack of clinical supervision and support for doctors in training, and lack of educational opportunities.

#### **Actions**

In 2014, after several subsequent visits and a lack of evidence of improvement, the GMC and the Dean agreed that he should plan to start removing doctors in training from the department. This would have had a significant effect on the ability of the trust to deliver the service. This triggered the trust, including the Board, into extensive action and this department became a priority. All levels of management were aligned in

making improvements. Subsequent visits in 2015 indicated a significant turnaround. The cultural shift within the department has been sustained; it is now a high-performing specialty within the trust.

#### **Challenges**

Once the issues were highlighted, the trust was empowered to make the changes required. The trust took the threat of removal of doctors in training very seriously, and the HEE threat was enough to encourage action. Through our enhanced monitoring process, the GMC was able to influence and enable HEE to act, but it was not necessary to take direct statutory measures.

#### **Outcome**

The Dean has attributed the turnaround to our presence during visits and input into high-level discussions around the issue. This is a prime example of how enhanced monitoring can work without the GMC taking direct action.

## Enabling all groups to reach their potential

Differential attainment (DA) is the gap between the attainment levels of different demographic groups of doctors in training. Differentials that exist because of ability are expected and appropriate. However, differentials connected solely to age, gender, ethnicity, disability etc (ie protected groups)\* may be unfair. Our standards require training pathways to be fair for all. The challenges outlined throughout this report demonstrate how important it is that we enable the whole workforce to fulfil its potential – supporting everyone to achieve high standards isn't just the right thing to do for the sake of fairness, it's also the right thing to do to help with workforce pressures.

The cause of the differentials is complex and our understanding is still developing. Research has identified a wide range of contributory factors which are believed to contribute to the differences.<sup>49</sup>

Two factors are previous educational attainment and a sense of belonging, which will be influenced by early access to economic and social capital, such as the level of parental education and support for educational or professional progression and aspiration.

In addition to the above, there are a wide range of contributory factors once someone is in medical education.

Firstly, unconscious bias or discrimination cannot be ruled out, although research suggests that it is unlikely to be the primary driver of the differential.

Secondly, other factors include stereotype threat,<sup>†</sup> increased anxiety arising from perceived bias or discrimination within the system, a lack of role models and champions from diverse backgrounds in senior roles, challenges fitting in or establishing relationships with a diverse network of seniors and peers, as well as increased risk of being placed in training environments that are distant from family and friends.<sup>50</sup>

Each doctor will have a uniquely personal experience of the training pathway. Most will overcome the barriers they face to achieve success and many doctors from protected groups excel throughout their training and career. We want to learn from these experiences to help better support those who are disadvantaged, due to either lower prior attainment or protected characteristics, when they enter training.<sup>51</sup>

## Holding organisations to account through capacity building and building the evidence base

We have strengthened our regulatory monitoring of how organisations responsible for the design and delivery of medical education are responding to the differentials as required by our standards. We have asked each HEE local office and Deanery, the deaneries in Scotland, Northern Ireland and Wales, and the medical royal colleges to describe how they are responding to the attainment gap.

We recognise that this is a complex area however an understanding of the issues and effective interventions are emerging. In order to support training organisations to meet our standards we are providing a range of support including data that enable them to explore outcomes

\* Protected groups are identified in the Equality Act 2010 as sharing a particular characteristic against which it is illegal to discriminate.

† Stereotype threat is a situational predicament in which people are or feel themselves to be at risk of conforming to stereotypes about their social group.

and perceptions broken by demographic characteristics within their region or specialty.

We are providing a platform through our website and a range of events for those organisations that have developed innovative solutions aimed at tackling the factors contributing to DA so they can share their ideas and evidence of impact (See box 7).

### Widening and deepening our understanding

We are continuing to move forward our collective understanding of the issues around DA. We will be publishing some new research from the Work Psychology Group<sup>52</sup> in which they explore other

measures which might provide additional insight into differential experiences and perceptions and DA in the earlier years of medical education. Many of these measures can be collected locally by organisations and some we hope to include in future GMC data publications.

In response to *Fair Training Pathways*,<sup>49</sup> which found a wide range of local interventions taking place, but little evidence as to their impact or effectiveness, we have published a toolkit which provides practical ideas on how organisations can evaluate the impact of their activities in the short and longer term. We are providing a forum in which their lessons can be shared with others nationally across regional and specialty boundaries.

### Box 7: Differential attainment tools and initiatives

- **An early performance indicator tool (i-Tap)** was created by HEE Midlands and East to determine which doctors may need more support to pass exams. It has been rolled out to the 2015 GP intake and an evaluation is being undertaken during 2018–2019.
- **Voluntary support sessions** have been rolled out for students with disabilities on the Gateways to the professions programme<sup>53</sup> to support their progression. The initial evaluation of the 2017 trial has been positive.
- **A unique personalised support programme** has been developed by HEE North West, which has enabled more IMG doctors to successfully pass their GP exams. Over two years, the third and fourth attempt pass rates for Clinical Skills Assessment (CSA) have almost doubled across the North West of England.
- **A peer mentoring service** has been rolled out by HEE Kent, Surrey and Sussex. Feedback has been positive and found that the mentors and mentees enjoyed taking part and found the additional support valuable.
- **Encouraging conversations around DA** through the use of a board game has been effective in HEE North West to support trainers and educators in thinking and talking about the subject. The aim was to build trainers' confidence to talk openly with trainees earlier, and to raise awareness around how attainment can be affected by different experiences and aspects of a doctors in training life.

## A common threshold for safe practice

When a doctor applies to join the medical register, we must be sure they are safe to practise. We already confirm this in a number of ways. Now we're developing plans to establish a Medical Licensing Assessment (MLA), which builds on our existing assurance work by setting a common threshold for safe practice.

This means that we and the wider community can be assured that doctors joining the medical register with a licence to practise meet that threshold, which will be the same no matter where they obtained their medical degree.

The MLA will comprise two elements: a computer-based test of applied knowledge; and an assessment of clinical and professional skills.\*

The assessment will be taken by UK medical graduates and IMGs from outside the EEA.

We also want to assess medical graduates from the EEA. That would mean nearly all doctors go through a common assessment. At the moment, the law says we cannot do this. The issue is part of the negotiations about Britain leaving the EU. Once we know the outcome of the negotiations, we will be able to plan further.

The GMC's Council has agreed that we will develop the MLA to start in 2022.

## Focus on quality for revalidation

Revalidation is an important aspect of maintaining standards with its emphasis on continued learning and professional development. We issued updated guidance in May 2018<sup>54</sup> to ensure doctors are clear about what is required and, why, for the revalidation process.† It provides information on the balance between the quality and quantity of supporting information that a doctor must collect, and explains that the GMC does not set a minimum or maximum amount. Given the pressures discussed in the previous two chapters, it is essential that the activities involved in revalidation are focused carefully on the aspects that will add value for each doctor involved.

## New guidance on reflection

We recognise that doctors are feeling concerned about practising reflectively and being open and honest if something goes wrong. We have responded to these concerns on our website.<sup>55</sup>

Doctors' reflections are central to learning and to safe practice and fundamental to medical professionalism. The importance of reflection is built into our guidance on what should be expected of UK medical graduates as well as the guidance we give royal colleges and faculties to help them develop postgraduate curricula. Moreover, reflections are an important requirement for annual appraisals and revalidation.

\* For the clinical assessment, all assessments will be quality assured against the same requirements.

† Licensed doctors are expected to collect six types of supporting information: continuing professional development, quality improvement activity, significant events, feedback from colleagues, feedback from patients, and complaints and compliments.

Working with the Academy of Medical Royal Colleges (AoMRC), the Conference of Postgraduate Medical Deans (COPMeD) and the Medical Schools Council, we co-produced and published new guidance on reflective practice, *The Reflective Practitioner*<sup>11</sup> in September 2018. The new guidance was in answer to calls from medical students, doctors, responsible officers and appraisers for clearer information on what is meant by reflection and how it can be used within medical practice. The short guide illustrates commitment to supporting an open and honest learning culture and offers clarity in a number of areas, including the following key points:

- Reflective notes don't need to give the full factual details of a case or situation, but should focus on learning and future actions.
- There is no one way of reflecting; how individuals reflect is personal.
- Tutors, supervisors, appraisers and employers should support individual and group reflection. It is important to have time to reflect on both positive and negative experiences, and group reflection often leads to ideas that can improve patient care.

- The GMC does not ask a doctor to provide their reflective notes in order to investigate a concern about them. The doctor can choose to offer them as evidence of insight into their practice, but it is entirely their decision.
- Reflective notes can, however, currently be required by a court if they are considered relevant. We continue to call for doctors' reflections to be protected in law.

Alongside these guidelines, AoMRC and COPMeD have issued a Reflective Practice Toolkit,<sup>56</sup> which lays out the principles for reflective practice and offers a number of examples and templates to support the writing of reflective notes.

We are currently producing learning materials, including case studies, to support doctors in applying the guidance in practice and being reflective practitioners. These will be published on our website in due course.

## Collaborating to improve working environments

We are very concerned to ensure that the environments in which doctors work are as safe and supportive as possible. We therefore need to be fully able to react to any concerns which could have an impact on patients and medical practice raised both internally and externally about organisations across the UK. In order to ensure our responses are coordinated and effective we have established an internal Patient Safety Intelligence Forum (PSIF). This is where senior managers from across the GMC meet to discuss how to respond to specific concerns in the healthcare sector that have been brought to our attention through our liaison and visits teams,\* via through other regulators, through the media, or other sources.

Ahead of the meetings, teams are informed about which organisations are of concern. Our field forces and intelligence teams collate relevant and up-to-date information gathered by us about these sites. This information is used to inform decisions at all levels within the GMC, and PSIF provides an opportunity to view all our evidence in one place and gain a high-quality overview of each site. Using this evidence, PSIF makes recommendations which can lead to proactive intervention and provision of support by our field forces. This can mean activity based at the organisation itself, or working with other healthcare bodies, such as other regulators, education deaneries, and local and national governments, to intervene and provide support.

Many of the sites discussed at PSIF have multiple issues, and we aim to support the organisation, where we can, with as many of these as possible.

Some sites are discussed at PSIF regularly, over a long period of time, as different issues emerge or change. As we continue to develop our intelligence gathering and upstream regulation<sup>†</sup> capabilities we are learning from each site that we support. As a result PSIF is increasingly able to look at sites and provide support before those sites become seriously compromised.

In England, we also attend the Joint Strategic Oversight Group (JSOG), which has a similar remit to our internal PSIF, for enabling collaborative working and information sharing. JSOG is an external group convened by NHS Improvement. We have been able to provide helpful intelligence to JSOG, which has been well received. We intend to continue our participation and in doing so, improve on the help we can give so that the whole sector can benefit from our data and expertise.

We also contribute intelligence and data to cross-sector projects in Scotland, Wales and Northern Ireland, including the UK Advisory Forums (UKAF) where issues in each country are discussed with stakeholders. We also work with our regulatory and improvement body partners in each country, including NHS Education for Scotland, Healthcare Improvement Scotland, Healthcare Inspectorate Wales, and The Regulation and Quality Improvement Authority in Northern Ireland, to enhance our collaborative offering and to inform action and conversation in each country. We will be continuing to grow our provision in this area.

\* Liaison and visits teams include: our offices in Northern Ireland, Scotland and Wales, and our Regional Liaison Service (RLS) in England, which works with doctors, educators, employers and other regulators to protect patients and support good medical practice, our Employer Liaison Service (ELS), which works with responsible officers, medical directors and medical managers to protect patients and support doctors to meet our standards, and our Education Visits team, who meet medical schools, deaneries and local offices and local education providers.

† Upstream regulation aims to drive improvement rather than taking action only once harm has occurred.

### Box 8: North Lincolnshire and Goole NHS Trust

In November 2017 PSIF discussed concerns about appraisal rates at North Lincolnshire and Goole NHS Trust. North Lincolnshire and Goole is a trust with multiple issues relating to recruitment, retention and staffing. This is due to a variety of factors, many linked to its geography as a dispersed trust, with individual sites being some considerable distance from each other and from populous urban areas. In cases like North Lincolnshire and Goole it is very important that all issues that can be addressed are dealt with, as even small improvements in the situation can have a strong impact.

The problems with appraisal were of interest to PSIF as appraisal is an important aspect of a doctor's development and is encouraged by both *Good Medical Practice*<sup>57</sup> and the revalidation system that the GMC is responsible for. At organisations where there are problems around recruitment and retention of staff it is essential that the staff who are already there feel engaged. These staff must be

allowed to develop their skills and interests, and their existing skills must be kept current and sharp. Lower than expected appraisal rates could be a sign that doctors are not sufficiently engaged or supported and this could lead to a loss of skill or interest, which could negatively affect what the organisation can provide for patients.

In November 2017 the concerns around appraisal rates were discussed, in addition to other educational, staffing and retention concerns. As a result our Employer Liaison Service met the medical director and responsible officer to see if there was any help we could offer, including running workshops for doctors raising awareness of the need for good appraisal and learning cultures. In April 2018 we heard from the trust that they had found this support to have been "very helpful". As of October 2018 there are no outstanding concerns about the appraisal and learning culture at the trust.

### Emerging Concerns Protocol

Nine health and social care regulators and other bodies (including ourselves)\* signed the Emerging Concerns Protocol (the Protocol), to help us share concerns with each other more effectively.<sup>58, 59</sup>

The Protocol seeks to provide a clearly defined mechanism for us to share information and intelligence that may indicate risks to users of services, their carers, families, or professionals in England.

We know that sharing concerns at the right time can make it easier to notice that a problem is emerging. We believe that working together more effectively can reduce regulatory burden by encouraging our organisations to come up with joint plans when we share similar concerns. The Protocol will help ensure regulators are transparent with the public, providers and professionals about the way that we work together.

\* Protocol signatories: Care Quality Commission; General Dental Council; General Medical Council; General Pharmaceutical Council; Health and Care Professions Council; Health Education England; Local Government and Social Care Ombudsman; Nursing and Midwifery Council; and Parliamentary and Health Service Ombudsman.

We will work together to review and evaluate the process to make sure that it works for providers, professionals and people who use services.

In addition to the signatories NHS England and NHS Improvement have also supported our emerging concerns working group.

The Protocol covers England only. We will continue to work collaboratively with the relevant national organisations in the other countries of the UK to achieve the same objective.

### Box 9: Using the Emerging Concerns Protocol

In one of the instances of the Protocol being invoked, a senior doctor approached a GMC regional liaison adviser with concerns about surgical equipment in their workplace which was an urgent patient safety concern. Some of the surgical packs were missing parts and there were surgical instruments which broke during operations. The GMC reported this to the Care Quality Commission (CQC), which agreed that we should use the provisions of the Protocol to initiate a regulatory review panel. The information gathered at this point was shared with the Nursing and Midwifery Council, a co-signatory of the Protocol.

A meeting was held where all sides shared their concerns and discussed what their own

data and intelligence said on the matter. The CQC was able to enhance its ongoing inspection of the organisation, and the Health and Safety Executive and the Medicines and Healthcare products Regulatory Agency were also informed. The dangerous equipment was removed from the site within hours, providing a tangible example of the Protocol having a positive effect on the safety of both patients and staff.

This case also illustrates the joined-up nature of healthcare and how actions in one area can have a positive effect elsewhere. The supplier of the substandard surgical packs was found to have provided packs to other organisations. These packs were also identified and removed.

## Collaborative quality assurance of training environments

Organisations that train doctors and medical students must meet our standards.\* Through our quality assurance processes, we work with medical schools and postgraduate organisations to check that our standards are being met.

Since 2011 we have gained this assurance partly through a series of regional reviews, which took the form of visiting each postgraduate organisation, each medical school and a sample of LEPs in each region. This schedule of reviews

## Raising concerns

Working and learning environments for doctors must be free of bullying and harassment. It is the responsibility of healthcare providers and employers of doctors to ensure that they are operating a positive culture where concerns can be raised with confidence. Doctors at all stages in their career should never hesitate to act openly and honestly if something has gone wrong.

There have been anecdotal reports from our Regional Liaison Service (RLS) and devolved offices that there is an issue with processes of reporting and acting upon concerns. The reports also imply that doctors are 'inoculated' against problems linked to resource shortages, in the sense that they have become 'normal ways of operating' and may not be reporting those concerns as a result. Some strategies reported on in chapter 3 represent this 'normalisation'.<sup>1</sup>

Our intelligence data indicate that there is a lack of awareness of Freedom to Speak Up Guardians (existing NHS staff in England with an additional role to facilitate candour, raising of concerns and other openness issues).

has now come to an end and we are undertaking a further review to determine how we will seek assurance in the future.

Our proposed approach will give us better, more continuous assurance as we work more closely with medical schools and postgraduate organisations. We will be more flexible and supportive with these bodies, allowing them to provide evidence in a way that fits with their activities. This will in turn enable them and us to spend more time making sure that training environments are safe and provide high-quality training for the doctors of the future.

There were also a number of issues raised with us at meetings and sessions with doctors about the software used to raise concerns, including problems with the length of forms or problems around the issuing or use of passwords.

## Doctors in training raising concerns

The national training survey (NTS) suggests that for doctors in training there is a largely positive picture about the reporting of patient safety and educational concerns but not uniformly. Four out of five (81%) of all doctors in training told us in the NTS, carried out in the spring of 2018, that there is a culture of proactively reporting concerns in their post. However, 4% disagreed or strongly disagreed that there was a culture of reporting concerns, and 15% neither agreed nor disagreed.

We can see from our internal analysis that there is also variation between specialties, with some having a more negative viewpoint than others, both from doctors in training and trainers.

\* Our standards for the management and delivery of medical education are laid out in *Promoting Excellence*<sup>60</sup>

Doctors in training in GP (89%), obstetrics (87%) and paediatrics (87%) posts are more likely to say that they agree or strongly agree that there is a culture of proactively reporting concerns compared with those in surgery (76%), medicine (77%), and occupational medicine (78%) posts. It is true that more than three quarters of doctors in training in these latter specialties are positive about the culture of reporting in their post, but the difference in responses (almost 13 percentage points between GP and surgery) is of note. It is also very worrying that a quarter of trainees in these specialties do not think such a culture exists.

Three quarters (74%) of doctors in training are confident that patient safety concerns are effectively dealt with in their post. Although this is positive for the majority, the fact that a quarter (26%) do not agree that patient safety concerns are adequately dealt with is also potentially worrying. This again varies between specialties with four in five doctors in training in GP posts being confident compared with 64% of doctors in training in psychiatry posts and 62% in surgery posts.<sup>23</sup>

### Raising educational concerns

In the 2018 NTS, nine out of 10 (90%) doctors in training said that they are confident they know how, or could find out how, to raise a concern about their education or training.

However one out of ten (10.5%) doctors in training are not confident that their concern would be addressed. Only two thirds (66.7%) are confident. Just three in five trainers in occupational medicine (61.2%), obstetrics and gynaecology (61.1%), and medicine (60.3%) feel confident that concerns will be addressed.<sup>23</sup>

### Raising concerns and leadership

NTS findings show that a substantial minority of doctors in training do not feel confident about raising concerns, nor do they feel that any concerns raised will be dealt with appropriately. In addition, our RLS and devolved offices have picked up significant anecdotal evidence that confidence in raising concerns is not uniform, highlighting the need for leaders to work proactively on ensuring just cultures where concerns can be raised easily, without fear, and appropriate learning or action can happen.

This issue, if not addressed, can have serious consequences for the wellbeing of doctors and the quality of care patients receive. In the many inquiries into patient harm such as Mid Staffordshire, and more recently Gosport, doctors reported that there is a lack of response from senior management and others when they raise concerns.

Jeremy Hunt, then UK health secretary, said Gosport showed there was a blame culture across the health service that made medical staff reluctant to raise the alarm about mistakes.<sup>61</sup>

Good leadership is crucial in creating a workplace environment where patients' interests are prioritised and staff are supported in maintaining standards. If the top of the organisation can demonstrate that the good clinician is one who learns from experience, this will help mitigate the fear of blame among staff, which may act as a barrier to reporting errors.

The qualitative data that we capture from the interactions of our staff with doctors on the frontline demonstrate that good leadership in this area can have a positive effect and is therefore worthwhile. We have captured some

instances of a positive mood coming from good leadership and doctors feeling listened to and prepared appropriately.

But our qualitative data also demonstrate that this level of leadership is lacking in some places. Some doctors have explained that they don't raise concerns, or that they feel unwilling to do so, because they worry about personal negative consequences if they do so. This includes being labelled a troublemaker, not being able to get references or other future damage to their careers, and getting other colleagues in trouble.

We also have evidence from our internal intelligence gathering that some consultants are discouraging less senior doctors from exception reporting or rota monitoring. These are the mechanisms for doctors in training across the UK to report concerns they have about the impacts of working in under-resourced environments.

Part of the independent review of gross negligence manslaughter and culpable homicide will address how doctors feel able and better supported to act on their concerns.

Doctors are also concerned that individual clinicians are being held accountable for system pressures. They fear they are getting the blame when things go wrong.

The independent review is also looking to address how accountability is appropriately apportioned between healthcare systems and individual doctors.

## **GMC response to raising concerns**

We are completely committed to playing our part in engendering a speak-up culture across the healthcare sector. We have a pivotal role to play

in making the health service a place for learning, not blaming.

## **The Emerging Concerns Protocol**

As we outlined above, we are one of eight health and social care regulators in England which have signed a new agreement to help them share with each other more effectively concerns that may indicate current or future risks to users of services, their carers, families or professionals.

In particular the Protocol will provide an avenue for raising concerns that might not have triggered other formal information sharing processes. There is significant emphasis on creating and nurturing open cultures where staff can speak up about their concerns.

## **Exception reporting and rota monitoring**

Since the introduction of exception reporting in 2016, organisational cultures, staff engagement and differences in local processes have all impacted on its effectiveness.

We have been pushing for the standardisation of exception reporting across England and are working with the BMA and the wider medical profession to improve how doctors of all grades can register safety concerns about working in an under-resourced environment.<sup>62</sup>

In June 2018, we, together with NHS Improvement, the AoMRC, the BMA, the CQC, HEE and NHS Employers, agreed a joint approach to improving exception reporting. We are also currently working with partner organisations in Scotland, Wales and Northern Ireland on issues around rota monitoring, in particular the BMA.<sup>63</sup>

## When doctors fail to meet standards

We have systems in place to support doctors who may be struggling to meet our professional standards as set out in *Good Medical Practice*.<sup>57</sup> When these standards are breached, doctors may become subject to fitness to practise investigations.

In the web annexe we detail our full fitness to practise data. Here we examine certain elements that relate to this chapter's themes of maintaining high standards and fairness.

### Complaints about doctors

Most doctors do not have complaints that question their fitness to practise and, as we saw in chapter 3, many doctors are going the extra mile to deliver high-quality care and cope with the current pressures in their work environments. Only a tiny minority are given sanctions or warnings each year.

### Complaints continue to decline

Complaints made to the GMC about doctors continue to fall. In the 2017 report we saw that the decline in complaints had slowed but the downward trend continued, with a year-on-year reduction of 8%.

Over the five years from 2012 to 2017 complaints reduced by 13%. Complaints from people acting on behalf of organisations (other than employers)

reduced by 46% between 2012 and 2017 to 869 in 2017, and complaints from members of the public reduced by 10% to 5,005 – the reasons for this reduction are unknown (figure 43, see page 124).

Referrals from employers reduced by 46% (from 604 to 328, between 2012 and 2017), which is in part due to a range of activities, such as our work to encourage more health cases being resolved at a local level where possible, and the Employer Liaison Services (ELS) work with employers to improve their understanding of our referral thresholds, ensuring only relevant cases are referred to us.

The number of complaints referred to employers dropped in 2013–14 (figure 44, see page 125), which may have been due to changes made to our online complaints form. These changes help complainants understand more clearly what types of complaint should be made to the GMC and which could be made locally. We also made changes to our guidance regarding doctors' duty of candour, which has resulted in the 98% increase in doctors self-referring to the GMC. The guidance says doctors must be open and honest with their regulators and raise concerns where it is appropriate.<sup>64</sup>

Figure 43: The change in complaints from each source, from 2012 to 2017

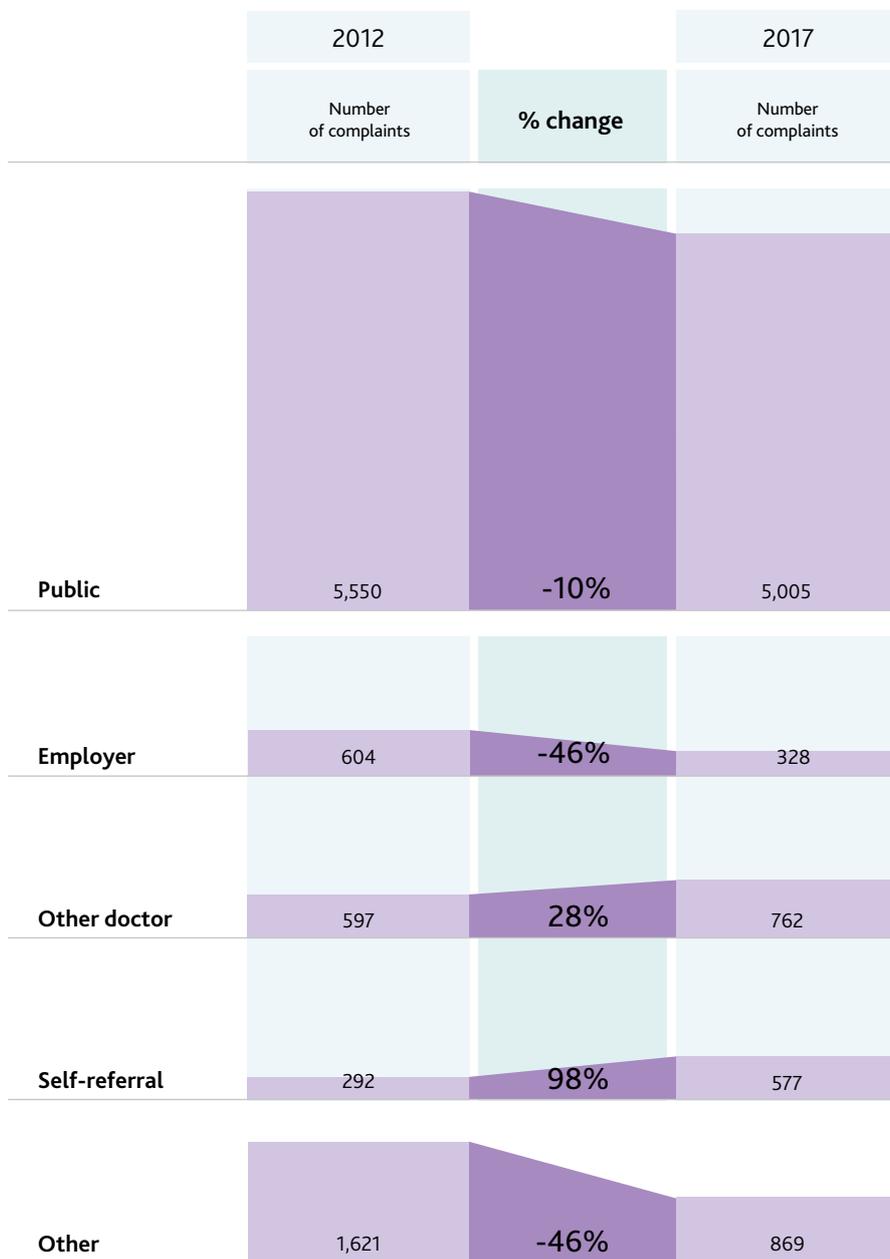
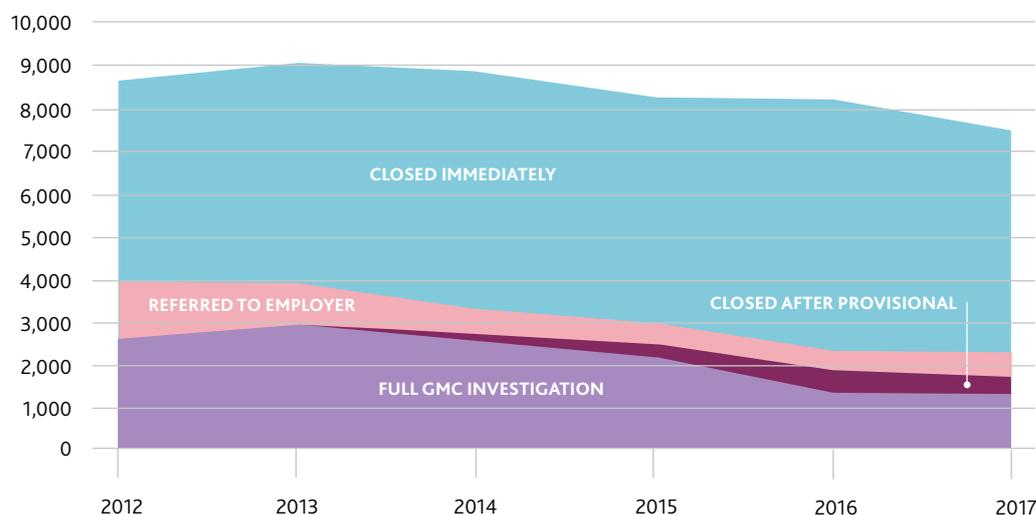


Figure 44: Complaints received by outcome,\* from 2012 to 2017



## Reforms to fitness to practise

Through our fitness to practise reforms, we are developing and implementing a range of actions to ensure high standards while also supporting doctors going through the process.

This includes reducing the number of full investigations, thereby minimising stress for doctors and time spent away from practice. We are also developing a ‘Local first’ approach (see below).

## Provisional enquiries

As figure 44 shows, most complaints about doctors are closed immediately where there are no grounds for further examination of the complaint. Where this is not the case, complaints are sometimes referred back to employers if they are the most appropriate body to handle them. For example some complaints made about behaviour or communication not linked to a wider pattern of behaviour. Prior to 2014,

all the remainder were subject to a full GMC investigation that would often put a significant burden on the doctor involved, even if the case were subsequently closed with no further action. Since then, as part of our efforts to reduce the burden on doctors who become involved in fitness to practise procedures, we have introduced provisional enquiries. This allows for further examination of some complaints to be made to determine whether a full investigation is really a necessary and proportionate response to the complaint.

The roll-out of this new process has meant that, by 2017, 40% of complaints that are not closed immediately or referred back to employers are now subject to provisional enquiries. Of these, 68% have not subsequently required a full investigation. Since being introduced, 951 complaints have been closed after provisional enquiries, reducing considerably the burden on the doctors concerned, compared with what would have been the case had they been subject

\* There are 94 complaints still being assessed not included in this chart, data as of 15 May 2018.

to a full GMC investigation. The proportion of complaints which go through to a provisional enquiry has been increasing as the process becomes more embedded (7.8% of complaints in 2017 went through to provisional enquiries compared with 6.9% of complaints in 2016 and 4.5% in 2015).

Details of the provisional enquiry process are described in box 10. The level of risk we are

willing to accept has not changed, nor the thresholds for investigation; we remain confident in the assurances our processes provide. However the success of the provisional enquiry process showcases that some innovation is possible within the restrictions of our current legislation.

### **Box 10: How we have implemented provisional enquiries**

A provisional enquiry is a limited, initial enquiry at the triage stage of our fitness to practise process to help us decide whether to close a complaint or open a full investigation. It is essentially a way of filtering our complaints to minimise the number of full investigations we need to carry out. It helps us to respond more quickly and proportionately to a complaint, and to accurately assess risk and to avoid unnecessary investigations.

We aim to complete provisional enquiries within 63 days compared with six months for a full investigation, helping reduce unnecessary stress and inconvenience to all parties involved, and reduce the time that the complainant spends waiting for a response. It also allows us to put more resources into the most serious cases.

During a provisional enquiry we gather one or two discrete and easily obtainable pieces of information such as medical records and/or a local investigation report. We may also seek an expert medical opinion to inform our decision making.

The introduction of our liaison teams, the ELS and RLS, has strengthened our relationship with the profession and their employers by facilitating closer working. This has enabled us, via the ELS, to gather the easily obtainable evidence which is needed to inform the provisional enquiry process. Through the ELS we are able to increase confidence in local processes and it is often as a result of our confidence in the robustness of local processes that we are able to close enquiries to us and allow them to be dealt with locally. Our ELS, RLS and devolved offices allow us to increase our understanding of what is happening on the ground in an area. The embedding of the revalidation process and enhanced local governance processes have also streamlined the way we can gather the necessary evidence.

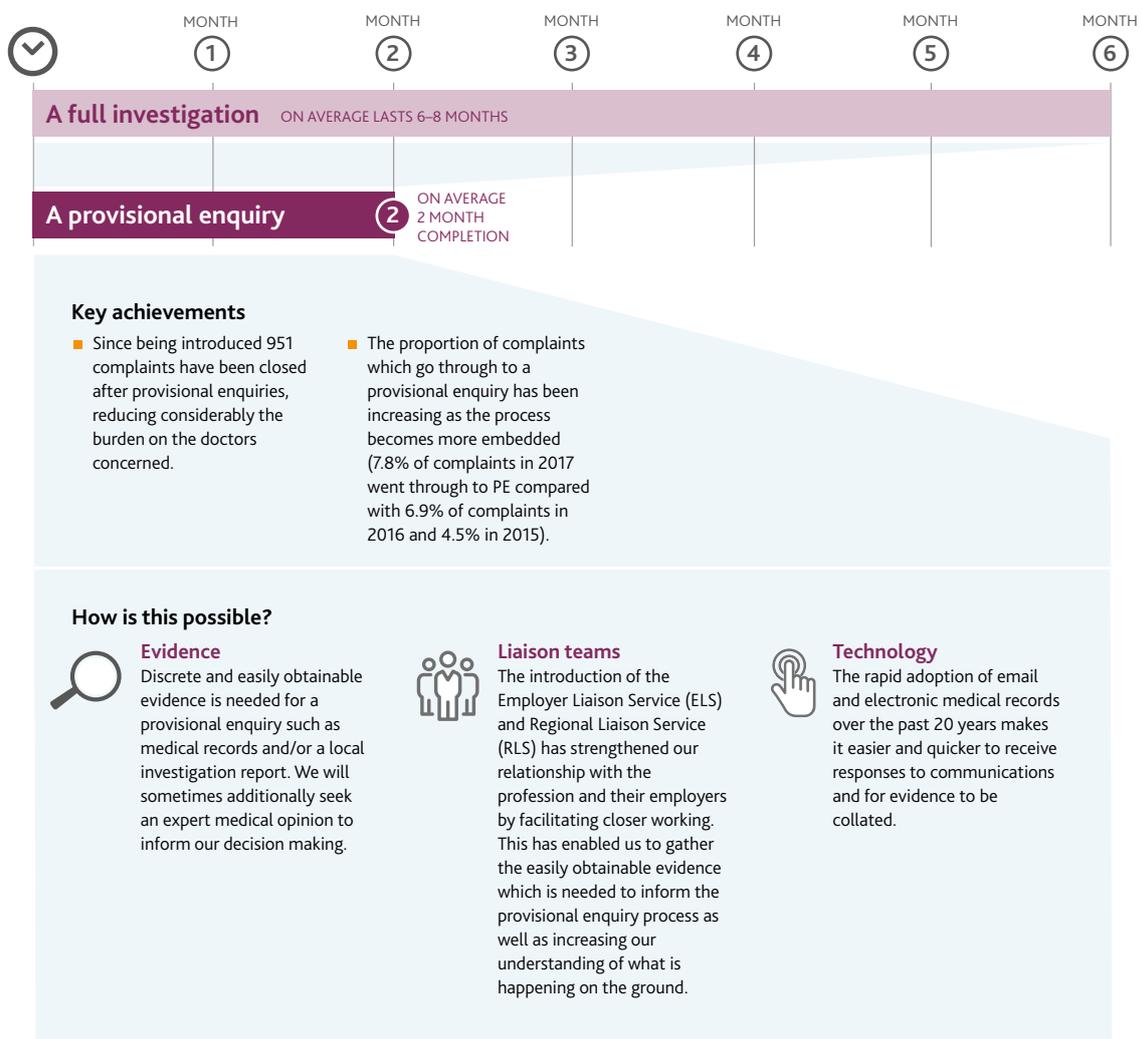
The rapid adoption of email and electronic medical records over the past 20 years makes it easier and quicker to receive responses to communications and for evidence to be collated.

## Why did we introduce provisional enquiries?

On reviewing our data, we found that between 2010 and 2013 85% of investigations were closed with no formal action against a doctor. We

therefore acknowledged that our current fitness to practise processes were not proportionate and sought a way we could improve our processes through our current legislative boundaries.

Figure 45: A full investigation compared with a provisional enquiry



## Local first

We've come a long way in recent years to improve how we handle complaints about doctors. But there is still much more we want to do to make sure concerns are dealt with as swiftly and efficiently as possible for everyone involved. We still know how stressful the whole complaints process can be.

Our long-term aim (requiring legislative reform) is that all complaints and concerns about doctors should be dealt with at the right level and, where appropriate, concerns should be addressed locally, only involving GMC action where necessary. Resolution at local level is likely to increase the learning from an incident within

the organisation where the incident occurred. This is particularly important as a variety of the strategies identified in chapter 3 are adopted in different places to deal with the pressures we have been reporting on.

Our corporate strategy<sup>16</sup> commits to a pilot of a 'local first' approach by 2020. We are currently carrying out a programme of research to help us understand and map out how this would work, what the challenges, risks and benefits are, and how we can work with our key partners to partially achieve this ambition within our current legislation, while also being clear about where legislative reform is most important.

### Box 11: How the GMC takes the context of an incident into account

When we consider a complaint, we look at potential individual or system failings (or a combination of both) and take these into account when considering whether action is needed.

We are now giving all fitness to practise decision makers, case examiners and clinical experts human factors training. Being aware of human factors means considering what people are being asked to do, the skills and competence of the person being asked to do it, and the environment in which they are working. These factors are all relevant to the context in which incidents take place, and we are committed to ensuring that they are always taken into account appropriately.

In cases where a healthcare organisation has referred the doctor to us, we also confirm whether the doctor has previously raised any concerns about patient safety or systems. This helps us understand the context of the case and reduces the risk of doctors being disadvantaged for raising concerns.

Our focus is on whether the concern and the doctor's response suggest that the doctor is likely to pose a risk to patients or to public confidence in doctors in the future, rather than on punishing doctors for what has gone wrong in the past.

The risk will be lower for a doctor who shows insight into what has happened and retracts to make sure that mistake can't happen again.

## Fairness in fitness to practise

We take our responsibility to be a fair and transparent regulator very seriously.

There have been claims that we act in a discriminatory way and that our fitness to practise procedures exhibit institutional bias against groups of doctors, such as BME doctors.<sup>65</sup> However research has indicated that it is the nature and seriousness of allegations that are the primary drivers of the outcome of an investigation.

Our data analysis and audits to date indicate that our processes do not introduce disproportionate outcomes for doctors of particular ethnicities. We continually monitor this issue and improve our methods of data analysis in this area. We are undertaking further analysis of our approaches and will fully publish this in 2019.

Although we have been assured that there is not disproportionality of outcome as a result of our processes once a complaint is received, we know that there is disproportionality in the flow of complaints into the GMC. Some groups are more prone to complaints or concerns from particular sources, such as the police or employers compared with other groups. Successive reports on *The state of medical education and practice in the UK* have found, for example, an overrepresentation of BME doctors being complained about by these two sources.<sup>66</sup>

Research has not yet established deeper reasons behind why certain groups of doctors are referred more often.

So, we have commissioned independent research to better understand this issue.<sup>12</sup>

It will include:

- understanding how clinical leadership influences the way healthcare organisations identify and respond to concerns that might result in referrals
- looking at how the complaints are dealt with locally, for example through disciplinary hearings, before a decision is made to refer to the GMC
- understanding how organisations assure themselves regarding their decision making about fitness to practise concerns and identifying where there is good practice that could be replicated more widely.

The research is being carried out by Roger Kline, Research Fellow at Middlesex University Business School, and Dr Doyin Atewologun, an expert in work psychology, diversity and leadership at Queen Mary University of London's School of Business and Management.

The work will cover all four countries in the UK and cover a broad range of types of employers across the health sector. The results will be published in the first half of 2019.

This will enable us to work more closely with clinical leaders to properly develop supportive and open workplaces. There will be important lessons for employers as well. We aim to work with employers to help us better understand and address the reasons for this, although solutions are unlikely to rest wholly with us.

### **Box 12: Diversity on our tribunal panels**

Of the Medical Practitioner Tribunal Service's 306 members, 46% are female and 19% identify as BME.<sup>67</sup>

This compares favourably with the most recently published figures for courts in England and Wales (28% female and 7% BME) and

tribunals in England and Wales (46% female and 14% BME).<sup>68</sup>

It also compares well with the UK population (51% female and 13% BME).<sup>69</sup>