



How we and others can build a sustainable workforce

The GMC can contribute to workforce strategies across the UK to deal with the pressures outlined in previous chapters. We outline some in this chapter



We are working with others to help recruit and retain more doctors, particularly GPs

We have started an independent review of medical student and doctor wellbeing



We are calling for changes to outdated legislation that blocks us from most effectively supporting health systems, doctors and patients in the 21st century

Our programme of 'Welcome to UK practice' inductions for doctors new to the UK is being expanded

We are making post-graduate training more flexible and relevant to meet changing workforce and patient needs



We are exploring with others establishing a national database that more accurately captures doctors' scope of practice so that capabilities and gaps can be better identified

Introduction

As demonstrated in the previous chapters, the health system across the UK is at a critical juncture: a combination of increasing demand on services, changing career expectations from clinical professionals, greater prevalence of multimorbidities in an ageing population, and the challenges of implementing, regulating and paying for new technology collectively creates significant pressures that are putting patients at risk now and in the future.

In our clinically led system, the medical workforce of nearly 245,000 licensed doctors in the UK is at the heart of this storm.

As the body responsible for regulating the medical education and practice of doctors in the UK, we can support the four governments, their health systems, and doctors, bringing ideas, data, insight and our regulatory toolkit to bear as part of a systemic response to a national challenge.

In this chapter we examine what could be done by us and in collaboration with others:

A Improving the supply of doctors: we believe we can build on our existing work set out in chapter 4. This includes in the short term making it easier for international doctors to work in the UK by reforming legislation to make the route for joining the GP Register and the Specialist Register more proportionate. And in the longer term making training more flexible and more relevant, by reviewing training pathways through allowing a more modular approach to postgraduate training. Finally to ensure relevant skills such as clinical leadership

and risk management in complex systems are included in training, we could promote these through generic professional capabilities or through weighting curricula outcomes.

B Better support to retain and attract doctors: we are continuing to build on our 'Supporting a profession under pressure' programme⁴⁸ so as to play our part in developing good workplace cultures and supportive environments. This will include acting upon the findings of the UK-wide review of medical students and doctors' wellbeing led by Professor Michael West and Dame Denise Coia. We are also reviewing the way we quality assure education and training whilst continuing to support those in enhanced monitoring and engaging on proposals for introducing credentialing in areas that are not currently regulated or where training opportunities are insufficient or too inflexible to support service delivery.

C Taking a more strategic approach to maintaining and improving standards: we recognise that we can better support the profession in partnership with other

parts of the health systems in the UK. For example we are working with partners to explore how more data on doctors' scope of practice might be captured to inform strategic workforce planning and reviewing how our front line engagement teams engage with the profession and the health systems in which they work.

Many of the options we present below can be implemented as part of ongoing work programmes, though some will need a willingness to challenge long-held assumptions about medical education and careers. Some

will require flexibility of regulation that can only be delivered through legislative reform to a legislative framework that is over 35 years old and becoming an active block to supporting the health systems and patients.

In the long term, we believe that with legislative reform of the Medical Act,²⁷ we could shift much of the significant resource that the GMC has into oversight of education and training and upholding medical standards whilst reducing pressures on practising doctors, improving their productivity and service to patients.

A: Improving the supply of doctors

In chapter 2, we looked at the medical workforce, highlighting specialisms and localities where there is the risk that there may not be the supply of doctors required to meet growing demand. Multiple approaches are possible to improve supply and here we consider some that we could particularly contribute to alongside others.

General practice

We have been working with NHS England (NHSE), Health Education England and the Royal College of General Practitioners (RCGP) to support the international GP recruitment programme. Part of that programme included mapping the UK GP curriculum against two GP curricula in Australia. This means that GPs trained in Australia under those curricula will be required to provide significantly less evidence as

part of any GP registration application for the UK. We have also supported NHSE and HEE to proactively contact overseas doctors currently training in the UK to encourage them to consider primary care for their specialty training and remain in the UK to work following completion of their certificate of completion of training (CCT).

In addition, we have begun to explore with partners what additional flexibility there could be with the Performers List in England. Work is under way to review these regulations in light of the wider service changes in primary care following the NHS five-year forward view and the establishment of sustainability and transformation partnerships (STPs) and accountable care organisations. Additional flexibility in the Performers List* could include adding the outstanding cohort of defence

* Each country in the UK holds a National Performers List for GPs which is set out in legislation. The list provides an extra layer of reassurance for the public that GPs practising in the NHS are suitably qualified, have up-to-date training, have appropriate English language skills and have passed other relevant checks. The Performers List also includes processes for responding to concerns about GPs and taking local action to restrict or suspend their practice when appropriate.

medical services GPs onto the list so that they can also work in the NHS. Further segmenting the Performers List to include other groups of doctors could support the retention of retiring or returning GPs to work within a limited scope of practice and the development of a specialty doctor cohort where non-GPs could work in limited primary care roles. These changes would expand the primary care workforce, lessen the demand on GPs for some aspects of care and free up capacity.

The GP Register and the Specialist Register

We are seeking legislative reform of the equivalence route for joining the GP Register and Specialist Register (also known as certificate of eligibility for specialist registration (CESR) and certificate of eligibility for general practice registration (CEGPR routes). This reform will provide greater flexibility in the process and support doctors with a wider range of options to demonstrate their knowledge, skills and experience for GP registration. In most cases, this would reduce the time required of doctors to collate the evidence for their applications, which should encourage more doctors to seek registration as well as shorten the amount of time it takes doctors to join the GP Register or Specialist Register.

Enabling IMGs to access PLAB more quickly

In order to obtain UK registration, most overseas doctors must pass the two parts of the Professional and Linguistic Assessment Board (PLAB) test. The numbers of overseas doctors seeking to sit the PLAB assessment test has

increased significantly in the past 12 months with around a 45% increase in PLAB1 candidates and more than 75% increase in doctors sitting PLAB2. To support this demand we have run more PLAB2 testing days than ever. We have also opened and/or expanded our existing PLAB1 assessment centres in numerous countries to make it easier for doctors to book onto a test. This included, for the first time this year, offering PLAB1 in our office in Scotland following discussions with the Scottish Government. In summer 2019 we will also open a new two-circuit clinical assessment centre in Manchester for the PLAB 2 assessment, which will reduce waiting times and support doctors to obtain registration more quickly.

Making training more flexible and relevant

We will continue reviewing training pathways, in particular looking at how postgraduate training can have a more modular approach to ensure doctors in training learn the relevant skills, such as clinical leadership. This review will also explore the legal possibilities for recognising experience gained outside approved training. This work would be undertaken with Royal Colleges, The Academy of Medical Royal Colleges, and Health Education England (HEE), NHS Education for Scotland (NES), the Northern Ireland Medical & Dental Training Agency (NIMDTA) and Health Education and Improvement Wales (HEIW). In addition, we want to explore the legal possibilities around recognising more of the experience gained outside approved training, as part of the overall educational approach.

Medical associate professions

We believe there's a strong case for one regulator to have oversight of both the medical profession we currently regulate and the medical associate professions (MAPs) and their training systems. We would be willing to take this responsibility if the government selects us.

Legislative reform will be required once the Department of Health and Social Care has made its decision on MAPs regulation.

Internationally based doctors treating patients in the UK

With advances and developments in technology and telemedicine, we are exploring how to maximise the longer-term potential for internationally based doctors to treat UK patients, with the same assurance on standards as when the care is provided by UK based doctors. Some developments in this area may require legislative reform.

Strengthening oversight of the training environment

We are seeking stakeholder support in all four countries for new and more proportionate powers that strengthen oversight of the training environment. This would allow a gradation of powers to intervene when necessary to provide support, which will make improvement possible. These are required particularly for foundation training and new initiatives such as trust fellowship* programmes.

Medical Licensing Assessment

In the medium term, the introduction of the Medical Licensing Assessment from 2022 means that UK medical students and IMGs will have to demonstrate that they meet a common threshold for safe practice in the UK before we register and license them. This will give greater assurance to patients, employers and educators that doctors entering the UK workplace have the knowledge and clinical and professional skills for safe practice.

Supporting doctors who are not on the GP Register or the Specialist Register and not in training

We will be surveying doctors on neither register and not in training in 2019 to seek greater insight into their motivations, experiences and challenges. By getting a better understanding of this group we will be able to identify the best ways to support and develop this part of the workforce.

Incentivising good workforce culture and employment practice

We will explore how we can incentivise good workforce culture and employment practice in partnership with regulatory colleagues within the health systems of the UK.

* Trust Fellowship Programmes are a new approach to training which some individual trusts choose to offer. They offer an alternative to formal postgraduate medical training. Non-consultant grade doctors are able to work permanently for a trust and receive additional training. Doctors are able to continue to develop their careers, specialise, and gain experience so that they can apply for a CESR in the future, rather than using formal postgraduate training to obtain a CCT.

B: Better support to retain and attract doctors

We have looked, particularly in chapter 3, at the pressures encountered by doctors and the support that they value. We have also shown in chapter 4 how we work with employers and educators to support doctors, particularly those in training. We are continuing to build on this through our 'supporting a profession under pressure' programme,⁴⁸ and the following proposals look at how we can do more by working with others to ensure we retain the workforce we have.

Supporting good workplace culture and wellbeing

We've started a UK-wide review of medical students and doctors' wellbeing, led by Professor Michael West and Dame Denise Coia. This review will identify the factors that impact on the wellbeing of medical students and doctors across the four countries of the UK.

The findings from this review will be published in 2019 and will enable us to work together with organisations across the UK to agree priority areas for collaborative action to help tackle the causes of poor wellbeing.

Enhancing support to doctors who are new to practice in the UK

Our 2018–20 corporate strategy¹⁶ is committed to enhancing support to doctors who are new to practice in the UK by encouraging them to attend our Welcome to UK Practice sessions.

Offering greater support to providers in enhanced monitoring

We currently have a review of our quality assurance processes in education and training underway. Additionally, we will also continue to support postgraduate bodies in their work with local education providers who are in enhanced monitoring.

Credentialing

We are engaging on a draft framework for credentials, which we plan to launch in 2019. This will address areas that are not currently regulated and enable greater flexibility to meet patient and service needs. This will recognise the experience and knowledge that has previously gone unrecognised.

C: Strategic approach - taking a more systemic approach to maintaining and improving standards

We recognise that no single organisation can deliver on reducing the pressures that threaten standards or develop the most optimal framework for understanding risk and thereby more effectively maintain and improve standards. A coordinated approach is necessary involving government, arm's-length bodies, professional regulators, regional leaders, providers, patients and the public, and, of course, the professions. This may require a strategic alignment of all these organisations.

Enhancing insight into distribution of doctors across the UK

We are undertaking work with partners to explore how more data on the scope of practice of doctors could be captured. A database of this information, identifying who is providing what practice and where, would enhance and better support workforce planning and the identification of gaps and capabilities across the UK. We have much data and insight to support this, so it could be developed with minimum burden to inform strategic workforce planning and to help target our support to maintain and improve standards.

Strategic approach to front-line engagement on continuing professional development

We are currently reviewing our field forces – those parts of the GMC that engage directly with doctors and the health care systems in which they work – in order to ensure we are engaging in the most effective way with regulatory partners in supporting providers and clinicians and protecting patients at a national, regional and local level.

Conclusion

We will be following up the research findings and issues reported in this year's report, looking at what we can contribute to address areas of concern. We will report back on progress in next year's report.