

<b>Agenda item:</b>	<b>2</b>
<b>Report title:</b>	<b>Horizon Scanning – findings from the first cycle</b>
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<b>Action:</b>	<b>To consider</b>

## Executive summary

The Horizon Scanning programme formally commenced in autumn 2017 and is now at the end of its first cycle. Supporting the aspiration for the GMC to become a more outward looking organisation, the focus and scope of the proposal agreed by SMT was for the work to take a principle focus on emerging issues that may have an impact over the next one to five years, and for it to pay particular attention to: risks and opportunities to the delivery of safe and effective medical practice; the ability of the system to support this; and the ability of our regulatory model to facilitate this. The overarching objectives of the work are to initiate and inform debate, and to help 'futureproof' the organisation and deliver more resilient policy making. This paper provides a high level summary of key findings from the first cycle and some key discussion points, as well as some reflections on the work to date.

## Recommendations

The Executive Board is asked to:

- a** Note the high-level findings from the first cycle of the horizon scanning programme and identify additional points for further consideration and exploration (paragraphs 4-14).
- b** Comment on the lessons learned identified in paragraph 15.

## Background & Introduction

- 1 Eight topics were prioritised for the first horizon scanning cycle, although resource pressures mean that we are only reporting on six of the eight topics here. Key findings and questions arising can be found at **Annex A**. Full briefings, literature reviews and other materials from the horizon scanning programme can be provided on request and are due to be made available on The Knowledge.
- 2 This paper summarises some of the headline findings that have emerged from the work and is intended to generate discussion. We will shortly be discussing these and any potential further work with the Policy Leadership Group (PLG).
- 3 The paper concludes by detailing some reflections from the course of this first cycle and outlines next steps.

## High-level Summary & Discussion Points

### *Legislative divergence*

- 4 Aside from the influence of broader debates about the devolution settlements and the impact of Brexit, legislative differences (for example, in the areas of mental capacity and revalidation) are already posing some challenges for policy makers. For instance, while we seek to adapt our standards guidance according to different contexts, our ability to continue with a generic four country approach may come under increasing challenge. We have heard from both the Employer Liaison Service (ELS) and UK, European and International Affairs (UKEIA) that there are some signs of a growing pressure for more tailored approaches towards regulation across the four countries.
- 5 There is a need for us to continue monitoring the prospect for further legislative divergence, and a new policy and legislation matrix that has been produced by the UKEIA Team should help with this. It perhaps also raises the question of whether, post-Brexit, a more tailored regulatory model might be required.

### *Health and Social Care Integration*

- 6 A common theme across all four countries is a desire for increased integration between health and social care. Northern Ireland (NI) already has a fully integrated model, and there are Integrated Joint Boards in Scotland and Regional Partnership Boards in Wales. Much focus is currently on England and, according to one prediction, more than half of the country will be covered by an integrated care system over the next year. Consequently, doctors may work across several different organisations (creating particular challenges for a regulatory approach that is focused on doctors undertaking the majority of their work within one location) and, increasingly, in multi-disciplinary teams.

- 7** We have more work to do in order to better understand the implications of this trajectory, and may wish to carry out some research, as well as targeted engagement with key policy makers in order to fully assess potential barriers to the pursuit of good medical practice that could arise from these changes. We may also wish to review how our data collection and analysis lines up with Integrated Care Systems and Sustainability and Transformation Partnership - and this could be considered further through our forthcoming 'field-forces' review.

### *New technology*

- 8** Despite the potential for Artificial Intelligence (AI) to be put to good use, it is not currently clear who is to be held accountable for patient harm caused by AI, what additional challenges this might pose to the process of seeking informed consent, and what the implications are for patient confidentiality. As well as considering whether a consolidated AI work-stream is required, we intend to engage with key stakeholders in order to further explore and address the above issues. We will also continue to reflect on what the adoption of new technologies could mean for the education and training of doctors.

### *Demographic changes*

- 9** It is accepted that the UK population is both rising and ageing, with an increasing proportion of people with several long term conditions. The number of people with over four conditions is set to double by 2035, with a 179.4% increase in the number of people of pension age being diagnosed with cancer, and a 118% rise in numbers of people with diabetes. The proportion of ethnic minority groups in relation to the population as a whole will increase, while we will continue to see an increasing life expectancy gap between those living in the poorest and those in the richest areas. These changes raise a number of questions for the GMC, including how can we ensure that the education programmes we approve meet the needs of an increasingly diverse 21st century UK population (and how our approval processes recognise and take into account future changes).

### *Increasing mismatch between supply and demand*

- 10** At present the system does not have the capacity to meet demand, and current trends suggest this is likely to increase over the next few years. The BMA predicts that between October 2019 and September 2020 there will be over a million more patients waiting over four hours in A&E (from 2.6m to 3.7m), 6.4m emergency admissions (up from 5.9m), 1.8m trolley waits (up from 600,000) and 5.1m patients on the elective treatment waiting list (up from 3.9m).
- 11** Our scanning has also considered the potential for the increased rationing of certain treatments, and the increased likelihood therefore of doctors encountering difficult conversations with patients. While the public remains satisfied with the NHS, they also think that quality of care has decreased and doctors perceive that patients

expect more from them. Key questions raised by this topic include whether there is a role for the GMC, working with others perhaps, to help manage this growing expectation gap, and support further moves towards greater levels of 'self-care'.

### *Workforce challenges*

- 12** The latest edition of *The state of medical education and practice in the UK* (SOMEPE) (2017) states there were 39,185 medical students at UK universities in 2016 compared with 41,422 in 2012, a drop of 5.4%. Despite a 1.7% rise in doctors in training this does not match the UK population growth of 3.7%. There is also a rise in the number of trainee doctors taking career breaks after finishing foundation training. And while we are seeing a growing trend of overseas doctors applying for GMC registration, Brexit is a source of uncertainty.
- 13** The challenge to fill posts is evident across different medical roles, as well as the broader health and social care system – with nurses, clinical support staff and non-acute services in short supply. Labour market projections for demand at the level of the health professional occupation forecast an increase of 55% in the UK between 2014 and 2024 (15% due to expansion demand and 40% due to the need to replace individuals due to replacement demand (retirement, maternity, mortality etc.)). However, these projections are not to the level of the medical profession and were generated before the UK voted to leave the European Union.
- 14** This returns us to consideration of what our formal position is on workforce planning, and whether we should be undertaking further work to model future flows of doctors entering and exiting the register (including retirement and migration patterns) in order to support wider conversations on this and to inform future revenue projections for the GMC.

### **Reviewing the first cycle**

- 15** This paper marks the culmination of our first cycle of horizon scanning. We have commissioned Lindsey Mallors, Assistant Director of Audit and Risk Assurance, to undertake a lessons learned exercise to review the costs and benefits associated with this work and to consider how the process might be improved for the second cycle. We will want to consider the function of horizon scanning alongside our other existing evidence gathering and risk assessing tasks in research and insight, so that it can be informed by (or trigger activity in) our other insight and research unit activities, and accommodate the knowledge surfaced in risk forums such as the Patient Safety Intelligence Forum (PSIF). Without wanting to pre-empt this, we have identified some initial learning points and challenges from this cycle. These include:
  - The importance of collaborative input across the GMC and the necessity of spare capacity to facilitate this. For the first cycle, horizon scanning support was impacted by changes in personnel and the emergence of competing local priorities. In future, we would recommend that teams nominate a horizon

scanning 'champion' who maintains responsibility for contributing team-based insights into the process.

- The importance of an external perspective. During the first cycle we have convened two cross-regulator workshops with professional regulators to bring to bear different perspectives on the impact of demographic change and new technologies. In future, we will consider how we might better draw on the views of external experts to inform our thinking (and both the relationships review and our research programmes will be critical here).
- The need to consider what constitutes an appropriate 'horizon' for this work. During the first cycle, it has been a challenge to strike an appropriate balance between issues that are happening now, albeit with longer term implications, and issues that may occur in 4-5 years (for which there is greater ambiguity and challenge associated with identifying implications and action points).
- In order to focus on issues that pose a more immediate threat to patient safety ('hot topics'), a separate strand of work has been undertaken in parallel to horizon scanning through the Strategic Patient Safety Intelligence Forum (SPSIF). The aims of this process have been to: Inform senior GMC decision makers about specific topics; provide reassurance that risks have been appropriately managed; and highlight areas where the GMC may want to take additional action, as prioritised by PSIF members. However, feedback has made clear that the purpose and aims have not been fully met. The effectiveness of the 'hot topics' process will be reviewed in concert with the Horizon Scanning process. In general, there is recognition that we need to improve our understanding of the environment in which we operate, and consider how we can maximise use of the intelligence module, media and social media monitoring.
- The need to clarify the scope of the programme. Further consideration required on whether our focus should be on breadth (identifying a broad range of changes in our immediate environment) or depth (considering a smaller number of more narrowly-defined issues in detail) – and their implications for the organisation.

## Next steps

- 16** This paper provides a distillation of a number of themes identified through our horizon scanning work, the questions these pose and potential actions that we may wish to consider in response. This is purely to inform debate, and will require a fuller discussion at the Policy Leadership Group to identify future areas for action, alongside consideration of the wider GMC policy business plan.
- 17** Our next cycle – due to commence in September – will be informed by the lessons learned review. We will present the key findings from this, together with our revised approach to horizon scanning, at a future meeting of the Executive Board.

## 2 – Horizon scanning – findings from the first cycle

## 2 – Annex A

### *Divergence between the UK's healthcare systems*

- 1 The possibility of further divergence between the UK's healthcare systems rests to a large extent on broader debates about the devolution settlements, and the issue that is probably most pressing for devolution at the moment is Brexit – which as the House of Lords European Union Committee point out, '[...] presents fundamental constitutional challenges to the United Kingdom as a whole.'<sup>1</sup> Indeed, the EU Withdrawal Bill has already exacerbated tensions between the UK and devolved governments.<sup>2</sup>
- 2 While the delivery of healthcare is a devolved matter, there is the potential for it to be drawn into these debates, particularly if it is considered to be affected or undermined by decisions taken in Whitehall about reserved matters. An example of this could be decisions about immigration policy and their impact on NHS workforce levels. The impact of Brexit on doctors and the GMC's regulation of the medical profession will depend on the precise form that the UK's withdrawal from the EU takes, and a separate programme of work is looking at this question.
- 3 We have heard that divergence between the four legislative frameworks is creating challenges for policy makers. For example:
  - Differences between mental capacity legislation and legislation relating to coroners' inquests can have some impact on FtP processes;
  - Responsible Officer regulations in Scotland and Northern Ireland are different to those that apply in England and Wales;
  - Although the Northern Ireland Act includes similar (but not identical) demands to that of the Equality Act 2010 in regards of the public sector equality duty, the discrimination protection offered by the complex web of other equality legislation is quite different to the rest of the UK. Doctors in NI report that they have limited

or no ED&I input as part of their training, and there is concern that their ability to understand health needs of diverse groups is limited as a consequence.

- Greater divergence between the healthcare systems could make it even harder for international medical graduates to orientate themselves as they move between unfamiliar systems.
  - Looking further ahead, different legislation between the UK countries relating to assisted suicide and conscientious objection is conceivable in the future.
- 4** In response to the challenges posed by legislative divergence, we have heard that more centralised coordination in order to keep track of parliamentary business that is coming-up across the four countries could be helpful. The UK, European and International Affairs Team (UKEIA) have produced a policy and legislation matrix and are currently developing this to include Devolved Office (DO) policy and legislation. The issue of legislative divergence also raises a question about how the GMC might respond if it is increasingly shown that a four-country model of regulation is no longer viable, and what would need to happen, within our external environment, for us to begin considering this.
  - 5** There are some signs of a growing pressure for regulation to adopt approaches that are more tailored to the needs of the four countries. This is particularly the case in Scotland. And the development of new NHS structures in England increases the potential for regional divergence, with one member of the Employer Liaison Service (ELS) telling us that a massive increase in the complexity of care in England (the example given being the shift towards greater integration between local authorities and the care sector) means that there may be substantially different expectations placed on doctors in England compared to those in other UK countries.
  - 6** Despite the focus of this topic on divergence between the four healthcare systems, shared challenges and a common goal to improve the integration of health and social care could provide extra impetus to strengthen what are already close ties. This raises a question about the GMC's role in facilitating greater alignment between the countries. For example, should we do more to share good practice from a systems standpoint (in terms of the system supporting professionalism) with system regulators and improvement bodies in other countries of the UK?
  - 7** There are already a number of existing projects that are of relevance to this topic, including a revised four country monitoring report that is produced by the UK, European and International Affairs Team; a proposed review of the GMC's field forces, to be led by the new Assistant Director for Strategy; and the current stakeholder 'Relationship Review'. The importance of taking account of perspectives from the devolved offices at an early stage in the policy development process will be highlighted by the new Policy Framework, which is intended to help provide a more structured approach to GMC policy making.

### *Actions and questions for the GMC*

- As a UK wide regulator, could the GMC be called upon to help facilitate closer working between the countries?
- Could we share good practice from a systems standpoint (in terms of the system supporting professionalism) with system regulators in other countries of the UK?

### *New NHS Structures*

- 8** While the four UK countries are structuring healthcare in different ways, they are all changing their systems in line with the same goals: increased integration between health and social care, moving care into the community and primary care at scale. A lot of attention has been placed on England where NHS England is following the Five Year Forward View and has developed new organisations like sustainability and transformation partnerships (STPs) and integrated care systems (ICSs). There are currently 14 ICS areas (covering over 12 million people).<sup>3</sup> According to one prediction, more than half of England will be covered by an integrated care system over the next year.<sup>4</sup>
- 9** These organisations and others are developing new care models within them (groups of several providers coming together to provide care). New care models currently cover 20% of the population, by 2020 it will be 50%.<sup>5</sup> These could improve care - vanguard new care model sites have shown lower growth in per capita emergency hospital admissions, while the Care Quality Commission (CQC) has found that care is better when it is more joined up.<sup>6,7,8</sup>
- 10** Through conversations with members of the ELS and Regional Liaison Service (RLS) we have heard that doctors and patients on the ground are largely unaware and quite sceptical of these changes. There are lots of challenges to integrated working, including cultural barriers, a lack of money and time, and the current legislative framework.<sup>9</sup> For the GMC, main impacts from the changes are:
- Doctors may work in several different organisations, which are all part of the same integrated care system. Doctors are already working more across several organisations, for example GPs doing the majority of their work in a hospital while remaining on the performers' list (and therefore NHS England is their designated body), this could impact on Responsible Officer's (ROs) oversight and there is already work going on to address this. Our new [supporting information guidance](#) emphasises that appraisal needs to cover the full scope of practice and we have published some [information sharing principles](#), which were developed with stakeholders. We are considering how we can strengthen this information sharing message (for example through our guidance, or by seeking to influence an amendment to the RO regulations in order to place a statutory duty on ROs to share information).

- NHS England has proposed that all accountable care organisations (ACOs, groups of organisations with a contract to provide care to an area) would become designated bodies (DBs). This would have an operational impact on us in terms of the work involved in setting up a new DB, particularly if all ACOs became one at once.
- If there continues to be a shift in care provision from hospitals to community settings, more specialist skill sets may be required within primary care settings. For example, GPs are already becoming GPs with extended roles (GPwERs), taking roles beyond the traditional scope of GP training, for example in A&E.<sup>10</sup> This potentially raises questions about the longer term implications for the GP curriculum (and degree of overseas 'equivalence'), and the distinction between the GP and Specialist registers.
- Clinical leadership will become more important as clinicians are needed to run and design the new organisations (for example the new Scottish GP contract emphasises leadership).<sup>11</sup> Our current research on the use of our guidance for doctors in leadership or management roles will help inform this issue.
- Doctors will work more closely in multi-disciplinary teams with other health and social care professionals. The NHS and social care cultures are very different, which may produce challenges.<sup>12</sup> The Data Research and Insight Hub (DRIH) are taking forward some work with other regulators on new models of care, as well as working on mapping standards between regulators to support multi-disciplinary team working, and this could address this point.
- We do not understand the implications of these changes and each area of the country will have a different structure, as the models will be tailored to the local population. The devolved offices are undertaking work within their countries on the changing structures, but there is a gap in England. The work that DRIH is doing with other regulators to understand new models of care, and the collective assurance project and field forces review, may address this.

#### *Actions and questions for the GMC*

- Liaise with the Research Team to agree an appropriate research exercise to understand the implications of new NHS structures and how we might need to adapt. This could involve looking at already integrated areas such as Northern Ireland or Scotland.
- To understand this, we may need a layered approach engaging with central policy makers driving the changes to understand the rationale and impetus. For example we may need to engage with NHS England and emerging ICSs to understand how far new structures and ways of working present potential barriers to pursuit of good medical practice, as well as to ensure that they take ethical and regulatory

issues fully into account – in a similar way to what we did when CCGs were formed.

- We can ensure our data collection and analysis lines up with these new structures. The corporate strategy ambition to align data at a 'healthcare economy' level could involve data aligning with ICS/STP areas, although more resource would be required to do this properly, to ensure that the members of these wider areas are accurate and up-to-date.

### ***New technological solutions***

- 12** The impact of new technologies on the delivery of healthcare services is a potentially huge field to consider and we have concentrated on the areas of telemedicine, artificial intelligence (AI), augmented reality (AR) and virtual reality (VR).
- 13** There are signs to suggest that the public are increasingly comfortable using virtual telemedicine healthcare services, although there are significant patient safety concerns and variations in the quality of care have been observed.<sup>13,14,15,16</sup> Alongside posing a risk to patient safety, source materials suggest that some aspects of telemedicine, such as remote consultations, could have an impact on the patient-doctor relationship.<sup>17,18</sup> The sources also indicate that the use of technology could lead to a two tier health system, leaving those who cannot use technology, in particular the elderly, at a disadvantage when accessing healthcare.<sup>19</sup>
- 14** This delivery model can be expected to continue to grow over the course of the next five years, and we are already undertaking work (coordinated by the Regulation Policy Team) to address the safety concerns. Meanwhile, the Department of Health & Social Care (DHSC, specifically, the Office for Life Sciences) is establishing a fund to support innovation in online care – focusing on triage, online consultations, and online patient bookings. We (via the Standards Team) will be providing input to the development of a regulatory framework for the roll out and adoption of new technology trialled through the fund.
- 15** We are at a much earlier stage in considering what our approach towards AI should be. AI is being used increasingly in healthcare, and can increase the efficiency of healthcare delivery, for example by reducing the time doctors need to spend on administrative tasks. Yet, despite its positive uses, the sources highlight that AI is currently a poorly regulated field. It is not currently clear who is to be held accountable for patient harm caused by AI, what additional challenges this might pose to the process of seeking informed consent, and what the implications are for patient confidentiality.<sup>20,21</sup>
- 16** The quality of the datasets that AI systems are trained on raise further issues, particularly if these contain biases that could be dangerous for some patient groups

and may lead to serious harm.<sup>22,23</sup> A report published by Future Advocacy in April 2018 suggested that concepts of patient safety aren't firmly entrenched in the tech industry, and that it's currently unclear how the duty of care upheld by the GMC applies to software developers and those purchasing software tools on behalf of a healthcare system.<sup>24</sup>

- 17** While there is considerable technological innovation in the NHS, it is noteworthy that a recent report exploring the use of instant messaging within the NHS found that 43% of NHS staff rely on consumer instant messaging (IM) at work.<sup>25</sup> The researchers questioned more than 800 individuals working in clinical and non-clinical roles across acute hospitals, GP surgeries, ambulance, community and mental health trusts, and other parts of the NHS. The authors suggested that the adoption of IM apps is a sign that staff are being driven to innovate faster than the Trusts they represent.

### *Actions and Questions for the GMC*

- As well as considering whether a consolidated work-stream that is focussed on AI is required, we intend to engage with key stakeholders in order to further explore and address the questions raised by its use.
- We will continue to reflect on what the adoption of new technologies could mean for the education and training of doctors. In April 2018, Jeremy Hunt announced that Dr Eric Topol will lead a review into how thousands of NHS staff could be trained to use artificial intelligence and robotics and the Education Team will be monitoring the progress of this work.
- Work is underway to consider how new technologies could benefit our own functions in the GMC. DRIH is currently considering whether AI could help us to make quicker decisions on registration, specialist registration (CEGPR/CESR) and revalidation. Also, our IS team is developing Virtual Reality programmes and considering their application in areas such as communications and marketing of GMC programmes and processes and staff training.

### ***Changes in the demographic profile of the UK***

- 18** The UK population is increasing rapidly - It is projected to increase by 3.6 million (5.5%) over the next 10 years, from an estimated 65.6 million in mid-2016 to 69.2 million in mid-2026.<sup>26</sup> The rise in population will create increased demands on healthcare services, particularly at a time when financial pressures are already acute, and there are other unknowns such as the effects of Brexit on recruitment in the NHS.<sup>27,28</sup>
- 19** This population growth is largely due to an increase in the numbers of older people, and there are associated increases in people with several long-term conditions. The number of people with over four conditions is set to double by 2035, with a 179.4% increase in the number of people of pension age being diagnosed with cancer and a

118% rise in numbers of people with diabetes.<sup>29</sup> This has led to calls for a flexible, adaptable workforce better able to cope with multiple morbidities – a more generalist and less compartmentalised approach.<sup>30</sup>

- 20** The ethnic profile of the UK is also due to change, with ethnic minority groups predicted to make up one-fifth of the population by 2051 (compared to 8% in 2001).<sup>31</sup> We know that rates of disease differ between ethnic groups. For example, Asian and black groups have higher rates of diabetes, and many minority ethnic groups have lower rates of cancer.<sup>32</sup> Another change of note is that conceptions of gender are become increasingly fluid. This is reflected in referrals to the gender identify development service, which have grown from fewer than 100 in 2009 to more than 2,000 now.<sup>33</sup>
- 21** Just as demographic changes will mean that doctors have to treat patients with different needs, the composition of the medical workforce can be expected to change too. GMC data suggests that older doctors receive more sanctions and warnings than those under 50, raising a question about what happens to these figures as the medical population ages.<sup>34</sup> Doctors are beginning to want a greater work-life balance, and increasingly demand flexibility in their own working and training arrangements and there is some evidence that younger doctors see medicine more as a job than a profession.<sup>35</sup>
- 22** Finally, the life expectancy gap between rich and poor areas is increasing and there is a danger of a 'digital divide' if technology takes a more prominent role in healthcare with those unable to engage with new technologies at a disadvantage.<sup>36</sup>

### *Actions and Questions for the GMC*

- What are the unique challenges presented by patients with increasingly complex needs and to what extent are they accommodated through our existing guidance (e.g. references to vulnerable adults and older people with frailty within the Generic Professional Capabilities)?
- An ageing doctor population may require more Continuous Professional Development (CPD) and support to continue practising and so we will need to consider how we might best facilitate this.
- We may wish to add gender neutral options to the register and/or our internal HR processes. The Equality, Diversity and Inclusion (ED&I) Team have consulted stakeholders about gender options on the register, and a consistent corporate position in terms of diversity monitoring is being discussed.
- Our new Equality, Diversity and Inclusion Strategy commits us to provide leadership and use our influence to identify, understand and address inequalities

for doctors and patients in the wider healthcare system. As a part of this, we might want to do some work to help raise awareness about equality and diversity issues that impact on patient safety and care and that need addressing, including by working more closely with other regulators. A starting point would be to improve our understanding about how regulators in the healthcare sector determine the ED&I issues that they prioritise.

- We will need to continue to ensure that the education programmes we approve meet the needs of an increasingly diverse 21<sup>st</sup> century UK population.

### ***Divergence between system capacity and public expectations***

- 23** At present, demand for healthcare services has increased, while capacity has reduced. Demand is growing faster than key staff groups (for example the number of GPs and nurses), as well as funding (with trusts and CCGs under severe financial pressure).<sup>37</sup> The complexity of demand is also increasing due to an aging population and increasing numbers of people with complex, chronic or multiple conditions. This is likely to continue and worsen over the next three years.
- 24** The system does not have the capacity to meet this demand, not because of lack of effort or poor management, but because it is over-stretched.<sup>38</sup> Current trends suggest this is likely to increase over the next few years. For example, the BMA predicts that between October 2019 and September 2020 there will be over a million more patients waiting over four hours in A&E (from 2.6m to 3.7m), 6.4m emergency admissions (up from 5.9m), 1.8m trolley waits (up from 600,000) and 5.1m patients on the elective treatment waiting list (up from 3.9m).<sup>39</sup> Due to reduced capacity certain treatments may be less available, locally and nationally. As a result, doctors are likely to face more difficult conversations with patients about providing certain treatments.
- 25** Because of fear of complaints amid rising clinical negligence costs, it is conceivable – but just speculation – that some doctors may also give in to demands for treatment that are not necessary and therefore may be practising more defensively. For example, GP prescribing of opioids has increased despite being ineffective for chronic pain, as many consider it unethical to refuse painkillers.<sup>40</sup> According to the Medical Protection Society, 84% of GPs have ordered unnecessary tests and 41% prescribe when not clinically required due to fear of litigation.<sup>41</sup>
- 26** While the public remains satisfied with the NHS, they also think that quality of care has decreased and doctors perceive that patients expect more from them.<sup>42,43</sup> The Nuffield Trust considers it unlikely that the public satisfaction with the NHS will improve in the near future.<sup>44</sup> The public may expect more customer-focused services, and may be unaware of their own responsibilities – for example a 2017 report found that almost half of respondents believed that social care services are free at the point of need.<sup>45</sup>

**27** There are signs to suggest that the patient-doctor relationship has become much less paternalistic, and according to a 2016 Ipsos MORI survey, 68% of people in the UK would like more control over decisions about their health – an increase on 2014 numbers.<sup>46</sup> An implication of this trend for doctors in the future is that they may need to take a more holistic approach to patient care.<sup>47</sup> Conversely, there is a feeling from doctors that if patients want more input, they may need to take more responsibility for their own health.<sup>48</sup> The relationship may change further in future with improvements in technology and remote consulting.

### *Actions and Questions for the GMC*

- How can we best highlight system pressures?
- Is there any more we can do with patients to ensure their expectations are in line with what doctors can provide? For example, might we consider similar approaches to the General Optical Council's campaign on contact lens safety?<sup>49</sup>
- Our research on 'What it means to be a doctor' may tell us about how doctors view system pressures and patient expectations – early findings suggest that stakeholders feel that unregulated information picked up online leads to unrealistic patient expectations.
- Ongoing work around reviewing our consent guidance will improve the process of taking patients' views into account and may help them to deal with the changing relationship referred to earlier. Also, much of the work for the Supporting a Profession under Pressure will touch on the effect of system pressures and our role and response to this.
- We may want to do some more work on defensive medicine as currently we do not know much about this issue, including the extent of its prevalence, and whether steps might be taken to mitigate its' occurrence. This work may involve carrying out research around the extent of the issue, why it happens, what problems it causes and what the GMC could do about reducing it.

## ***Workforce shortages***

- 28** Workforce shortages have been a leading concern raised by the health sector for many years. For doctors and patients, workforce shortages can lead to risks for patient safety; delays in treatment and the closure of services; reduced learning opportunities for junior doctors; pressure on doctors to extend working hours and work beyond their competence; and low staff morale and work-related stress.
- 29** The main supply of workforce comes from new graduates; returning practitioners and overseas recruitment. SOMEP 2017 states there were 39,185 medical students at UK universities in 2016 compared with 41,422 in 2012, a drop of 5.4% and despite a 1.7% rise in doctors in training this does not match the UK population growth of 3.7%.<sup>50</sup> There are also gaps in recruiting trainee doctors, with one in five GP and psychiatry training places unfilled in 2017.<sup>51</sup> Further to this there is a rise in the number of trainee doctors taking career breaks after finishing foundation training.
- 30** The shortfall and challenge to fill posts is evident amongst GPs, specialists, A&E consultant posts as well as in specific regions. The Royal College of Physicians reported in March 2017 that 84% of their members were experiencing staffing shortages across the team, with rota gaps occurring on a regular or frequent basis.<sup>52</sup> And although we are seeing a growing trend of overseas doctors applying for GMC registration, Brexit remains a source of uncertainty.
- 31** Workforce shortages are not only confined to the medical workforce but across the health and social care system as a whole with nurses, clinical support staff and non-acute services in short supply. An ageing workforce could present further challenges. Almost one in three qualified nurses, midwives and health visitors are aged 50 or older, whilst one in five GPs are at least 55. There are concerns that difficult working conditions could lead these groups to retire early.<sup>53</sup>
- 32** According to the NHS stability index, on average the NHS has more difficulties in retaining doctors compared to the nursing workforce and other nonmedical staff. The Review Body on Doctors' and Dentists' Remuneration Review for 2018 suggests that the higher turnover in medical staff might be attributed to a higher proportion in this staff group deciding to retire early or to practice abroad. A larger share of doctors taking career breaks could also represent a driving factor. In the last five years no progress has been made on the retention of doctors.<sup>54</sup>
- 33** Labour market projections at the level of the health professional occupation forecast an increased demand of 55% in the UK between 2014 and 2024 (15% due to expansion demand and 40% due to the need to replace individuals due to replacement demand (retirement, maternity, mortality etc.)).<sup>55</sup> These projections are not to the level of the medical profession and were generated before the UK voted to leave the European Union. Meanwhile, analysis from Independent Age and think tank, International Longevity Centre-UK (ILC-UK), concludes that demand and recruitment

difficulties could lead to a near doubling of the 'care ratio' of care workers to older people, from one worker per seven older people today, to one worker per 13.5 older people in 2037.<sup>56</sup>

- 34** In terms of working patterns in the future, less than full-time hours may be preferred by some doctors with caring responsibilities or those nearing retirement, and evidence suggests that some of the more recent cohorts of doctors are more likely than previous cohorts to want non-traditional working arrangements. This is partially supported in the responses of some of the Royal Colleges in response to SOMEPE. Finally, as individuals remain healthier for longer and work for longer, there is potential for individuals to join medicine as a second career at a later stage of life, meaning that the implications for future training pathways would need to be considered.

#### *Questions and Actions for the GMC*

- The GMC is carrying out various pieces of work which directly or indirectly consider workforce shortages, but is somewhat restricted in its remit in this area as it is not a workforce planning organisation. The Regional Liaison Service is actively discussing workforce issues with the profession, while the National Training Survey monitors the experiences of doctors in training and their trainers.
- The 'What it Means to be a Doctor' project will be address a variety of issues relating to professionalism, including current challenges and future intentions. The EU Exit Working group is considering further research to understand doctor migration patterns and the push and pull factors influencing this.
- Potential future work could include using this insight to undertake longer term forecasts of the shape and nature of the medical register – potentially to inform both workforce planning conversations but also future revenue streams for the GMC.
- We have set out the support available for doctors and highlighted the importance of reporting unsafe workloads or environments, trainees' exception reporting, and good wellbeing. In the last edition of SOMEPE we expressed a desire to be an active partner in helping address workforce pressures but there remains an open question about what this will look like in practice and what role the GMC might adopt. And related to this, how do we obtain the necessary assurances that workforce shortages are not compromising the ability of doctors to practise safely and ethically (and how would we know – beyond anecdote – if this were indeed the case)?

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