November 2018 - Council Meeting external

MEETING
6 November 2018 11:00

PUBLISHED
30 October 2018
Council
Meeting Room 2.08
350 Euston Road,
London, NW1 3JN

Agenda

Tuesday 6 November 2018
11:00 - 12:00

Meeting
11:00 - 11:05 M1 Chair’s business
5 mins

11:05 - 11:05 M2 Minutes of the meeting on 27 September 2018
0 mins

11:05 - 11:35 M3 Credentialing update
30 mins

11:35 - 11:40 M4 GMC annual report of customer complaints
5 mins

11:40 - 11:50 M5 Review of customer complaints
10 mins

11:50 - 12:00 M6 Any other business
10 mins

M7 Taking Revalidation Forward: End of programme report
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27 September 2018

Council

Draft as of: 11 October 2018

To approve

Minutes of the meeting on 27 September 2018*

Members present

Terence Stephenson, Chair

Steve Burnett  Deirdre Kelly
Shree Datta     Paul Knight
Christine Eames Suzi Leather
Anthony Harnden Denise Platt
Helene Hayman   Amerdeep Somal

Others present

Charlie Massey, Chief Executive and Registrar
Susan Goldsmith, Chief Operating Officer
Paul Buckley, Director of Strategy and Policy
Una Lane, Director of Registration and Revalidation
Colin Melville, Director of Education and Standards
Anthony Omo, Director of Fitness to Practise and General Counsel
Neil Roberts, Director of Resources and Quality Assurance
Mark Swindells, Assistant Director, Corporate Directorate

* These Minutes should be read in conjunction with the Council papers for this meeting, which are available on our website at http://www.gmc-uk.org
Chair’s business

1. The Chair welcomed members, the Senior Management Team and observers to the meeting.

2. It was noted that apologies had been received from Paul Reynolds.

Minutes of the meeting on 6 June 2018

3. Council agreed to amend paragraph 25 to include a reference to the Board of Pension Trustees. With this amendment, Council approved the minutes of the meeting on 6 June 2018 as a true record.

Chief Executive’s Report

4. Council considered the Chief Executive’s Report, noting developments in the external environment, progress on the GMC’s strategic priorities and how the GMC’s major work programmes were progressing, including reference to:

   a. The Court of Appeal overturned the decision of the High Court in the case of Dr Bawa-Garba and that the GMC fully accepted the Court’s ruling and would not appeal it.

   b. The GMC’s progress in key areas to support a medical profession under pressure including an independent research programme led by Roger Kline and Dr Doyin Atewologun to help understand why some doctors are more likely to be referred to the GMC by employers for fitness to practise issues than others, and another programme of work to explore how the GMC could incorporate human factors training into the training of fitness to practise Case Examiners, and the medical experts used in GMC processes.

   c. The positive response to the publication of Reflective practitioner guidance which had been co-produced by the GMC, Academy of Medical Royal Colleges, the UK Conference of Postgraduate Medical Deans, the General Medical Council, and the Medical Schools Council.

   d. The ongoing independent review, led by Leslie Hamilton, into how gross negligence manslaughter and culpable homicide is applied to medical practice.

   e. Preparation for the publication of State of Medical Education and Practice Report 2018.

   f. The GMC’s work with Government, NHS England and Health Education England to support the development of plans for the future of the NHS workforce in England and meetings with ministers will take place in the coming weeks.
Chief Operating Officer’s Report

5 Council noted declarations of interest from Susan Goldsmith, Paul Buckley, Steve Burnett and Paul Knight in relation to their role as directors of GMC Services International (GMCSI).

6 Council considered the Chief Operating Officer’s Report and noted:

   a All key performance indicators (KPIs) had been met up to the end of July 2018.

   b Due to the uncertainties the GMC’s Brexit project had been escalated to red.

   c Format revisions to the Corporate Opportunities and Risk Register to make it more accessible.

   d The reasons the revised forecast year-end position had moved to a forecast surplus of £0.9m; a difference of £6m from the budgeted surplus position of £6.9m including:

      i 17% increase in tribunal costs at the MPTS than previously projected and associated costs in fitness to practise.

      ii High levels of registration applications from International Medical Graduates (IMGs), with 41% more applications for the end of July 2018 than at the same point in 2017 which generated a higher demand for Professional and Linguistic Assessments Board (PLAB) tests.

   e Contingency plans for increasing capacity to deliver PLAB tests in Manchester.

Mental health programme: Verbal update and next steps

7 Council received an oral report on the next steps for the mental health programme. Council noted:

   a Progress since the oral report to Council on the project at the Council meeting on 24 April 2018.

   b The Terms of Reference for the project had been agreed.

   c An outline of the key themes of the project, with a key focus considering how a person’s environment impacted their work.

   d The team were working towards publication of the report in summer 2019.

   e Ongoing collaboration with other organisations working on mental health and well-being.
8 During discussion, it was suggested that a significant event review, recently considered by the Audit and Risk Committee, should be considered and reflected on during the development of the programme.

**Update on implementing the Corporate Strategy**

9 Council considered and approved the approach to implementation of the Corporate Strategy and in particular the reporting of 'lag' indicators.

10 During discussion, Council noted:

   a The actions points and ideas from the Council away day had been fed into the business planning process.

   b Consideration would be given to the best way for Council to continue to monitor progress on the 2018 away day action points and ideas alongside monitoring progress of the Corporate Strategy.

   c A request to finalise the lag indicators as soon as possible, particularly as once the GMC had a full suite of indicators it would be better able to consider issues such as the negative trade media coverage referred to in the report (75.5% negative).

   d It would consider progress against Corporate Strategy at its meeting on 11 December 2018.

**Report on GMC Group Personal Pension Plan governance**

11 Council noted the report on GMC Group Personal Pension Plan governance.

**Any other business**

12 Council noted the date of its next seminar and meeting on 5 and 6 November 2018, in London.

Confirmed:

Terence Stephenson, Chair 6 November 2018
### Executive summary

In June, we set out our approach to Council for developing the emerging credentialing framework. We are now starting to engage on a draft framework with stakeholders across the UK.

The draft framework focuses on clarifying the need for credentials and how we will identify credentials to ensure proportionate regulation. It also sets out our plans for a phased implementation to allow ongoing learning and management of resources. The draft framework is attached at Annex A, with supplementary information at Annex B.

We are carrying out engagement with stakeholders until January 2019. Our approach and the key issues we are addressing with each stakeholder group are set out at Annex C. This includes summaries of feedback from engagement to date.

We will return to Council in April 2019 to seek approval of the final framework, which will take account of feedback and discussion during this engagement period.

### Recommendations

Council is asked to:

a) Consider the draft framework, engagement update, and plans for implementation.

b) Agree our approach to continuing engagement, with the intent to launch in April 2019.
Development of a draft framework

1 In a seminar in June 2018, Council explored our early thinking about the development and regulation of credentials. Council members acknowledged the issues were complex, raised a number of risks, and asked for more clarity.

2 Throughout 2018 we worked collaboratively with the UK Medical Education Reference Group (UKMERG) which has representation from the four UK governments and their statutory education bodies. With UKMERG agreement on our proposals, we can be assured that ongoing changes to postgraduate training, including the introduction of credentials, are proportionate, fair, and consistent across the UK.

3 We are proposing a new regulatory framework for areas with significant patient safety issues, or where training is insufficient for effective service delivery. This is attached at Annex A, with supplementary information at Annex B.

4 We are continuing to address stakeholder concerns during engagement. Our engagement plans and the positions of key groups are set out at Annex C.

What problems are we trying to solve?

5 Two main drivers support the introduction of a credentialing framework:

   a Addressing significant patient safety risks in areas of limited regulation. This is usually where doctors develop expertise outside of an approved training programme, such as cosmetic interventions.

   b Enabling training in optional areas to meet patient and service needs, while clarifying opportunities to develop doctors in subspecialty and special interest areas. Ongoing reforms to postgraduate training have identified substantial areas of practice that can be offered more flexibly to address service gaps. Regulatory oversight of these training components is needed to ensure fairness and to maintain consistent standards across the UK.

Benefits of introducing credentialing

6 In addition, credentials may offer a number of further benefits including:

   a Supporting more flexible career development and lifelong learning, allowing opportunities for doctors to change career direction or enhance expertise.

   b Supporting doctors to acquire new skills in areas where needed by patients.

   c Informing employers and patients of a doctor’s competence or expertise in an area of practice, ideally on the List of Registered Medical Practitioners (LRMP).
Identifying credentials

7 We are considering a process for identifying and regulating credentials, described in detail in the framework at Annex A. These will be optional components within specialty training or substantial areas that exist outside training entirely.

8 These components of training will become credentials where there are significant patient safety risks, or where training is inadequate to deliver a service effectively. They will be on the scale of a subspecialty or a larger special interest area.

9 It is clear that the word ‘credential’ can have a number of meanings. We are seeking stakeholder views on the most appropriate terminology during engagement.

Proportionate regulation

10 We will only approve and assure credentials if there is a demonstrable need for recognised standards. This will be where there is a significant risk to patients, or a gap in training to support a service or patient need, that can’t be met by postgraduate training alone.

11 In response to Council’s feedback at the seminar earlier this year – we do not intend to run a process that is going to ‘let a thousand flowers bloom’. Indeed, our view is that we need to be careful to limit the number of credentials to only those areas that meet a high threshold, with defined, decision-making criteria based on the potential risks to patients if we don’t regulate.

12 We plan to update the List of Registered Medical Practitioners (LRMP) in the same way as we recognise trainers. This would offer a more transparent and assured way for patients, employers, system regulators, and insurers to confirm their doctors’ capabilities. We recognise there are sensitivities around what information is presented on the LRMP, and are actively engaging with stakeholders on this option.

Managing expectations

13 As part of our engagement plans, we are speaking to a wide range of stakeholders, including government representatives, medical colleges and faculties, deans, doctors in training and lay representatives. More information is set out at Annex C. As part of these discussions, we are being clear that credentials will be limited in number. We are aware that many organisations want a more extensive approach to credentials, covering post-CCT fellowships and highly niche areas. We are exploring if there are more appropriate ways to support these additional skills opportunities – for example through our quality assurance processes – and will use this engagement to gain views on alternative options.
A major challenge is reconciling divergent views around the risks and benefits of recognising learning outside of postgraduate training. We’re aware of the concerns of doctors in training that credentialing could lead to a sub-consultant grade, and of the need to recognise skills and provide training options for SAS doctors. We will be clear in engagement with these groups that anything expected from all doctors in a specialty will remain in specialty training, and that credentials will enable independent practice in particular areas, while supporting flexibility and lifelong learning.

There are a number of other challenges and risks which we will discuss during engagement, such as the potential for doctors without an approved credential being limited or disadvantaged. We will look to emphasise that this is an enhancement that will not be required for roles in the short or medium term, though some trusts may help to use this as a differentiator. Given staff supplies, we do not believe that employers could limit opportunities, and this needs to be balanced against patient safety. Some other issues are touched on at Annex B, and we are maintaining an active risk register to help us manage all current and future risks.

**Phased implementation**

Our aim is to seek Council approval on the framework in April 2019. We will prepare to introduce the operational processes from mid-2019.

We are planning a phased implementation to allow continued learning from pilots. This will also help alleviate resource issues within our operational teams, and for colleges who will be continuing to make sure all curricula are on track to meet our *Excellence by design* standards by 2020.

In the first implementation phase (2019 to 2022), we will prioritise credentials that have been identified as part of the ongoing curricula review. Some colleges and faculties will have proposals for credentials ready to submit with their curricula from mid-2019, while others will need more time.

We are also working towards introducing a credential in cosmetic surgery, as an area where there is limited regulation and an established patient safety risk.

Details of our implementation plans are included at Annex B.

**Equality and diversity**

We have an equality analysis completed for this project. We regularly review the equality issues with our Equality and Diversity team and our health and disability working group. We are actively working to engage with key groups that represent doctors with protected characteristics, such as SAS doctors, part-time workers and doctors with disabilities.
M3 – Credentialing update

Credentialing:
a draft framework

For engagement September-December 2018
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A case for change

We are proposing a new regulatory framework for credentialing. All four UK governments have agreed this must be put in place for particular areas of practice where:

- there may be significant patient safety issues, or
- training opportunities are insufficient or do not provide adequate flexibility to support effective service delivery.

What problems are we trying to solve?

There are two drivers supporting the introduction of a credentialing framework:

- Unregulated areas of practice where there may be significant patient safety risks. Usually, doctors develop expertise outside of an approved training programme and a consistent standard is absent, such as with cosmetic interventions.

- Flexible training in substantial practice areas are needed to address service gaps. These training components need ongoing regulatory oversight in order to maintain consistent, UK-agreed clinical standards and ensure continued high standard for patients. The ongoing postgraduate training reforms have identified these training areas that can be offered to either doctors who have not obtained a CCT (doctors in training or service grades) or as training available after the certificate of completion of training (CCT).

Proportionate response to risk

We will only approve and assure credentials if there is a demonstrable need for recognised standards. This will only apply where there is a significant risk to patients or a gap or need in service provision that can’t be met by changing numbers in postgraduate training alone.

Benefits for introducing the framework

Credentials will offer a number of benefits including:

- Supporting more flexible career development and lifelong learning, allowing opportunities for doctors to change career direction or enhance their expert skills.

- Supporting the development of trained doctors more quickly for areas where they are needed by patients and the service – by allowing existing trained doctors to acquire new skills.

- Enabling patients to confirm a doctor is working as an expert in these particular areas of practice – ideally on the List of Registered Medical Practitioners (LRMP).
Phased approach

We will introduce credentials in a phased approach, to make sure we get it right. We will continue to work with all stakeholders across the UK, to align expectations and to gain four-country consensus through the UKMERG on the final framework.

We have set out our proposals in this ‘straw man’ for the purpose of engagement with stakeholders during late 2018. Following this we will launch the framework in spring 2019, with the first credentials expected soon afterwards.
Defining credentials

We are introducing a process which will support doctors to gain recognition for training or expertise in a particular area of practice. These areas are optional components within specialty training or substantial areas that exist outside training entirely. They are likely to represent significant areas of practice on the scale of a subspecialty or a larger special interest area.

Credentials as approved training components

The majority of learning and development, outside of formal training, won’t need approved standards and outcomes. Some areas warrant the same treatment as postgraduate training. These components of training – credentials – will apply where there is a need to address particular areas of practice where there may be significant patient safety issues, or where training opportunities are insufficient or do not provide adequate flexibility to support effective service delivery.

Like postgraduate curricula, they will describe the expected outcomes and capabilities that doctors must demonstrate as they become experts in the field. The GMC will approve and quality assure these key areas if there is a demonstrable need, based on patient safety, for consistent standards, training, experiences and assessments. We intend to recognise attainment of the credential on the List of Registered Medical Practitioners (LRMP).

Emerging examples

We have looked at a number of existing or emerging examples where this approach might add value. We are not indicating that these will or should become credentials. They are helping us test the feasibility of credentials.

Increasing flexibility within broad specialty areas

Liaison psychiatry is a subspecialty undertaken by some, but not all, psychiatry trainees during a year of the three year general or old age psychiatry specialty programmes. About 50 doctors train each year in this subspecialty. Health Education England (HEE) has indicated that more liaison psychiatrists are needed because of the priorities from the UK government to improve mental health. Some practising psychiatrists have indicated they are keen to refocus their careers into this area. To address this mismatch between service need and the available trained medical workforce, HEE commissioned the Royal College of Psychiatrists to pilot a credential in liaison psychiatry aimed at consultant general or old age psychiatrists. The credential is a one year training programme based on the new outcomes, expectations and assessments a consultant would need to acquire from the subspecialty curriculum. Consultants are not required to repeat training gained from their specialty programme (eg leadership, research, communication and professional behaviour competencies). So far 17 doctors have completed this programme with positive feedback from both employers and doctors.
'The credential year came at a perfect time. It allowed me a structured learning environment with a well thought through teaching programme in liaison. The portfolio suited my (adult) learning style and gave ample chance for reflection. The peer group consisting of other consultants doing the credential was a valuable support system and new friendships were forged. My transition to liaison has been made feeling confident and empowered, and this has allowed me to progress very quickly in my new chosen career.'

(Quote from doctor who undertook liaison psychiatry credential)

**Cross-specialty development**

Mechanical thrombectomy is a proven treatment for stroke patients with large vessel occlusion – offering improved outcomes over conventional care in many cases. Doctors able to perform this interventional procedure work in a small number of tertiary hospitals. Providers are keen to expand this service to neuroscience centres and other large hospitals throughout the UK as a successful outcome is time critical. Training in this area is part of the Royal College of Radiologists’ interventional radiology curriculum, but there are insufficient trained operators currently available to deliver this service 24/7 nationwide.

The college believes that the specific skills and capabilities may be taught to other specialists, including neurosurgeons, neurologists, stroke physicians and cardiologists. With a consistent and rigorous training package, additional doctors across the UK can learn this technique, with significant short and long term benefits for stroke patients. This approach could apply to both emerging techniques and areas where there are shortages caused by gaps in workforce capabilities, both applicable in this situation.

**No formal training pathway**

Cosmetic practice is a particularly risky area from a regulatory perspective. There is no formal or quality assured training for doctors to become experts in cosmetic interventions. Many doctors piece together qualifications in procedures or interventions from different sources – often overseas. Coupled with this unconventional training, doctors work predominately outside the NHS or managed care systems. The Keogh review, among other inquiries, indicated that people are often very vulnerable when they seek cosmetic interventions – and this vulnerability can put them at risk of poor or unethical treatment. A number of serious adverse events demonstrated that serious harm can be caused to patients by inconsistent and unregulated standards. In answer to this challenging area of practice, the Royal College of Surgeons of England has introduced a certification scheme for cosmetic surgeons. Doctors who want to be certified by the English College would be required to provide evidence to demonstrate that they have met specific standards around training, clinical outcomes and behaviours which are based on safe practice. This includes the completion of a course on the ethical and professional obligations of doctors working in cosmetic surgery. We are considering how this approach may support better regulation in cosmetic surgery.
Different needs across the UK

Officers from the four governments, on behalf of ministers, have been clear that they need a more robust and transparent way of developing their medical workforce to meet local needs. In particular, Scotland and Wales representatives have suggested they need a consistent approach to train doctors in rural and remote health. Large parts of these countries have populations that live a significant distance from places where they can access emergency healthcare. There is a clear patient and service need for a credential that extends the skills and capabilities of general practitioners or other generalists to care for people in these remote areas.

Terminology and definitions

It is clear that the word ‘credential’ is used to mean a number of different things, both within the UK health services and elsewhere. It might be better to use an alternative term for the processes we’ve described here – such as approved training component. We are seeking stakeholder views on the most appropriate terminology as part of discussions on the draft framework.
Identifying credentials

Strategic oversight of training

Credentials will be identified and prioritised by the UK Medical Education Reference Group (UKMERG) – which includes representatives from the four UK governments and their statutory education bodies. Employers and workforce planners across the UK – as well as Health Education England, the Northern Ireland Medical and Dental Training Agency, NHS Education for Scotland, and NHS Education for Wales – will have the flexibility to commission or fund credentials based on patient and service needs.

We will identify and prioritise these areas of practice in two ways:

- Our Curriculum Oversight Group (COG) will identify training components that can be delivered to doctors that have not obtained a CCT (trainees or service grades) or after the Certificate of Completion of Training (CCT). These credentials will likely align to, and lead from, specialties. They will be identified when we review curricula as part of our approvals processes.

- The UKMERG will consider proposals for new areas of practice and determine if they should be developed into a credential. If authorised, these proposals would then come to the GMC for consideration through our approval processes.

Threshold for approval

The decision to approve a credential by the GMC has to be a proportionate response. The threshold for credentials will restrict approval to those areas that meet patient safety or service need though a risk ‘test’. We have identified criteria that will consider the level of risk involved in an area of practice, and therefore whether it needs our full regulatory approach of approval, quality assurance, and recognition on the register.

Criteria for credentials

We will make a prospective judgement about risk and scale to determine the answer to two questions.

- Is there a need for consistent professional/clinical standards and outcomes in this area of practice?

- Does the area need GMC oversight?
A proposed credential will be considered against these factors:

These criteria will be considered together, looking at the balance of all the factors, though key considerations are risk to patients and service need.

<table>
<thead>
<tr>
<th>Complexity</th>
<th>Breadth of practice</th>
<th>Level of specialty expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>(more complex in procedures or clinical context = more need)</td>
<td>(broader than clinical techniques or CPD = more need)</td>
<td>(general/generic = less need/part of PGT)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service needs/gaps</th>
<th>High risk to patients</th>
<th>Number of current/future doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>(more experts/expertise = improve service/patient outcomes)</td>
<td>(any other factors that indicate significant risk to patients)</td>
<td>(larger numbers = more need)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Delivery of service</th>
<th>Outside NHS</th>
<th>Number of current/future patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>(multiple site/hub and spoke = more need)</td>
<td>(outside NHS/weaker clinical management = more need)</td>
<td>(larger numbers = more need)</td>
</tr>
</tbody>
</table>
Regulating credentials

We are proposing that credentials will go through approval and quality assurance processes in the same way as postgraduate training, but will be recognised on the register in a different way. Annex C contains more details on how these processes might look.

Approval

Credentials will be approved alongside any postgraduate curricula to which they are linked as part of the training pathway, through the processes that have been set up for approval against the curriculum standards, *Excellence by design*.

For proposed credentials in areas of practice that are carried out outside of the NHS and training system, such as cosmetic surgery, we will develop additional requirements to bring them into our processes.

Quality assurance

We are currently carrying out a review of our quality assurance processes. Our new processes will need to consider how we quality assure credentials including those outside the NHS.

Recognition on register

We will consider how credentials will be annotated on the LRMP. Our intention is that credentials will be noted on a doctor’s entry on the LRMP in a similar way to how trainers are recognised. This will remain separate from being on the specialist or GP registers, but will allow employers and patients to see if a doctor has a credential in particular area.

Future work on developing the register will consider how to align the ways different levels of attainment are presented. If legislative change is granted we can review how we might recognise credentials differently on the register.

Maintaining credentials

Credentials, like postgraduate curricula, will be reviewed regularly through our curricular approval processes.

We anticipate that doctors with credentials will confirm they are continuing to meet the standards and expectations of the credential with the organisation responsible for the credential. These organisations will have to have a process by which employers can ensure doctors are maintaining their capabilities in the area of practice – the outcome of these evaluations will feed into appraisal and revalidation.
Other developments to support flexibility

While our focus now is on developing a way to regulate particular areas of practice, we are also exploring how we might support other training outside the CCT pathway.

This is early thinking which we may develop further.

**Endorsed modules**

Some parts of curricula can be, or already are, modularised – usually as a special interest option. These stand-alone modules could be offered to doctors who are not in that training pathway to support their development. Employers might use them to develop particular skills in their training workforce to support local service needs. We would expect the same standards, outcomes and quality assurance to apply. These would be areas within existing training programmes which may not be large enough to be considered areas of practice, such as specific clinical interventions. They wouldn’t be recognised on the register.

An example might be the SPINS in paediatric training.

**Additional skills areas**

Some areas of practice may not meet the threshold to become a credential. They would be managed by education organisations. We want to explore bringing them into our quality assurance system, including meeting relevant requirements in *Excellence by design* and *Promoting excellence*.

These would include post-CCT fellowships.
Implementing credentials

A phased approach
We intend to introduce credentials in a phased approach starting in April 2019.

The framework will set out criteria and processes for identifying and approving credentials, including our plans to support the curricula review and for regulating cosmetic surgery.

Phase 1 implementation
We will work with both the UKMERG and our COG to prioritise areas suitable for the first credentials. We will aim for these first credentials are approved shortly after their proposals are considered by COG.

As the curricula review progresses, we expect that most curricula will be reviewed by 2020, and will be in the process of being signed off. We anticipate that during this process, it will become clearer which areas will be appropriate for credentials.

Phase 2 development and implementation
As the first credentials are introduced, we will learn from the process and make ongoing improvements. Once we have successfully completed phase 1, we will consider how to identify and approve new and emerging areas of practice into ‘credentials’. We are developing a number of policy workstreams to support further development and implementation of credentials.
Credentialing: supplementary information

Annex to draft framework
For engagement September 2018-January 2019
Contents

Why we’re introducing credentials

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   Impact on the profession 7

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Why we’re introducing credentials

Background

We began looking at credentialing several years ago as a way to recognise doctors’ capabilities in particular practice areas. We consulted on a proposed framework in 2015, and Council agreed in 2016 that we should continue working to test the model. Since then we have been challenged to work towards a broader definition of credentials, to enable development of the medical workforce to address emerging service and patient needs.

Our website has full details of the background to credentialing and previous papers.

Part of wider postgraduate training reforms

Credentialing can be seen as part of a wider movement to reform postgraduate medical training, and a potential solution to multiple problems. It has been a recommendation or expectation in a number of reviews and reports in recent years.
What problem are we trying to solve?

During 2017 we reviewed our earlier work in light of expectations that credentialing should enable more flexibility in training pathways and supporting doctors to meet patient and service needs. We looked at where there were concerns about assuring doctors’ capabilities, and where using our regulatory function could improve patient safety and workforce flexibility. We wanted to define where credentialing will add real value to professional development and workforce management.

We undertook a problem tree analysis to help identify the different problems credentialing was expected to solve, and to clarify where credentials were needed and where there might be a more appropriate or proportionate solution.

We want to make sure credentialing meets the needs of patients and the services in the four countries of the UK, as well as the expectations of government and the profession for more flexibility in postgraduate training. We have been working closely with members of the UK Medical Education Reference Group (UKMERG) in recent months, to make sure that we develop our framework for credentialing with UK-wide consensus.

As the regulator, our goal is to address the areas circled in red below, which is linked to the UKMERG’s priority of addressing workforce concerns, circled in green.

![Problem Tree Diagram]

What is the problem credentialing is trying to solve?

<table>
<thead>
<tr>
<th>Consequences</th>
<th>Core Problem</th>
<th>Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical workforce isn’t responsive to changing needs of population/planning</td>
<td>Patient safety is at risk due to regulatory gaps in the recognition of doctors’ capabilities</td>
<td>Training is slow to address shortages and surpluses in medical workforce</td>
</tr>
<tr>
<td>Patients can’t tell if a doctor is capable in an area of practice</td>
<td></td>
<td>Need identified to move areas out of PG training for improved flexibility</td>
</tr>
<tr>
<td>Patients are at risk in areas of practice where regulation is weak</td>
<td></td>
<td>Areas of practice have developed outside of regulated PG training</td>
</tr>
<tr>
<td>Non-training grade doctors lack recognition and career support</td>
<td></td>
<td>Some areas of practice lack formal recognition</td>
</tr>
<tr>
<td>Doctors lack flexibility in career development</td>
<td></td>
<td>Experience gained outside of training/ equivalence lacks formal recognition</td>
</tr>
<tr>
<td>Patient safety is at risk due to regulatory gaps in the recognition of doctors’ capabilities</td>
<td></td>
<td>Non-clinical expertise lacks formal recognition</td>
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<td>Regulated PG training is inflexible and lengthy</td>
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<td>Some optional and subspecialty areas developed without workforce planning</td>
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<td>Regulated PG training is inflexible and lengthy</td>
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<td>Development after PG training lacks agility and regulatory oversight</td>
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<td>MR only recognises completed PG training/experience to CCT level</td>
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<td>Non-clinical expertise lacks formal recognition</td>
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<tr>
<td>Some areas of practice lack formal recognition</td>
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<tr>
<td>Experience gained outside of training/ equivalence lacks formal recognition</td>
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<tr>
<td>MR only recognises completed PG training/experience to CCT level</td>
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</table>

Key:
MR = medical register
PG = postgraduate
CCT = certificate of completion of training
Putting it into practice

How we propose to regulate credentials

From proposal to approval

*Initial identification of suitable areas*

As part of the current curricula review process, the Curriculum Oversight Group (COG) is working with colleges to identify areas that might be suitable for credentials. Some of these areas might be further developed into training components that can be delivered pre-CCT or as a stand-alone option after the CCT.

*Proposals to the Curriculum Oversight Group*

In phase 1, a college or other relevant body will submit the proposed training pathway to the GMC for approval. This will set out proposals for the specialty curriculum and any linked credentials.

For areas not delivered in a regulated training environment or not managed or commissioned within the NHS, such as cosmetic surgery, we will develop processes for organisations to submit proposals for stand-alone credentials. Work on these processes is ongoing, but we expect this to be part of the framework we launch and begin to implement in 2019.

*COG recommends areas for approval*

The COG will look at the purpose statement (addressing Theme 1 in *Excellence by design*) which describes the entire training pathway, to make sure the proposals meet our requirements in *Excellence by design* and are aligned to the principles of Shape of Training.

In evaluating the purpose statements, COG will test any proposed credentials against the agreed criteria.

Considering these factors overall, COG will make a recommendation to the GMC about which areas should become credentials. We will then evaluate these proposals through our full approval processes.

*Approval*

Proposed credentials will be approved alongside linked postgraduate curricula, through the processes that have been set up for approval against the new curriculum standards, *Excellence by design.*
The GMC will make a decision to approve the whole package, following recommendations from the COG, the Feasibility group, and the Curriculum Advisory Group (CAG).

For new areas, the UKMERG will consider if a proposed credential is necessary. If endorsed by UKMERG, the appropriate body will develop the purpose statement for submission to COG. Following endorsement at this stage, a curriculum will be developed and submitted to the GMC and will be reviewed by our CAG.

For proposed credentials in areas of practice that are carried out outside of the NHS and training system, such as cosmetic surgery, we will develop additional requirements to bring them into the above processes.

The diagram below shows the approval process that will apply to credentials.

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**Regulating cosmetic interventions**

We recognise the importance of bringing regulatory oversight to cosmetic practice. The UK government has identified this as a priority, and our Council agreed we should progress this in 2016, following our credentialing consultation. Events in recent years have made it clear that more is needed to protect patients in this area, and while we have focused on developing the framework first, we will prioritise a credential in cosmetic surgery.

We expect that this type of credential may initially need to be based around demonstrating experience, rather than training. We are currently considering the possibility of a ‘practice credential’ where proxies might be used for training and quality assurance requirements.

We will continue working with the RCS England to pilot for cosmetic surgery as a credential while we carry out engagement from September 2018 to January 2019. We will look at options for what we might be able to do in the wider area of other cosmetic interventions – and ensuring they are relevant for practice in the four UK countries. We will also look further into what we can do more generally around regulation in the independent sector.
Plans for implementation

A phased approach
We aim to introduce credentials in a phased approach, starting in April 2019.

We have identified the main areas of work and approximate stages.

Phase 1 implementation
We will expect the first submissions for credentials to be in priority areas, or areas where discussions with COG have progressed and colleges and faculties are ready.

We will continue to test and refine our processes as the first credentials are submitted for approval, to help to ease the transition over the next few years.

Phase 2 development and implementation
Following the first phase, we will continue to work with organisations that are ready to submit credentials.

During 2019 we will also begin work on a number of related workstreams:

- explore how SAS doctors might have existing skills and competences which could be recognised through credentials
- develop processes and systems for annotating the List of Registered Medical Professionals (LRMP) with credentials
- develop QA processes for credentials, working with the QA review
- piloting and developing processes for QA of endorsed training modules
- work with training organisations to explore any educational governance issues
- continue to explore options for further development of cosmetic practice credentials, which will include looking at regulation of the independent sector.

From 2020 we expect credentials to be embedded in our QA and curriculum approval processes and subject to periodic review.
Impact and issues

Benefits to patients and health services

Patients and health services need a workforce that can adapt to changing needs, and credentialing is designed to enable doctors to move more quickly to areas of practice where there is greatest need.

Credentials will allow employers and workforce planners to better meet patient need, and to plan for anticipated future population healthcare needs. Credentials will support the need for more generalism, and will support patient safety by improving opportunities for doctors to supplement their training.

Credentialing will directly benefit patients by enabling better workforce management. Individual patients will also benefit indirectly through improvements to services.

Publishing credentials on the list of registered medical practitioners will improve information available about doctors’ skills, assuring employers and the public about a doctor’s capabilities in an area of practice.

Providing a process for regulated credentials in cosmetic surgery will potentially reduce risks for cosmetic surgery patients by offering a recognised standard, and informing the public whether individual doctors have met the standard.

Impact on the profession

We have developed the framework with an awareness of the conflicting interests and depth of feeling among some stakeholder groups. While some doctors see credentialing as providing opportunities for training or recognition of their capabilities, others see possible negative effects. We will continue to work to deal with these concerns through engagement with the profession.

One issue that could potentially affect doctors at any stage of their career is the possibility that doctors without a credential could be disadvantaged by being restricted in their ability to practise. While we do not have the legal powers to make credentials compulsory for doctors to be able to work in a particular area of practice, concern remains that employer or patient choices could lead to this situation.

One of the criteria for approving a credential is that there is a clear patient or service need in an area of practice, so it is unlikely the introduction of a credential will lead to doctors who are otherwise qualified being unable to work in one of these areas. Where credentials have already been introduced, such as liaison psychiatry, this hasn't happened. Similarly, many doctors currently work in areas of practice without being on the specialist register in that specialty. And while introducing credentials in areas of practice where patients are at risk may affect patient choices, this is in the interest of improving patient safety.
Doctors in training

While there are some concerns among doctors in training that credentialing has the potential to impact negatively on training programmes, it also offers clear benefits. Credentialing will support flexibility in career development, allowing opportunities for doctors to change career direction or enhance areas of practice. It will bring flexibility to benefit doctors throughout their career, and support bespoke career pathways.

We know that some doctors in training have concerns that credentialing will shorten training and/or lead to a CCT of lesser ‘value’. However, credentialing is designed to be complementary to training, not to replace or alter it. It is intended to provide a more flexible model so that when training clearly needs to adapt to keep up with patient needs or medical advances, it will be easier for doctors to keep up to date, and easier for the service to meet the needs of patients.

Credentialing does not directly impact on duration of training. While the curricula review aims to ensure that the right content is in curricula, Excellence by design requires that all curricula will be based on outcomes, not time. It also requires that stakeholder groups, including doctors in training, are consulted about changes to curricula.

We have heard concerns that credentialing could potentially devalue training, or create a sub-consultant grade. But what credentialing will actually do is provide opportunities for doctors to gain additional training to deliver what’s needed on the job, with recognition of their level of expertise. Advances in medicine and technology mean training needs to be much more adaptable, and credentialing will provide a mechanism to assure training quality and consistency in areas that might not be part of postgraduate training – now or in the future – and where patients are at risk. There will also be defined criteria for entry, providing fair and transparent access to these areas of training.

SAS doctors

We recognise the major contribution this group of doctors makes to the health service, and the need to provide better support and opportunities for their development and recognition. Along with the education statutory bodies, we are committed to developing solutions to support these doctors through credentialing and other means. We will be holding a symposium in 2019 to explore how we can do this.

There may also be potential benefits around outcomes-based curricula in terms of ability to gain a certificate of eligibility for specialist registration (CESR) or certificate of eligibility for GP registration (CEGPR).

Consultants and general practitioners

Many of the benefits described above in relation to doctors in training, are about supporting doctors throughout their whole career, and will apply to consultants and GPs.
The introduction of credentialing will provide opportunities for consultants and GPs for career movement, access to training in new areas, and recognition of skills in areas of development different to their original training.

**Cosmetic practitioners**

Introducing a regulated credential in cosmetic surgery will offer cosmetic surgeons an opportunity for recognition of skills, and a way to demonstrate their safe practice. It will bring the opportunity for skills development to doctors who meet the entry criteria.

**Other healthcare professionals**

We recognise that some credentials approved for doctors may be applicable to other healthcare practitioners. We will work with other healthcare professionals and their regulators to consider how these may apply.

Other professional regulators and employers may consider how medical credentials can offer opportunities for developing training that can be accessed by other healthcare professionals, working in multiprofessional settings. Although we only regulate doctors, we will look at how we can be more facilitative to help employers to develop other multidisciplinary team members.

**Managing issues and risks**

**Resource implications for organisations**

*Education organisations*

We know that as part of the curricula review following the launch of *Excellence by design*, the *Generic professional capabilities framework* and supporting guidance, colleges and faculties and the statutory education bodies have a significant job to do in revising all postgraduate curricula to make sure they are on track and delivered to meet the new standards by 2020.

We are concerned that the addition of credentialing could cause a strain on resources. Although credentialing will bring the benefit of more options for how to package learning, and allow the specialties to train up consultants in new areas more quickly, we are proposing a phased approach to allow time for colleges and other bodies to identify and develop proposals for credentials. We will however be ready to approve the first credentials in 2019.

A phased approach will also allow time for training organisations to develop arrangements around delivery and maintenance of credentials.
GMC

Our quality assurance teams who manage the curriculum approvals process along with the Curriculum Oversight Group (COG), and our visits and monitoring teams, will also need time to manage the changes credentialing will bring, and the potentially huge resource implications. The UK Medical Education Reference Group will also be taking on a significantly increased workload with credentialing.

Colleagues in the areas of registration and revalidation will also need to look at potential impacts on equivalence applications and on revalidation.

Some potential risks

We are aware of a number of areas of risk or questions around credentialing which we will need to consider as we continue our policy development.

These include the risk that while credentialing will allow opportunities for organisations to make training available to meet a patient or service need, it may be seen as a business opportunity. Clearly credentialing could provide a potential revenue stream for organisations to charge fees for membership, exams, ePortfolio access etc. It is not our intention to create a credentialing industry or generate ways for organisations to make money, and we will need to think about how to make sure credentials are developed for the right purposes and in the right ways.

Related to this is the question of how to decide which organisation should ‘own’ a credential if there are competing interests. There are currently a number of subspecialties which are linked to multiple specialties, and some areas which have been proposed as credentials are clearly opportunities for training doctors from more than one specialty. In some cases it may not be clear which college or faculty or other body is best placed or has more claim to create and manage the credential. This is an issue for cosmetic surgery too.

We will continue to work on these issues and others that may impact on training organisations or doctors, and welcome input from stakeholders on how we might deal with them.
Engagement on draft framework

External engagement

1 From September to November 2018 we are engaging with a range of external stakeholders on the draft framework. We are giving presentations and hold discussions, but we are also circulating the framework and providing an online form for written feedback. A summary of the meetings is included below.

2 Different stakeholder groups hold widely varying views, expectations and concerns around credentialing. To address the impact on them and to support discussions during engagement, we have summarised key messages for each group.

Key messages for stakeholder groups

<table>
<thead>
<tr>
<th>Doctors in training</th>
<th>Credentialing will allow for more flexibility within training and enhance a doctor’s ability to have a bespoke career pathway, alongside the CCT.</th>
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<tr>
<td></td>
<td>Process will support lifelong learning and a commitment to quality of training.</td>
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<td>Approved credentials will allow greater opportunities for wider training and will be supported by those funding or commission the training.</td>
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<td></td>
<td>The process is neutral on the length of training – curricula and training pathways are shifting to outcomes rather than time.</td>
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<tr>
<td>SAS doctors</td>
<td>Credentialing will provide an opportunity for recognition of training and career development.</td>
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<td></td>
<td>We are aiming to hold a symposium in 2019 to discuss how to develop credentialing for these groups.</td>
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### Council meeting, 6 November 2018

**Agenda item M3 – Credentialing update**

| Consultants and GPs | Credentialing will provide an opportunity to access training, allow recognition of expertise and ongoing career development.  
This will not impact on the GP or specialist register. |
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<tbody>
<tr>
<td>Wider profession</td>
<td>Access to further training, lifelong learning and recognition.</td>
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</table>
| Education organisations | Colleges are aware of credentialing developments through the curricula review process, where they are having ongoing discussions with the UK Medical Education Reference Group (UKMERG) to identify changes to curricula, including potential areas for credentials. This includes bringing new areas to discussions with UMERG to determine suitability as a credential.  
Will be a collaborative approach with other bodies, for example where an area of practice is linked to more than one specialty, we will ask the colleges to work together to develop a proposed credential.  
We will be supporting them throughout the process and implementation of a new credentialing framework.  
We need to ensure that credentialing is proportionate and follow criteria; we want to be able to manage the numbers. |
| Employers and workforce planners | Process will support transparency of training and better resource management.  
Clear mechanisms to develop and train staff in particular areas where demand can emerge quickly.  
Provides opportunities for team development, as identified as a priority by the new Secretary of State for DHSC in England.  
Mechanism to confirm expertise in particular areas of practice if on the LRMP. |
| Patients and public | Process supports transparency of training, provides assurance of standards, as well as regulating areas that are currently not within the GMC’s remit.  
Able to confirm expertise in particular areas of practice if on the LRMP. |
| Government | Reassurance on our progress on taking forward the actions agreed by the Shape of Training Implementation group and the four governments.  
Credentialing will allow more flexibility within training, and training for specific needs eg remote and rural. |

[www.gmc-uk.org](http://www.gmc-uk.org)
Council meeting, 6 November 2018

Agenda item M3 – Credentialing update

Governments and their officials will have mechanism to prioritise areas that they need to become credentials to manage their service/patient needs within their countries.

Close working with UKMERG throughout the development of the process.

<table>
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<tr>
<th>GMC</th>
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<tr>
<td>Process gives us better oversight of areas where patients may be at risk if there are not consistent UK standards and expectations.</td>
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<tr>
<td>Protects the quality of training, through the approval and quality framework.</td>
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<tr>
<td>Supports us in being responsive to the needs of patients and supporting the service to deliver safe care.</td>
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<tr>
<td>Supports the ambition to make postgraduate training more flexible and agile.</td>
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<tr>
<td>The process is neutral on the length of training – curricula and training pathways are shifting to outcomes rather than time.</td>
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Summary of external engagement

Meetings with COG and colleges

We’ve facilitated meetings between the individual colleges with UKMERG and considered curricula changes through our Curricula Oversight Group (COG) as part of the ongoing curricula review.

These meetings have explored proposed areas for credentialing, as part of discussions to make sure all curricula can meet the requirements in Excellence by design and Shape of Training principles.

Joint Academy Training Forum (JATF)

06/09/2018

We presented an outline of our proposals and answered questions.

Members agreed this is important work, but highlighted the need for sensitive handling of concerns around the potential to undermine curricula, and the need to engage with trainees. Members were keen to see the framework and to learn if particular areas might become credentials.

BMA Junior Doctors Committee – call with Chair

14/09/2018

Colin Melville spoke with the BMA JDC Chair and Deputy about progress.

They were reassured to hear about proposed processes around approval and quality assurance, but remain concerned about what might come out of CCT. They emphasised the need for clarity and definitions, and for the trainee voice to be part of the decision-making.
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<tr>
<th>Event Details</th>
<th>Description</th>
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<tr>
<td><strong>Health and disability reference group</strong></td>
<td>This is a small group of medical students and doctors who volunteered to help develop supporting resources for our <em>Welcomed and Valued</em> guidance. We gave a brief update on our plans, to promote awareness of the draft framework and answer any questions. We followed up with circulating the draft framework to them.</td>
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<tr>
<td><strong>GMC education roundtable – Northern Ireland</strong></td>
<td>This was our first wider engagement event, before circulating the framework. Attendees commented on the complexity of proposals, the importance to SAS doctors, and whether cost effectiveness should be considered among criteria. They agreed with a phased approach, and broadly with recognition on the LRMP.</td>
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<tr>
<td><strong>RCPsych credentialing working group</strong></td>
<td>We presented our proposals to this group which included attendees we’ve worked with on a pilot credential in liaison psychiatry. The group welcomed our plans, and were keen to progress credentials in other areas such as perinatal psychiatry.</td>
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<tr>
<td><strong>Joint Committee for Surgical Training (JCST)</strong></td>
<td>We presented to a reference group on a post-certification fellowships in surgical training project, which included lay and trainee representatives. They were positive about the benefits of credentialing for workforce planning and the value of aligning the process they are developing for fellowships with the credentialing criteria. A member from the Royal College of Surgeons in Ireland advised that Ireland is introducing a process similar to credentialing.</td>
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<tr>
<td><strong>Conference of Postgraduate Medical Deans (COPMeD)</strong></td>
<td>We presented and held a discussion at COPMeD which was a joint meeting with the Committee of General Practice Education Directors (COGPED) and which includes representatives from the BMA JDC, colleges and others. We received general positive support for the draft framework, with deans interested in thinking through how credentialing would be managed and implemented. The group felt they were gaining clarity and understanding about how credentials will work, allowing them to start planning and thinking. They still want further understanding about how new areas might be identified and developed. And there was interest in whether credentials would be applicable to other members of the healthcare workforce. The BMA JDC representatives continued to voice concerns about whether credentials would lead to a dilution of status and quality of training leading up to the Certificate of Completion of Training (CCT) and whether particular areas currently within training would come out to become credentials.</td>
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## Further engagement meetings

<table>
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<tr>
<th>Date</th>
<th>Event Description</th>
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<tr>
<td><strong>16/10/2018</strong></td>
<td>GMC education roundtable – Wales</td>
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<td><strong>30/10/2018</strong></td>
<td>GMC education roundtable – Scotland</td>
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<td><strong>01/11/2018</strong></td>
<td>GMC doctors in training roundtable – representatives from BMA JDC, Academy Trainee Doctor Group (ATDG), Association of Surgeons in Training (ASiT), and medical students</td>
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<td><strong>09/11/2018</strong></td>
<td>Quality leads – postgraduate training</td>
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<td><strong>Date tba</strong></td>
<td>Doctors in training workshop – with Faculty of Medical Leadership and Management Fellows, BMA, AoMRC, college and four-country representatives</td>
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<tr>
<td><strong>Dates tba</strong></td>
<td>Meetings with doctor in training groups: ATDG; possibly BMA JDC and ASiT</td>
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<tr>
<td><strong>Dates tba</strong></td>
<td>HEE SAS Career Grade Doctor Working Group; other SAS doctor groups</td>
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<tr>
<td><strong>Dates tba</strong></td>
<td>Meetings with patient and public representatives</td>
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<tr>
<td><strong>Dates tba</strong></td>
<td>Meetings with NHS and employer organisations</td>
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<tr>
<td><strong>Dates tba</strong></td>
<td>Meetings with medical school representatives</td>
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<tr>
<td><strong>Ongoing</strong></td>
<td>Meetings with organisations interested in piloting or developing credentials, including: Royal College of Radiologists; British Association of Dermatologists; Royal College of Surgeons; Royal College of Psychiatrists; Faculty of Pain Medicine</td>
</tr>
<tr>
<td><strong>Ongoing</strong></td>
<td>Meetings with organisations interested in credentials for cosmetic practice, including: Royal College of Surgeons; Medical Defence Union; British College of Aesthetic Medicine; and other cosmetic practice associations</td>
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<tr>
<td><strong>Ongoing</strong></td>
<td>Work with partners in the UK Medical Education Reference Group (UKMERG) and Shape of Training groups across four countries, as well as the COG and our Curriculum Advisory Group for expert input</td>
</tr>
<tr>
<td><strong>Ongoing</strong></td>
<td>Briefing our Employer Liaison Advisers to share our proposals with Responsible Officers; and Regional Liaison Advisers to share with all contacts</td>
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</table>
Council meeting, 6 November 2018

Agenda item: M4
Report title: GMC annual report of customer complaints
Report by: Dan Donaghy, Assistant Director, Office of the Chief Operating Officer, dan.donaghy@gmc-uk.org, 020 7189 5266
Janet Gray, Head of Corporate Review Team janet.gray@gmc-uk.org, 0161 923 6517
Action: To consider

Executive summary
In December 2015 Council agreed that an external organisation would be engaged to audit a sample of complaints to help provide assurance that the GMC’s complaint handling process was fair and fit for purpose. Verita, an independent consultancy, provided a report of its findings and recommendations to Council in September 2016.

Verita were commissioned to annually review the GMC’s complaints handling process and their previous findings and recommendations were considered by Council in November 2017.

This year Verita conducted their third annual review of the process from 1 July 2017 to 30 June 2018. Its report is included at Annex A. This paper sets out the main findings from Verita’s review and the GMC’s initial response.

Recommendation
Council is asked to consider Verita’s report: Independent review of the General Medical Council customer complaints handling: Annual report at Annex A.
Key points from Verita’s report

1. Verita, an independent consultancy that specialises in managing reviews for regulated organisations, has conducted three annual reviews of the GMC’s customer complaints handling.

2. Verita has significant experience both in managing complaints and as a supplier of an independent complaints review service. Its clients include The Law Society, British Council, Department of Health, NHS England and various NHS Trusts, the Lottery Forum and police authorities.

3. Their first two Annual Reports have been considered by Council in September 2016 and November 2017. Verita’s third report: Independent review of the General Medical Council customer complaints handling: Annual report is at Annex A.

4. The GMC received around 1,535 complaints in the 12 months from 1 July 2017 to 30 June 2018. Verita extracted a random sample of 308 complaints across the period for detailed analysis. This provides a confidence level of 95% (margin of error 5%) that the sample is representative of the whole data set.

5. The review included desk top audits and face to face interviews with complaints handlers. Verita assessed our performance against our own processes and procedures, their own metrics and the Parliamentary and Health Service Ombudsman’s ‘Principles of Good Complaint Handling’.

6. Verita’s overall findings are very positive. They continue to observe the strength in our use of complaints as a corporate intelligence and business improvement tool and believe that our complaints function “remains among the very best that we have seen and [the GMC] should be congratulated on their continuing excellence in most areas”.

7. While Verita make recommendations for continuous improvement in some areas they were particularly impressed with:

   a. responses were well structured, easy to follow, friendly and professional in tone of voice with limited use of jargon

   b. 92.5% complaints were adequately addressed by the first response

   c. staff have an excellent grasp of the appropriate legislation and can explain this very effectively and explained any required next steps to the complainant

   d. routinely signposting complainants to alternative means of resolving their queries as an example of offering complete customer service and the GMC performs strongly in this area
the enthusiasm, commitment, competence, motivation and engagement of our complaints handling staff who proactively respond to complaints

senior managers support for complaints handlers.

**Recommendations**

8 Verita noted that their previous recommendations were taken on board with positive effect including; adoption of vexatious complaints and unreasonable behaviour policies and the resulting support from senior managers for staff who feel more empowered in dealing with difficult situations, a forum for complaints handlers from different teams to meet regularly and categorising general comments and feedback as correspondence rather than complaints.

9 Verita note that the areas that are praiseworthy are many and varied; however, there are a few areas that they recommend for development and make 8 recommendations. Some of these centre on our database, its completion and aim to reduce the potential for errors in reporting. The publically facing documents explaining our complaints process are described as excellent but they suggest further navigational guidance to this on the new website which we have raised with colleagues who manage this process.

10 Two key action points for the GMC are:

a The need to consider our communications materials regarding voluntary erasure, making very clear that it is a legally mandated process that the GMC is required to undertake.

b Complaints handlers should remain vigilant for opportunities to improve processes and communications around GDPR compliance.

11 We have done a lot of work as an organisation to ensure we fully comply with GDPR but we can never be complacent and will take on board the learning from the examples identified in this review. We will work on this and the other actions through our cross-directorate steering group. With support from the Chief Executive and Chief Operating Officer, we will move to address these actions formally within the coming year.

**Conclusion**

12 The recommendations made by Verita will be acted upon within the coming 12 months. We feel the recommendations made are ‘continuous improvement’ to what is an already strongly performing complaints system. We hope that in large measure, Verita’s detailed findings give reassurance that our complaints handling process is
fair, fit for purpose and high quality in comparison with other organisations. We see this as a fitting testament to the investment of time, energy and resource that Council and the GMC Executive have dedicated since the Horsfall Review of complaints handling in 2014.

13 Notwithstanding the positive review within this report, we continue to work hard to balance the difficult task of providing complainants with empathetic responses in the correct tone which also explain, without ambiguity, our procedural and legal processes; that can withstand judicial review and legal challenge if needed. This is an ongoing and iterative task and one that we hope to continue to make progress on in the coming 12 months.
M4 – GMC annual report of customer complaints

M4 – Annex A

Independent review of the General Medical Council customer complaints handling: annual report
Independent review of the General Medical Council customer complaints handling: annual report

A report for
The General Medical Council

October 2018
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9. Complaint handler interviews 55
1. Introduction

1.1 The General Medical Council (GMC) is an independent organisation that helps to protect patients and improve medical education and practice across the UK. It works closely with doctors, their employers and patients. Its functions and the way it carries them out are set out in law. The GMC:

- decide which doctors are qualified to work in the UK and it oversees UK medical education and training. There are over 270,000 doctors registered to practise in the UK, and over 30,000 registration transactions are processed each year;
- sets the standards that doctors must meet and makes sure that they continue to meet them throughout their careers. It monitors the standards of over 30 medical schools, and processed more than 70,000 revalidation transactions in 2015 to ensure the ongoing competence of doctors; and
- takes action to prevent a doctor from putting the safety of patients, or the public's confidence in doctors, at risk. In 2014 the GMC received almost 10,000 complaints or enquiries about doctors resulting in almost 2,750 full investigations.

1.2 The GMC acknowledges that, on occasion it makes incorrect decisions or that it is unable to help its 'customers' in the way that it would like. It has a customer complaints process which enables customers to give feedback on the service they received from the GMC. On average, the GMC received approximately 2,500 customer complaints per year, though this number has fallen below 2,000 for the last three years.

1.3 The GMC commissioned an independent review of its complaints handling in 2014. One of the recommendations of this was for the GMC to consider a regular independent review of corporate complaints. In addition, the GMC Council asked that the GMC explore the feasibility of appointing a suitably qualified organisation or individual to independently review its new complaints handling processes.

1.4 As a demonstration of its commitment to excellence in complaint handling, the GMC Resources and Performance Board committed the organisation to achieving British Standards Institute (BSI) ISO 10002 complaints handling certification. This accreditation was achieved in January 2016.
1.5 In May 2016, Verita was commissioned via competitive tender to undertake the independent audit service. The first Verita audit report was delivered in September 2016. This is third annual report and examines the period July 2017 – June 2018. We build on our observations from previous years.

1.6 Verita is a consultancy specialising in the management and conduct of investigations, reviews and inquiries in public sector organisations. Verita has significant experience in managing complaints both at the ‘front line’ and as a supplier of an independent complaints review service.
2. **Terms of reference**

2.1 The provider will deliver an independent report covering these key areas:

- Review of a representative sample of corporate complaints to help the GMC understand the effectiveness of its customer complaints policy, and its operational use.
- Write an annual report of its complaints handling suggesting good practice, areas for improvement and how the GMC is performing against its policy and standards in general.
3. Executive summary and recommendations

Executive summary

3.1 The General Medical Council (GMC) is an independent organisation that helps to protect patients, improve and regulate medical education and practice across the UK. It works closely with doctors, their employers and patients.

3.2 The GMC acknowledges that, on occasion it makes incorrect decisions or that it is unable to help its ‘customers’ in the way that it would like. It has a customer complaints process which enables customers to give feedback on the service they received from the GMC.

3.3 In May 2016, Verita was commissioned via competitive tender to undertake the independent audit service. The first Verita audit report was delivered in September 2016. This is third annual report and examines the period July 2017 – June 2018. We build on our observations from previous years.

3.4 Our independent audit has reviewed a representative sample of corporate complaints to help the GMC understand the effectiveness of its customer complaints policy, and its operational use. This annual report of the GMC’s complaints handling suggests areas of good practice, areas for improvement and examines how the GMC is performing against its policy and standards in general.

3.5 In both the 2015 / 16 and 2016 / 17 reports, Verita made a range of observations and recommendations to the complaints department. In this version, we assess to what extent these recommendations have been actioned, and what, if any, effect this has had on operations.

3.6 The GMC received around 1,535 complaints in the 12 months from 1 July 2017 to 30 June 2018. We extracted a random sample (the audit sample) of 308 complaints across the period for detailed analysis. This provides a confidence level of 95% (margin of error 5%) that the sample is representative of the whole data set. It is generally accepted that the 95% confidence interval strikes the best balance between statistical rigour and maintaining a manageable sample size.
3.7 Interviews were held with three members of GMC staff in the Manchester office. These were front line complaints handlers drawn from different directorates. The nature of the interviews was to test any theories we developed as a result of our data analysis and gain an insight into the general culture and operation of the complaint handling function.

*Overarching findings of the study*

3.8 The customer facing material about how to complain and what to expect of the complaints process remains strong. Although the website is generally well-designed and clear in its messages there are a few possible improvements in navigation that would make the section on complaints easier to find.

3.9 Internal policy documents on complaints remained largely unchanged from previous years. Again, we find that ‘policy manual’ provides an excellent background to the work of the complaints function. In our discussions with staff, we were pleased to find that staff were knowledgeable about the complaints policy and knew how to find support and guidance on internal systems if needed.

3.10 Following our recommendation from last year, we note that use of the vexatious complaints and unreasonable behaviour policies has been implemented. We were told that this action is largely taken by the corporate review team. In our meetings with staff, we noted that they felt comfortable and confident to use the mechanisms of these policies. Staff clearly understood the basis for the policies. Staff we spoke to felt that the adoption of these policies supported them in their role and allow them to be clearer and more assured in the advice they give to customers. We believe that the extension of these policies has had a positive effect on the morale and efficiency of the complaints team.

3.11 We are confident that the GMC’s reporting on complaints strikes a good balance between producing a variety of metrics and being a useful and proportional document. The use of the complaints department to identify potential business improvement opportunities remains excellent. The fact that staff at the GMC say they can see real changes being made as a result of reporting and raising of their own concerns is both unusual and notable.
3.12 Last year, we recommended that a forum should be established for different teams within complaints to share their experiences and observations. We were told that complaints teams across the GMC now meet to identify issues, share learning and formulate improvements. Staff spoke positively about these meetings, so we encourage their use to be continued.

3.13 Between the 2017 to 2018 reporting years, there has been a decrease in the total number of complaints logged in Siebel of over 10%.

3.14 We have previously made a recommendation that general comments about the organisation should not be classified as complaints. We saw fewer of these in this year’s sample.

3.15 In many instances, the complaints we reviewed were around a greater variety of more complex issues. We think that it is likely that this is as a result of better underlying processes and better information available to customers so fewer, but more complicated complaints are received. Despite the increased complexity of complaints received this year, we are pleased to see that the overall quality of responses has remained strong.

3.16 On all the key metrics that we used to audit quality, the GMC remained outstanding, with little statistically significant change from last year. Particular improvements have been made in reducing the overall handling time of complaints received by the GMC. Complaint responses are invariably friendly and professional in tone of voice and limit the use of jargon where possible.

3.17 As we have noted in both previous reports, we found complaints staff at the GMC to be were extremely enthusiastic and committed to their roles. This is rare within complaints departments. Staff genuinely identified with the ethos of viewing complaints and comments as feedback for improvements in the GMC’s service to ‘customers’. One member of the team told us they saw complaints and a “invaluable” source of information for the GMC. We believe this approach is evident in the responses we have reviewed in our audit sample.

3.18 Staff that we spoke to felt that overall improvements had been made to GMC processes that allowed for a more efficient, streamlined service to be delivered to
customers. Staff have noted examples where improvements made to services or published information have resulted in a reduction of complaints generated on the topic.

**Concluding comments**

3.19 In our report last year, we concluded that the GMC has a high-functioning, well-motivated and impressive complaints team. We are happy to confirm that in this report, we can draw the same over-arching conclusions.

3.20 We are confident that our previous recommendations have been actioned appropriately and we have been able to observe positive changes resulting from their implementation.

3.21 In our audit work for the GMC, we at Verita find ourselves in the somewhat incongruous situation whereby those areas that we recommend for development or improvement are few, and the areas that are praiseworthy are many and varied. This is a rare situation. We believe that the complaints function remains among the very best that we have seen and should be congratulated on their continuing excellence in most areas.

**Recommendations**

R1 We recommend that the GMC review their communications materials regarding voluntary erasure, making very clear that it is a legally mandated process that the GMC is required to undertake.

R2 Complaints handlers should remain vigilant for opportunities to improve processes and communications around GDPR compliance.

R3 If possible, the GMC should examine the feasibility automating the input of ‘system dates’ to ensure accurate record keeping. Alternatively, data should be validated upon entry.

R4 Staff should be made aware that there is still potentially a degree of error in their completion of the database.
R5  The GMC should look into improvements to Siebel that automatically saves (or prompts the user to save) changes made to the record. Alternatively, staff should be mindful to check that all relevant correspondence has been saved to the database for completeness.

R6  The GMC should ensure that staff recognise all aspects of a complaint and do not use a 'template response' in isolation if this does not address all issues.

R7  We would suggest that our findings relating to handover of complaints from other parts of the GMC are shared with the complaints teams in order to avoid an unhelpful feeling that other departments are 'holding up' the complaint process.

R8  The sharing of subject knowledge within teams should continue and be encouraged in all directorates in order to build resilience for the organisation as a whole.
4. **Approach**

4.1 Our evaluation of the GMC is designed to objectively assess the performance of the complaint handling function against both its internal policies and targets, and also against best practice we have observed in different departments across sectors and individual organisations.

4.2 The review has involved audits of policies and procedures (what ‘should’ be done) against the answering of actual complaints randomly selected from the Sebel complaints database (what is done). These exercises were followed up by face to face interviews with complaints handlers in order to get an ‘on the ground’ perspective of the functioning and dynamics of the complaint handling team.

4.3 In both the 2015 / 16 and 2016 / 17 reports, Verita made a range of observations and recommendations to the complaints department. In this version, we assess to what extent these recommendations have been actioned, and what, if any, effect this has had on operations.

4.4 We have previously noted that, as would be expected from an organisation with ISO 10002 certification, the complaints team routinely produce a wide range of genuinely strong, comprehensive reporting against key performance metrics (10-day closure in line with SLA’s, team performance, source of complaints by process, category etc.). Again, this year, rather than simply telling the organisation what it already knows by replicating these core metrics, we have used a bespoke template to assess the strength of complaint responses against criteria that we know from experience to be important to complainants.

4.5 We have reviewed the GMC’s policies and procedures relating to complaint management to assess their inherent strength, and to determine how well complaints are managed against these internal standards. We have also reviewed a sample of complaints reports.

**Complaint audit methodology**

4.6 The GMC received around 1,535 complaints in the 12 months from 1 July 2017 to 30 June 2018. We extracted a random sample (the audit sample) of 308 complaints across
the period for detailed analysis. This provides a confidence level of 95% (margin of error 5%) that the sample is representative of the whole data set. It is generally accepted that the 95% confidence interval strikes the best balance between statistical rigour and maintaining a manageable sample size.

4.7 We then designed a framework against which to assess all the selected complaints. This included judging whether the responses met several criteria:

- **Complaint correctly classified and escalated** – This is important as we have seen on many occasions in other organisations complaints being referred to the wrong team / department, inevitably leading to delay and frustration on the part of the complainant. Initial triage of the complaint is key;

- **Referencing and applying appropriate regulations and legislation** – Particularly in regulated environments, it is key that complaints are judged against the correct standard, be that internal or external (mandatory);

- **Whether there was an appropriate investigation of the concerns and an evidence-based analysis** – For this criterion, we assess whether there is evidence that the complaint has been properly considered, investigated thoroughly and appropriate evidence gathered; and

- **Whether the responses addressed the concerns raised and were written in plain English** – Do the responses provided by the GMC directly address the issue raised, and are these responses in plain, understandable, appropriate language?

4.8 In order to ensure that we properly randomised our audit sample, we received the data from Siebel in an unfiltered form, i.e. we had every record over the period. While much of our analysis was performed on the audit sample, in some instances we felt that there would be benefit in looking at the complete data set. In section 8 below, we identify whether the analysis was on the audit sample or complete data set.

**Staff interviews**

4.9 Interviews were held with three members of GMC staff in the Manchester office. These were front line complaints handlers drawn from different directorates. The nature of the interviews was to test any theories we developed as a result of our data analysis
and gain an insight into the general culture and operation of the complaint handling function.

4.10 This year, we were also able to assess whether any recommendations made in our report last year have been actioned and, if so, to what effect.

4.11 The findings from the work described above are given sections 5-9 of this report. They describe the ‘as-is’ situation for the GMC.
5. **Good practice in managing complaints – an overview**

5.1 In evaluating performance in complaints management, it is important to consider the objectives of the work - why the complaints process is important to an organisation.

5.2 The motivation for complaints management is often seen in a negative light – avoidance of bad publicity or legal challenges, or simply as a “necessary evil” – but there are also many positive ways in which to look at complaints management.

5.3 The Parliamentary and Health Service Ombudsman’s ‘Principles of good complaint handling’ suggests a number of benefits of managing complaints well. These include:

- providing a good service to customers or service users;
- they give feedback to the organisation about problems or where things are not working well; and
- that they give an early warning sign of problems or failures of the organisation to update procedures or services to meet changing needs.

5.4 In short, complaints provide both a warning of things that are not going well and the information to enable improvement to services. They can help senior managers to ‘sleep better at night’ in the knowledge that they are aware of (and on top of) any issues with the operation of the organisation and are able to plan how to respond. This frame of mind can make real the cliché of ‘being a learning organisation’.

5.5 The Ombudsman’s guidance also emphasises the importance of having good procedures which, it says, “can save ... time and money by preventing a complaint from escalating unnecessarily”.

5.6 It is easy for an organisation to respond to complaints in a defensive way. Dealing with complaints properly can be time consuming and feel unrewarding. It is natural for those responding to want to stand up for their colleagues and to present the best face of the organisation. An overly defensive response can, however, lead to an adversarial relationship with the complainant, a loss of confidence in ‘the system’ and is, therefore, likely to be counter-productive.

5.7 Key features of a good complaints system include:
• strong leadership from the top of the organisation;
• a focus on outcomes to be delivered both for the complainant and the organisation;
• fairness and proportionate responses;
• sensitivity to complainants needs;
• a clear and straightforward process, which is therefore accessible to users; and
• efficiency – with decisions taken quickly, things put right, and lessons learnt.

5.8 In the end, a good complaints process comes down to giving clear, balanced responses to the issues raised, while building a positive culture so that the organisation as a whole, and those responding to complaints, regard them as useful intelligence and a resource to aid learning and improvement.

5.9 We have observed in previous years that the GMC is notably strong in its use of complaints as a corporate intelligence and business improvement tool. We comment further on this in this years’ report.

5.10 In the rest of this report, we assess the performance of the GMC complaints function against recognised best practice in complaint handling and build upon our observations from previous reports.
6. The GMC's complaints processes, policies and reporting

6.1 We reviewed the GMC's policies relating to complaints, including public-facing information contained on the GMC website and in policy documents which are available on the GMC website.

Public-facing documents

6.2 As we have noted in previous years, the information on the GMC's website relating to complaints is generally very good. We note, however, that since the update to the website, the section on complaints is difficult to find.

6.3 The "Feedback and Complaints" section is located in "About / Get Involved / Feedback and Complaints". While this page appears if the term "GMC complaints" is entered to a search engine, it only appears as the tenth result if the term "Complaint" is entered in to the "Search the Site" box on the GMC website.

6.4 The "Feedback and Complaints" page makes clear that it is for giving feedback or making a complaint about the GMC's work. It refers to these as "customer complaints". This nomenclature is not used systematically, however, and parts of the website relating to complaints about the GMC are not always labelled as such (and clearly distinguished from complaints about doctors).

6.5 Not unreasonably, the GMC website focusses on raising concerns about doctors. "Concerns" is one of the sections highlighted on the website home page, which leads to the section on raising concerns about a doctor. It might be helpful if somewhere on the "Concerns" page a link we provided to raising complaints about the GMC itself.

6.6 We note that the GMC has launched a protocol together with other regulators to ensure the sharing of information. This is welcome.

6.7 The guidance itself on making complaint about the GMC is excellent. It is written in plain English and is set out in a logical order.
6.8 The complaints process is initially represented in a clear graphic. The following text is concise, well-constructed and provides complainants with a clear guide as to what will happen and over what timescale.

6.9 The customer facing material about how to complain and what to expect of the complaints process remains strong. Although the website is generally well-designed and clear in its messages there are a few possible improvements in navigation as discussed above.

Complaints about doctors

6.10 As we have noted previously, the section of the website relating to complaints about doctors is also very strong, both in terms of the language used and the explanation of the process. The video on raising concerns is also user-friendly and welcome.

Internal documents

6.11 Internal policy documents on complaints remained largely unchanged from previous years. Again, we find that ‘policy manual’ provides an excellent background to the work of the complaints function. It is comprehensive, explaining both the high level operational aspects of the work, but also the aims and philosophy behind it. In keeping with the rest of the written output we have reviewed, it is superbly written, avoiding jargon and conveying messages in a clear and well-constructed fashion.

6.12 In our discussions with staff, we were pleased to find that staff were knowledgeable about the complaints policy and knew how to find support and guidance on internal systems if needed.

Vexatious complaints

6.13 In our 2017 report, we recommended that the GMC should emphasise to staff that the vexatious complaints and unreasonable behaviour polices are legitimate policies and
should be used if complainants 'cross lines' or when continued correspondence would prove counterproductive.

6.14 Following our recommendation from last year, we note that use of the vexatious complaints and unreasonable behaviour policies has been implemented. We were told that this action is largely taken by the corporate review team. In our meetings with staff, we noted that they felt comfortable and confident to use the mechanisms of these policies. Staff clearly understood the basis for the policies, notably the distinction that the policy applied to vexatious complaints and not a vexatious complainant.

6.15 Staff described the processes that they undertake and were comfortable and knowledgeable regarding the next steps for those subject to the policy. Staff explained that all correspondence received is filed and reviewed to ensure that the issues discussed are the same as those covered by the vexatious complaint. Staff routinely signpost complainants to outside organisations if appropriate.

6.16 Staff we spoke to felt that the adoption of these policies supported them in their role and allow them to be clearer and more assured in the advice they give to customers. One member of staff said that they felt more "empowered" in their interactions with difficult customers. We found that having such policies in place helped staff feel more supported by senior managers. We were confident that these policies were implemented proportionately and as a 'last resort'.

6.17 We believe that the extension of these policies has had a positive effect on the morale and efficiency of the complaints team. We encourage the GMC to continue to use these policies in this way.
6.18 Each directorate complaint team produces a shorter monthly report on performance against key metrics. As an easily read, familiar ‘snapshot’ of current performance, it’s brevity is a real strength.

6.19 A quarterly report is produced to report on complaints performance across the GMC. The quarterly report combines ‘hard’ data, alongside some narrative on trends across the period.

6.20 Staff members we spoke to saw these monthly and quarterly reports as ‘live’ documents from which actions are taken and changes made. We are confident that the GMC’s reporting on complaints strikes a good balance between producing a variety of metrics and being a useful and proportional document.

6.21 The use of the complaints department to identify potential business improvement opportunities remains excellent.

6.22 All too regularly, we observe that the complaints function in organisations is seen, essentially, as an administrative function rather than a potential learning centre in its own right.

6.23 The fact that staff at the GMC say they can see real changes being made as a result of reporting and raising of their own concerns is both unusual and notable.

6.24 We were impressed by staff members’ awareness of future updates and improvements in development.

6.25 Last year, we recommended that a forum should be established for different teams within complaints to share their experiences and observations.

6.26 We were told that complaints teams across the GMC now meet 8-10 times per year to identify issues, share learning and formulate improvements. Staff spoke positively about these meetings, so we encourage their use to be continued.
Finally, the noting of compliments received by the complaints team again represents best practice. Staff say that new guidance on logging compliments is due to be implemented in the coming months. Again, we firmly support and endorse this initiative.
7. General observations

7.1 Between the 2017 to 2018 reporting years, there has been a decrease in the total number of complaints logged in Sebel of over 10%. This is clearly positive simply as a barometer of the performance of the organisation as a whole, though its roots are undoubtedly in several different areas.

7.2 We have previously made a recommendation that general comments about the organisation should not be classified as complaints. We saw fewer of these in this year’s sample.

7.3 The absolute number of complaints can be influenced by events entirely beyond the control of the GMC. For example, last year we saw many ‘complaints’ generated by the junior doctor strike. We have not observed any external event of the same magnitude this year, again probably accounting for a percentage of the reduction.

7.4 In this year’s sample, we did observe a reduction in the total number of escalated complaints. We believe that this reflects improvements in the initial responses to complaints, resulting in fewer complainants feeling the need to demand an escalation.

7.5 In every audit that we have undertaken for the GMC, we have been very complimentary about the organisation’s real commitment to learn from complaints and to change things as a result. Although anecdotal at this stage, we can see evidence that this approach is paying dividends for the organisation.

Complaint themes

7.6 We note a greater variety in the types of complaints logged this year. This indicates that the steps taken to eliminate serial issues before they occur are working.

7.7 In many instances, the complaints we reviewed were around more complex issues. We think that it is likely that this is as a result of better underlying processes and better information available to customers so fewer, but more complicated complaints are received. Despite the increased complexity of complaints received this year, we are pleased to see that the overall quality of responses has remained strong.
7.8 Staff in R&R noted two areas of increased activity in complaints - the availability of PLAB tests & issues with on-boarding of the newly accepted OET test. Staff were pleased that practical solutions to the roots of these issues were suggested and implemented promptly, again demonstrating that there is an effective route for the complaints team to identify issues and have them addressed.

Voluntary erasure procedures

7.9 We would suggest that there is one area which, over the course of all three of our audits, has generated many complaints.

7.10 The issue of voluntary erasure, especially for individuals wanting to retire or de-register following illness, has been a recurrent theme.

7.11 We were told that the GMC reviewed the process of voluntary erasure in December 2016 and made changes where possible. We fully appreciate that voluntary erasure is a tightly prescribed, legally driven procedure. We observe, however, that the majority of complainants in this area appear to think that it results from ‘GMC-mandated bureaucracy’. We believe there is an opportunity to improve communications around the voluntary erasure process. While GMC are acting within legal mandates, this is not necessarily clear to those undergoing the process. We also note that the majority of doctors undertaking this process are retirees or suffering with long term illness and are therefore do not necessarily engage with the guidance available online.

Recommendation

R1 We recommend that the GMC review their communications materials regarding voluntary erasure, making very clear that it is a legally mandated process that the GMC is required to undertake.
7.12 A second area that we believe would benefit from further development would be around GDPR regulations.

7.13 Needless to say, this is an area that many organisations (including Verita) have struggled with in recent months. It is therefore unsurprising that people are more alert to data protection issues and so is very likely to generate complaints and queries. Notwithstanding this, we have examples of where greater clarity on the measures taken by the GMC to protect data would, we believe be of benefit.

7.14 Within the audit sample, we reviewed a few complaints concerning the use of data held by the GMC. Unfortunately, in some of these cases we found that the responses given by complaint handlers may not have effectively communicated the measures taken by the GMC to comply with the new General Data Protection Regulations. We believe that this is to be expected with the introduction of new, complicated and widely mis-interpreted regulations which require widespread adaptations to various processes which are often not immediately apparent for reform. We found in these cases that specific opportunities for learning and review of processes that these complaints presented were not always taken as they could have been.

7.15 We found overall that the GMC handle the personal and sensitive data it receives with appropriate care. However, we believe the GMC should remain mindful of ensuring they have the relevant consent for all uses personal data.

Recommendation

R2 Complaints handlers should remain vigilant for opportunities to improve processes and communications around GDPR compliance.

Overall comment

7.16 In our audit work for the GMC, we at Verita find ourselves in the somewhat incongruous situation whereby those areas that we recommend for development or
improvement are few, and the areas that are praiseworthy are many and varied. This is a rare situation. We believe that the complaints function remains among the very best that we have seen and should be congratulated on their continuing excellence in most areas.
8. Performance analysis

8.1 In this section, we review the complaints team performance against the following criteria:

- How long does it take to deal with a complaint?
- Are complaints acknowledged on receipt?
- Is the Sebel database correctly completed?
- Is the background / context / previous correspondence / complaints included and easily accessible?
- Is the complaint correctly classified (high profile / repeat complainant)?
- Where necessary, was the complaint correctly escalated?
- Does response show a clear understanding of the issue of the complaint? Does the response adequately address the specific concerns of the complainant?
- Where appropriate, is the approach/methodology used to address the issue clearly set out?
- Where appropriate, are appropriate regulations, legislation, benchmarks referenced?
- Where appropriate, is there evidence of a comprehensive investigation of concerns?
- Is the response written in plain English, with good spelling and grammar?
- If opportunities for learning were identified, were the recommendations SMART?
- Did the complaints team respond within the agreed timeframe?
- Are next steps (if any) outlined?

General comments on context and approach

8.2 As with our previous reports, we had access to the full GMC complaints data set. For the period June 2017 to July 2018, there were 1,535 records. We extracted a random sample (the audit sample) of 308 complaints across the period for detailed analysis. This provides a confidence level of 95% (margin of error 5%) that the sample is representative of the whole data set.
8.3 As such, there a + / - 5% statistical variance can be applied to all analysis based on the audit sample. Moreover, there is an inbuilt margin of error applicable to all systems (such as Siebel) which are reliant on human input. The fact that a particular field has not been populated does not mean that an action has not been done – rather just that it has not been recorded.

8.4 In most instances, we performed our analysis on the audit sample. However, in some cases we have analysed the full data set. This is useful in potentially identifying anomalies that may not be picked up in the sample records.

8.5 We have indicated below where analysis is on the audit sample or the full data set.

**Days from complaints team receipt to closure**

8.6 The initial analysis that we did on the full data set was to look at the number of days each complaint was ‘in the system’ prior to closure. In our experience, this is useful to demonstrate the number of ‘problem’ (i.e. long standing) issues, and to highlight any issues in the data set.

**2016 results**

![Days From Receipt To Close](image)
8.7 In 2016, we identified that 18 records (0.8%) were, in system terms, closed before they were opened (the left-hand side of the chart above), i.e. there was an obvious data cleanliness issue.

8.8 It also identified that, while the vast majority of complaints were closed in a timely fashion, there was a small number of complaints that had been in the system for a significant period of time.

2017 results

8.9 As can be seen below, the 2017 data had resolved the data cleanliness issue – all the records had an end date after the start date. The shape of the curve is very similar, i.e. there remain a number of issues that take a significant period of time to resolve.

2018 results

8.10 In this year’s data, as can be seen below, there has been a return of the data cleanliness issue. There were 8 records (0.5%) which show as closed before they opened.
8.11 In this year’s data, we have identified a number of instances of questionable data cleanliness, particularly with regards to the input of dates that cannot be correct. We believe in some cases it may be more appropriate for data to be automated to reduce the likelihood of incorrect data being logged.

Recommendation

R3 If possible, the GMC should examine the feasibility automating the input of ‘system dates’ to ensure accurate record keeping. Alternatively, data should be validated upon entry.

8.12 Again in 2018, the shape of the curve is similar to previous years, showing that there are still a number of ‘problem’ complaints which take a long time to resolve. In reality, given the complexity of some of the cases addressed by the department, this is not surprising and should not be seen as indicative of poor performance.
Acknowledgement sent if required

8.13 As in previous years we have analysed the full data set to test for completion of the ‘Acknowledgement required’ field. As last year, we have found this field to be completed 100% of the time.

8.14 We have, therefore, checked to see how many times, when ‘acknowledgement required’ was stated as yes, that the field ‘acknowledgement sent’ was also completed. We believe that this is important, as it sets the tone of the engagement with the complainant and gives them early reassurance that their issue is being looked at.

8.15 We cannot say with certainty if the acknowledgement was sent or not in the missing cases — just that the database was not completed for this field.

2017 results

8.16 As can be seen above, the ‘Acknowledgement Sent’ field was completed across a range from 99% in September 2016 to 94% in August 2016.
**2018 results**

**8.17** As can be seen below, the ‘acknowledgement sent’ field was completed across a range from 100% in October 2017 and 86% in April 2018.

![Acknowledgment sent if required 2017 / 2018](chart)

**8.18** We would rate any average completion rate of 95% as very good. While this was consistently achieved in the earlier part of the period, was not achieved in the last seven months of the sample period. As stated above, we cannot be certain if up to 14% of complainants did not receive an acknowledgement, as this could simply be an issue with the database not being completed correctly.

**8.19** Notably, in our discussions with staff, we were told that effort and improvements had been made with regards to sending acknowledgements in a more timely and consistent manner (we explore this below). The data does not obviously support this, particularly in the latter part of the year. In this instance, the failure to enter correct data may have masked some of the achievements of the complaints team.

**8.20** In any case, we believe this represents an area where improvement could easily be achieved. Last year we recommended that staff be made aware of errors in their record keeping. It appears that this remains an issue this year.
Further to our previous recommendation, this is not an area that necessarily lends itself to automation of data. It is therefore incumbent on staff to ensure data is entered into the database correctly.

**Recommendation**

**R4** Staff should be made aware that there is still potentially a degree of error in their completion of the database.

**Time to acknowledge complaints**

One area, however, where we have observed significant improvement is in the time taken to acknowledge receipt of complaints (when it is recorded that the acknowledgement has been sent).

As can be seen above, the average days taken to send an acknowledgement has fallen significantly since last year. As is shown below, this has been consistently achieved over the period.

As discussed, we were told that this has been an area of focus for the team, hence it seems incongruous that the percentage of times that acknowledgements have been sent
has ostensibly fallen. We are inclined to believe, therefore, that the apparent fall is more to do with data cleanliness than failure to send. This should be checked.

Is the Siebel database correctly completed?

8.25 Using our analysis of the audit sample, the below chart shows our results for the check on whether the Siebel database was completed correctly.

8.26 The level of completion on this metric has shown a slight decline from the previous year. The majority of the records we found to be completed incorrectly were as a result of
responses to complaints not being included on the complaint record. In most cases, it is
evident from the summary information (and the absence of a repeat complaint) that the
response has been sent but not saved to the system. While this is unlikely to have any
significant ramifications, it would clearly be preferable that every record is complete and
does support our hypothesis that the underlying issue is data completion.

8.27 Staff told us that Sebel does not automatically save uploads and on occasion staff
have forgotten to save the record manually. This would appear to us the most common
cause of missing information on the Sebel database.

8.28 Notwithstanding this, we would emphasise that if we saw a 94% completion rate in
other clients/organisations, we would view this as a major success. One other factor to
consider is the inherent variation in our sampling. As we have discussed, there is a + / -
5% variability in the data, so it is perfectly possible that performance has been maintained
but that the sample has simply drawn in a greater preponderance of incomplete records
than in previous years.

Recommendation

R5 The GMC should look into improvements to Sebel that automatically saves (or
prompts the user to save) changes made to the record. Alternatively, staff should be
mindful to check that all relevant correspondence has been saved to the database for
completeness.

Is the background / context / previous correspondence / complaints included and
easily accessible?

8.29 Maintaining full records of complaint activity, including past correspondence allows
complaint handlers to provide more effective, tailored responses to the complainant as
they are able to respond with knowledge of the ‘whole picture’. In turn, complainants are
more likely to feel their concerns have been listened to and understood.

8.30 With this in mind, an important criterion for effective complaints management is
whether this background information is recorded and easily accessible.
8.31 As the chart shows, although there has been a slight decline, the GMC remains strong in this area.

8.32 In the vast majority of cases, records are complete and all details relating to the complaint are included and available for complaint handlers to view.

8.33 As we have described in the section above, we believe that most of the 7.1% of complaints where the record is incomplete have indeed been responded to, but the response has not been included on the record.

8.34 Given the relatively high standard of responses, this can be seen as an area for improvement. Missing documentation was a factor in 69.2% of the worst rated complaints in our sample. This further highlights the importance to our previous recommendation.

Is the complaint correctly classified (high profile/ repeat complainant)?

8.35 We believe that the classification system is comprehensive and effective. The level of completion of the classification fields remains very strong.
### Table: Field Completion Rates

<table>
<thead>
<tr>
<th>Field</th>
<th>2016 Completion</th>
<th>2017 Completion</th>
<th>2018 Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Profile</td>
<td>100%</td>
<td>100%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Repeat Complaint</td>
<td>99.96%</td>
<td>100%</td>
<td>100.0%</td>
</tr>
<tr>
<td>E&amp;D/ Equality Act</td>
<td>100%</td>
<td>100%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Team Handling</td>
<td>100%</td>
<td>99.9%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Stage</td>
<td>99.6%</td>
<td>98.9%</td>
<td>98.1%</td>
</tr>
<tr>
<td>Status</td>
<td>100%</td>
<td>100%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Category</td>
<td>100%</td>
<td>100%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Sub-Category</td>
<td>100%</td>
<td>100%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

8.36 All but one field reported a 100% completion rate. In the 2017 / 2018 period, 29 records (of the entire 12-month data set) did not have the ‘stage’ field completed, but we view this as a minor concern as this information can be deduced from examination of the file and has little material effect on the reporting of performance statistics.

**Categorisation**

8.37 In our previous reports, we expressed concern that the fields ‘category’ and ‘sub-category’ have many options available - in 2017 we found 85 possible responses in ‘category’ and in ‘sub-category’, 210. We were sceptical as to the practical value of many of the options open.

8.38 The data for 2017 / 2018, shows 74 categories used, and 194 ‘sub-categories’. Of the ‘categories’, 20 are used two or fewer times, and in the ‘sub-categories’, 60.

8.39 In previous years we have recommended further rationalisation of the category and sub-category fields as those which are little used serve little practical or statistical value.

8.40 On speaking with staff about the use of categories, we were told that categories are used to ease searching for complaints on highly specific and nuanced issues. Staff said they were frequently asked by other departments within the GMC for information on complaints covering these narrow issues.

8.41 In light of this, we will not make a further recommendation on this issue.
Correspondence classed as complaints

8.42 In previous years, we found several records that could not reasonably be classified as complaints. Rather, they appeared to be questions about a specific area or process, or simply 'statements of opinion'. We therefore recommended that the GMC should consider introducing a means within the classification hierarchy of differentiating complaints from more general questions or expressions of opinion from correspondents.

8.43 We have been made aware that a policy of categorisation of correspondence has recently been developed, but that it was still in early implementation stages. Staff were able to show us the new classification on the complaints database and were largely aware of its purpose.

8.44 That said, in this year’s audit sample data we have found significantly fewer examples where we believed that ‘complaint’ was not the correct classification.

8.45 We note that correspondence, enquiries for clarification of policies and statements of opinion can also serve as valuable sources of ‘soft’ intelligence for potential problems in the future. As such, we believe these should continue to be logged and used to generate business and service improvements.

8.46 We are confident that the GMC and the complaints teams are engaged and view complaints and all such correspondence in a positive, proactive way, focused on learning and improvements to services. We look forward to the further implementation of the complaints classification policy to encompass the balance between learning and efficient management of the complaints function.
Where necessary, was the complaint correctly escalated?

8.47 In 2017 audit sample, we found 50 instances where complaints had been correctly escalated. In one instance, we believe that it should have been, but was not.

8.48 In the 2018 sample, we found that all cases had been properly escalated when required.

8.49 In the 2018 sample, as in previous years the majority of complaints did not require escalation. We found 72 records which had been correctly escalated according to the GMC’s escalation policies.

8.50 We did, however, identify 8 instances where the complaint had been escalated, but the incorrect level (0) was seen on the database. Most of these are repeat complaints where the responses prove that the matter has been escalated, but the stage has been input incorrectly as 0. Again, this points to a need to ensure more accurate record keeping and data entry as we have recommended above.
The chart above shows the proportion of complaints at each stage in the full data set has remained relatively stable. There is a decrease in the numbers escalated to stages 2 and 3 which would indicate that complaints are now being resolved more efficiently at the first point of contact with complaints staff. Again, this is to be applauded.

**Does response show a clear understanding of the issue of the complaint? Does the response adequately address the specific concerns of the complainant?**

**2017 results**

In the 2017 report, we found that GMC responses in the audit sample were excellent in their clarity in addressing the specific responses of the complainant. In only one instance did we have cause to question whether the response answered the stated concerns of the complainant.
8.53 This year, the percentage of cases where the complainants concerned were understood and addressed remains excellent at over 96%.

8.54 As we have stated in section 7 above, the complaints we reviewed were more varied and were overall more complex than received in previous years. While this is a testament to improved service elsewhere in the organisation, this presents the complaints handlers at the GMC with increased challenges in delivering high quality responses.

8.55 As such, we would usually expect to see a decline in quality of responses. While there has been a very small decline against this metric this year vs. last, we believe this is to be expected given the more difficult challenges faced. We therefore feel that the GMC’s performance has proven remarkably resilient.

8.56 Of the 8 cases where the complaint was not fully addressed or understood, this occurred where the complainant raised multiple issues within the complaint, but not all were responded to.

8.57 Further, we note, that responses were less likely to demonstrate understanding of the complaint when the topic was one of the more common types of complain received, but also introduced some specific concerns. While we support using ‘template’ style responses for common queries (indeed, this was one of our recommendations last year), staff should be mindful to ensure that their responses are tailored to the complainant’s
individual situation and guard against using the ‘template’ response where more than one query is found in a single complaint.

**Recommendation**

**R6** The GMC should ensure that staff recognise all aspects of a complaint and do not use a ‘template response’ in isolation if this does not address all issues.

**Complaint outcomes**

8.58 Again, this year, we observed a range of complaints from the very simple to the highly complex. The vast majority were answered with an appropriate level of detail, and with specific reference to the complaint made. We only found one record where the response was questionable in tone and proportionate to the issues at hand.

8.59 In the audit sample we found that 92.5% complaints we reviewed did not lead to a further complaint being generated. There is a significant improvement in this metric from last year as can be seen above. This is a testament to the strength of responses sent by complaint handlers and demonstrates the high level of satisfaction among complainants that their concerns have been adequately addressed.
8.60 There is a clear ‘GMC style’ employed across all of the directorates, which indicates that training is consistent and effective across the entire complaints function, whatever team an individual may be in.

8.61 Again, we support the organisational structure, whereby complaint handlers are embedded within their directorates. The expertise that this places at the disposal of complaints handlers in answering the more complex issues is very clear.

8.62 This year staff told us that, within each team, efforts have been made to ensure that all team members build and retain knowledge on all subject matters within the directorate. We believe this is a useful measure which will support the resilience of complaints teams.

Where appropriate, is the approach/methodology used to address the issue clearly set out?

8.63 Our experience in complaint handling tells us that complainants like to know the process by which decisions are taken. We find that this is particularly important when a decision is not what the complainant would have wanted, as at least they can appreciate that their issue was given fair consideration and that a strong process was followed.

8.64 In our audit sample this year, in all but one instance where explanation behind a finding was required it was given and explained effectively. This represents a continuation of the excellent performance against this (traditionally difficult to achieve) metric.
As can be seen in the chart above, we found that in 9.4% of cases there was no methodology or explanation required. This is a small drop from last year and is likely to be the result of the increase in more complex complaints that the GMC has received this year.

In these cases, no explanation or justification was offered, which again we support. There is little utility in over-complicating a simple issue. GMC staff understand this, and routinely address issues with appropriate depth.

We observed that responses were routinely well structured and easy to follow. Again, this is excellent.

Where appropriate, are appropriate regulations, legislation, benchmarks referenced?

In previous audit report, we noted this metric as a particular area of strength for the GMC complaints team. We simply restate our finding on this metric from last year, as it remains as valid now as it was then.

Given the complexity of many of the issues addressed by complaints handlers in the GMC, we found that their grasp of the regulatory and legislative environment under which the GMC operates is excellent. This will undoubtedly be the result of many positive aspects of operations – the low staff turnover, the easy availability of subject matter
experts as a result of co-location within directorate teams, the ‘specialisation’ of individuals within teams in specific areas, good training and leadership. We commend the teams on their ability to convey a mastery of ‘the rules’ and how these relate to the specific issues of most complainants. We did see instances where responses were long and “technical” but found that these were in response to similarly detailed complaints, so we believe that they were appropriate to satisfy the needs of the complainant.

8.70 In 2018, we found that GMC staff still have an excellent grasp of the appropriate legislation and, where necessary, explain this within complaint responses very effectively.

8.71 As is shown on the chart below, we found that 71.8% of complaints in the audit sample required the application of benchmarks or legislation. In all but one instance where it was necessary, we found that complaints staff referenced these well, explaining their particular application to the complaint.

![Regulations referenced chart](chart.png)

**Where appropriate, is there evidence of a comprehensive investigation of concerns?**

8.72 As is shown below, in the sample interrogated this year, fewer complaints required a fuller investigation of concerns. There were two records where we believe further investigation should have taken place but did not. This represents a completion rate of 95% against this metric.
8.73 In those instances, where investigation is required, it is important to explain to complainants the actions that were taken to investigate their concerns, and to give them a full explanation as to what was found and the reasons behind it.

8.74 As with last year, we found that GMC responses were very clear on the steps that were taken in reaching their conclusions.

Is the response written in plain English, with good spelling and grammar?

2017 results

8.75 In 2017, we found that, where there was a written response, there was not a single instance where we believed that the text was not clear, concise and effective.

8.76 In those instances, where we are unable to comment, this is because the final response is not attached to the file or, more often, because the complaint has been resolved over the telephone or, in one instance, Twitter.

2018 results
8.77 In this year’s audit sample, we find that the quality of written English remains exemplary.

8.78 We found one complaint with some grammatical errors in the response. This still represents an extraordinarily strong performance.

8.79 Complaint responses are invariably friendly and professional in tone of voice and limit the use of jargon where possible.

**Did the complaints team respond within the agreed timeframe?**

8.80 In accordance with the stipulations of ISO 10002 certification, the complaints team aim to respond to complaints within 10-days in line with its service level agreements (SLA).

*Handling speed*

8.81 The average ‘age’ of complaints has decreased this year. For the full year data set in 2018, complaints took on average 10 days from receipt to close. This means that on average, the GMC is now meeting its SLA for responding to complaints. This is a marked improvement from last year in which the average age of complaints was 14 days.
8.82 Below, we have segmented the for 2016/17 and 2017/18 records into deciles by time in the system.

8.83 The average age of all complaints has significantly reduced this year compared to last. Notably, the time to complete the slowest 10% of complaints has been reduced by 10 days.

8.84 It is clear that the most complex cases should take longer to resolve. In order to identify potential further improvement, we looked at the stage of the complaints process reached by the tenth decile of this year’s sample compared with 2017.
8.85 The data for this year remains largely consistent to last. A significant majority of the ‘slowest’ cases did not progress beyond the first stage of the escalation process. On average in 2018, these stage 0 cases had been in the system for 25 days. The comparative figure for 2017 was 34 days.

8.86 We made the recommendation in the 2016 report that the GMC might consider a certain number of elapsed days as a trigger for possible escalation. We understand that an exception reporting process has been implemented, whereby complaints open for 35 days are flagged for potential escalation, and those reaching 42 days are automatically escalated.

8.87 For the past two years we can see that this has been effective in reducing the average elapsed time for the slowest 10% of stage 0 cases. The average figures in both years fell below the 35-day limit. With this proven improvement in mind, and given the generally lower number of complaints escalated, the GMC may like to consider setting earlier ‘trigger points’ for potential escalation.

*Working to deadlines*

8.88 In last year’s analysis of the audit sample, we observed that there appeared to be a high preponderance of cases being closed on, or near to the response deadline day.
2017 50% of cases were closed within 2 days of the SLA deadline, with 28.5% occurring on deadline day itself.

8.89 We found a pattern whereby deadline day answers closely mirrored the total number of complaints received. From this, we concluded that team members were simply modulating their effort by the volume of work on their desks. We recommended that staff be encouraged to close complaints at the earliest opportunity.

8.90 We are pleased to see that this issue has been largely resolved in this year’s dataset. As can be seen below, the number of complaints resolved as deadline day approaches have been significantly reduced.

8.91 Instead, complaints are now more routinely settled on average 3 days before the SLA deadline. Comparatively, in 2017 on average, complaints were closed on deadline day. This is an outstanding improvement and shows that complaints handlers have adopted a more proactive approach to responding to complaint.

8.92 We know from our work with other clients that a delay in receiving answers to complaints is the single largest source of dissatisfaction among complainants. In our analysis of the GMC sample, we saw very few such instances, and this is borne out in the full database analysis.
Delays in receipt to complaints team

8.93 During our discussions with staff, we heard that there was an increasing issue with the time taken for communications to reach the complaints department when initially received elsewhere in the organisation. We did not receive this information in the 2015-16 data sample but have analysed the full data sets for 2016-17 and 2017-18.

8.94 In the 2018 full data set, there was in increase in citing delay in receiving complaints as the reason for SLA breaches. After workload issues, it was reported as the second highest reason for SLA breaches.

8.95 At the aggregate level, we can see no evidence that it is taking longer for complaints to reach the department.
Although there is some variation month by month, the general picture appears to be one of slight improvement year on year:

In order to determine if the averages are, in reality, masking an increase in the number or severity of ‘problem’ cases, i.e. where there is a significant delay in receipt, we looked at the percentage of cases that take three or more days to reach the department. Again, the numbers are little changed year on year:
Finally, we plotted the elapsed time for all cases to reach the department. As can be seen, the curves are extremely similar (with a correlation coefficient of close to 100%):

In summary, then, we can find no evidence in the data that the situation has worsened between our two available data sets – indeed, if anything the trend appears to
be toward a reduction in elapsed time. It is interesting, however, that the staff perception appears to be the opposite of this.

**Recommendation**

R7 We would suggest that our findings relating to handover of complaints from other parts of the GMC are shared with the complaints teams in order to avoid an unhelpful feeling that other departments are ‘holding up’ the complaint process.

**Are next steps (if any) outlined?**

8.100 In the 2018 audit sample, we found that over two thirds of complaints required a next step or further action to be taken by the GMC or the complainant. Of these we found that in the vast majority of cases the next steps to be taken were explained to the complainant.

![Next steps outlined chart]

8.101 Complaint responses routinely signpost complainants to alternative means of resolving their queries and invite complainants to respond if they would like any further clarification.
8.102 We believe that outlining next steps is an important facet of complaint handling as this gives the complainant an avenue for future remedy. It therefore a good example of offering complete customer service. It is encouraging that the GMC performs so strongly in this area.
9. Complaint handler interviews

2018 Interviews – Synopsis

9.1 In addition to our review of cases from the database, we carried out interviews with three members of staff who work in complaints handling teams with the aim of getting their views about the processes that are followed any possible areas of improvement. The interviews took place in GMC’s Manchester office on 18 September 2018.

Overview

9.2 As we have noted in both previous reports, we found complaints staff at the GMC to be extremely enthusiastic and committed to their roles. This is rare within complaints departments. Staff genuinely identified with the ethos of viewing complaints and comments as feedback for improvements in the GMC’s service to ‘customers’. One member of the team told us they saw complaints and a “invaluable” source of information for the GMC. We believe this approach is evident in the responses we have reviewed in our audit sample.

9.3 We have noted in past years that complaints teams in different directorates operate to slightly different processes and norms. This is, of course, to be expected due to the differing nature of the types of complaint each deals with. In an area such as fitness to practice, for example, the concerns that complainants raise are often not resolvable through the complaints process (as opposed to a re-opening of the decision that has been made). By contrast, complaints received by the registration and revalidation directorate are more likely to be solvable, and a definitive ‘answer’ provided. We had previously recommended, however, that team members in different directorates spent more time with counterparts in other directorates in order to reduce the likelihood of these different working practices becoming a source of tension between directorates.

9.4 Staff have been co-located in the Manchester offices for some time now. We were told that complaints staff from all directorates meet 8-10 times per year to share learning and issues within their directorate. We believe that staff feel they have a reasonable understanding on how other teams function and are comfortable and knowledgeable about
the operation of their own team. From reviewing the complaints sample, we do not see any discrepancy in the quality of responses to complaints between the teams. As such, we are confident that all teams produce similar ‘GMC style’ responses.

9.5 Our view is that if teams work well on their own and within the whole, then these differences in operation are manageable if, as stated above, it does not lead to friction between directorates. We are glad to report that this issue, raised two years ago in our discussions with staff, was not mentioned this year.

9.6 Staff that we spoke to felt that overall improvements had been made to GMC processes that allowed for a more efficient, streamlined service to be delivered to customers. Staff have noted examples where improvements made to services or published information have resulted in a reduction of complaints generated on the topic.

Shared learning

9.7 While some members of the complaints team undertook job shadowing and secondments this year, we were told that this was fewer than in previous years. Those who undertook a secondment to another directorate found that this improved their perspective on their current role as they were able to contextualise the complaints they received into the wider realm of other GMC activity. Staff in the R&R directorate told us that a period of shadowing other teams is included as part of the induction for new staff in the complaints team. We continue to support this approach.

9.8 Staff felt that if they made mistakes in handling a complaint, particularly those noted as service issues on the database, these are addressed appropriately with the relevant staff member or team. Staff did not feel blamed and viewed the experience as a collaborative learning opportunity.

Raising concerns

9.9 Staff told us that they felt well supported by senior managers in carrying out their roles. Staff commented that senior managers were on hand for advice, or assistance in managing potentially difficult complaints.
9.10 We were told that staff felt their concerns were listened to and that there was an positive interest in complaints activity at the highest levels within the organisation. Staff were aware that senior managers and directors had “championed” specific issues for improvement and welcomed this.

9.11 As we stated in section 7 above, the availability of PLAB test slots and issues with the on-boarding of the newly accepted OET tests were highlighted within R&R. Staff were very positive about the fact that both issues were swiftly resolved, with practical solutions implemented promptly.

Workload balance

9.12 In our 2017 report we undertook analysis of the workload spread of individual members of the complaints team. We recommended that the GMC should be careful that individuals were not swamped with difficult issues – ‘workload issues’ was cited a common reason for breaching SLA in some of the more difficult cases over the course of the 12-month period.

9.13 In 2018, we have found that complaints are handled in a much timelier manner, resulting in fewer complaints breaching SLA this year compared to last. While ‘workload issues’ is still cited as the highest cause for breaching SLA, this percentage of this has also decreased. Moreover, we find that there is less concentration in the members of staff reporting SLA breaches.

9.14 In our discussions with staff, we were assured that staff felt there was better recognition among senior management of the workloads of the complaints team, both as a whole and for individual members of staff. Staff said that their personal workloads were more balanced.

9.15 Staff also told us that they had made efforts within their teams to ensure that all individuals were assigned a greater variety of complaints topics. This was with the aim of enhancing the knowledge of team members, but also built resilience of the team in the event of sickness or absence.
9.16 There is clearly a balance to be struck between the efficiency of having a high performing ‘expert’ responding to queries, but also spreading knowledge throughout the team. We fully support this more balanced approach, particularly in teams where there is a concentration of knowledge in fewer members of staff. Expertise can be shared, and thereby retained within the organisation if any individual were to leave.

Recommendation

R8 The sharing of subject knowledge within teams should continue, and be encouraged in all directorates in order to build resilience for the organisation as a whole.

Challenges

9.17 As in previous years, the GMC have been involved in some high-profile cases which have received significant public scrutiny. Staff in the fitness to practice directorate told us that in the last year, the prominence of the Bawa-Garba case had created extra work for the team, as they received more open challenges to their decision making and saw complainants linking their personal experience to the case.

9.18 This can often be a challenging task for complaints handlers as they are prompted to comment on both the customer’s specific complaint, and at times an unrelated issue. We were told, however, that the GMC had very effectively communicated their agreed position, which was well understood and supported by complaint responders. This is excellent practice and should be continued.
Executive summary
We published the external action plan for Taking Revalidation Forward (TRF) on 20 July 2017. Since then, we have worked with partners from across the UK healthcare system to deliver the recommendations from the Pearson report.

Following the completion of the TRF programme in September, we plan to publish a report summarising the work delivered and the potential benefits for key groups including Responsible Officers, doctors and patients. This will be accompanied by some low key promotional activities.

Recommendation
Council is asked to note the end of programme report at Annex A of the paper.
Taking revalidation forward work programme

1 Following the publication in January 2017 of Sir Keith Pearson’s review of revalidation, *Taking Revalidation Forward*, and his recommendations to improve some aspects of revalidation, we published our action plan for the Taking Revalidation Forward Programme on 20 July 2017.

2 The programme of work to deliver the action plan is now complete and we plan to publish a report summarising this work. The report has been shared with members of the Revalidation Oversight Group and includes content from a number of them about their work.

Why are we publishing a report?

3 The launch of the action plan was well covered in the trade press, including the BMJ, Pulse and GP online. The accompanying blog was viewed over 10,000 times which is the most read blog related to revalidation, and in the top 10 of all GMC blogs published.

4 The end of programme report will outline what we and our partners have delivered against the commitments we made and the action we have taken to address the concerns and challenges doctors and others reported to Sir Keith Pearson during his review.

Summary of the content in the report

5 The report is split into three distinct areas:

   a Improvements for doctors – the wide range of improvements and new material to better support them with their revalidation and professional development.

   b Improvements for patients – new products to help patients understand revalidation and encourage lay involvement in revalidation and local processes.

   c Improvements for responsible officers, suitable persons and healthcare providers – a revised clinical governance handbook, new information sharing principles and improved guidance to better support those responsible for managing revalidation systems and processes.

6 The report will contain a foreword from Charlie Massey, who was chair of the Revalidation Oversight Group. The final chapter of the report sets out the future of revalidation, and the further initiatives that will be delivered in 2019.
Promoting the report

7 We plan to publish the report on our website before the end of November and will be sharing it with key stakeholders, including members of the Revalidation Oversight Group and other partners. Given the programme has been supported by a range of organisations, we will encourage them to also promote it through their own channels and networks.

8 To support publication we plan to develop a blog which will highlight the key improvements that have been made specifically for doctors through the programme. Discussions are underway, but we hope this blog will be written by a revalidation lead in Wales, offering an external voice and perspective. Through our other publications, for example our responsible officer bulletin, we will highlight the key changes for responsible officers and healthcare providers.

9 In promoting the report, our messaging will acknowledge ongoing workload pressures and how we hope the changes made will make engaging in revalidation and appraisal more positive, valuable and less burdensome. It will give us an opportunity to reiterate our commitment to giving doctors the support they need to do their job well.

10 The report will be a useful tool for our external facing teams who will highlight key improvements through meetings and events. We will also identify other appropriate opportunities to promote the report through future revalidation updates or announcements.