General Medical Council

IMPACT REPORT 2016

Working with doctors Working for patients

How do we help to improve healthcare?

We work with 270,000 registered doctors on behalf of patients and the public across the UK. Our job is to help protect the public by setting standards for medical education and practice and making sure these standards are followed.

We are shifting the balance of our work to focus more on the ways we can help and support doctors to provide better care and treatment for patients. We will, of course, still have to take action against a small number of doctors who put the safety of patients or the public's confidence in the profession at risk. But we believe many of the less serious cases can and should be handled at a local level.

Ten ways we make a difference…

01 Providing useful, accessible information about every registered doctor in the UK

02 Addressing problems before patients are harmed

03 Making sure doctors have the right skills to work in the UK

04 Developing guidance for doctors that promotes patient safety

05 Making sure every doctor can show they are competent and fit to treat patients

06 Tackling problems that can arise in the way doctors are trained

07 Giving doctors relevant, accessible support to put standards into practice

08 Helping future doctors to meet patients' needs

09 Using our data to drive improvements in education, training and care

10 Taking action to prevent doctors from putting patient safety at risk

01 Providing useful, accessible information about every registered doctor in the UK

The medical register is the only place where anyone can check whether a doctor is qualified and has a licence to practise in the UK.
It is a key tool for protecting the safety of patients.

270,000

doctors are on the GMC's medical register.

7 million

searches of the medical register in 2015.

73 doctors were banned from practice in the UK in 2015 and were removed from the register for the most serious offences – such as those convicted of violent crimes, incompetence and failing to treat patients safely.

459 new restrictions placed on doctors' registrations in 2015.

800 NHS organisations receive automated updates of the medical register every day via the NHS Electronic Staff Record programme, including NHS trusts, private employers and locum agencies.

The medical register helps to give NHS organisations essential information about the doctors they employ, freeing up time and resources for NHS organisations to focus on providing frontline care for patients.

Paul Spooner is Programme Director for the NHS Electronic Staff Record (ESR) programme – the workforce management solution used by almost every NHS organisation in England and Wales.

"ESR is updated overnight with changes to the register, and [employers] will receive an alert at the start of the working day that they can act on straight away. That contributes to safe staffing, and helps to improve clinical governance…

It also helps trusts to be more efficient, as the medical staffing officers can spend less time on manual administrative processes, and more time on other tasks that add value."

02 Addressing problems before patients are harmed

Increasingly, we work with doctors and employers to understand where there are risks in medical practice, to reduce harm to patients and to make sure they are better protected.

650

Responsible Officers took part in more than **1,300** meetings with our Employer Liaison Service in 2015. Responsible Officers are senior doctors with local responsibility for the conduct and performance of licensed doctors.

96%

of Responsible Officers said that meeting their Employer Liaison Adviser was helpful in managing concerns about their doctors.[1]

Comments from employers on our Employer Liaison Service:

> "Our local ELAs [Employer Liaison Advisers] have been a tremendous help in dealing with a whole range of difficult problems – they are indispensable."

> "The ELA team has been one of the most positive innovations by the GMC to make the GMC as relevant as possible to medical care and clinical practice, resulting in safer care for patients."

> "The ELA relationship has been pivotal in managing some complex cases in a way that protects patients but also supports doctors."

We give data to the Care Quality Commission (CQC) in England ahead of every major inspection. In 2015, we provided data on **149** hospitals and NHS trusts and **2,127** GP practices. This includes vital evidence about how doctors in training judge their departments, as well as other key information about education, training and practice on the front line.

Case study: **A tailored support programme at a trust in special measures**

Working with Ian Grant, Responsible Officer at Barking, Havering and Redbridge University Hospitals NHS Trust, our Regional Liaison Service designed a programme for doctors who were new to practice in the UK. It focuses on the ethical issues most likely to present challenges, and provides a safe space to explore questions and concerns.

Dr Grant said: 'This was a fantastic programme… The practical exercises were particularly useful. As an education it was very strategic.'

94% of participants in this programme said they would change their practice as a result of taking part in it. Our Regional Liaison Service has agreed to deliver programmes with **ten** trusts in 2016.*

* Figure correct at 1 June 2016.

03 Making sure doctors have the right skills to work in the UK

Controlling who is qualified to work as a doctor in the UK is fundamental to protecting the public.

We campaigned for five years to be allowed to check that European doctors have the appropriate English language skills to practise in the UK. In 2014, the law was finally changed – giving us the right to make sure doctors from Europe can speak English well enough to be able to practise safely. We also got the right to act where there was evidence that a registered doctor's language skills could pose a risk to patients.

1,000

doctors from Europe have not been granted a licence to practise since the law changed, because they did not give sufficient evidence of their English language skills.

69

fitness to practise investigations have been opened into language concerns since legislation changed in 2014.

46

doctors have been suspended or ordered to work under supervision where language difficulties contributed to patient safety concerns.

Case study: **Doctor's right to work is suspended due to poor English language skills**

Following referral by an NHS trust, we asked Dr T to take a language assessment. This confirmed his English was below the standard we required for registration. As a result, he was suspended for nine months and will need to pass language tests before we agree to lift his suspension.

04 Developing guidance for doctors that promotes patient safety

As well as our core guidance *Good medical practice*, we produce a wide range of detailed guidance, covering everything from confidentiality and consent to end of life care. Our guidance sets out what doctors should deliver and what patients can expect.

270,000 doctors and **692,000** nurses and midwives are now working to a common standard to be open and honest when things go wrong. In 2015, we produced joint guidance with the Nursing and Midwifery Council, which sets out a professional duty of candour. It makes clearer what doctors and nurses can expect of themselves and each other, and places the focus where it should be – on patient safety.

30,000 hits on Twitter, Facebook and LinkedIn for our cosmetic practice patient leaflet, which we published alongside new guidance for doctors involved in cosmetic practice.

Case study: **Making guidance visible and useful**

More than **50,000** surgical cosmetic procedures were performed in 2015.[2] Patients need honest, straightforward advice about the risks and benefits of such interventions.

Our cosmetic practice guidance – published in April 2016 – was developed with other partners, including the Royal College of Surgeons. It sets out new requirements for doctors around consent, marketing, and consideration of patients' psychological needs.

Catherine Kydd, a patient who has campaigned for better regulation of the cosmetic industry, said: 'The GMC's new guidance will significantly strengthen the protection patients have, and make it easier for them to seek action if things do go wrong. It's a big step forward for patients.'

Case study: **Responding to current issues**

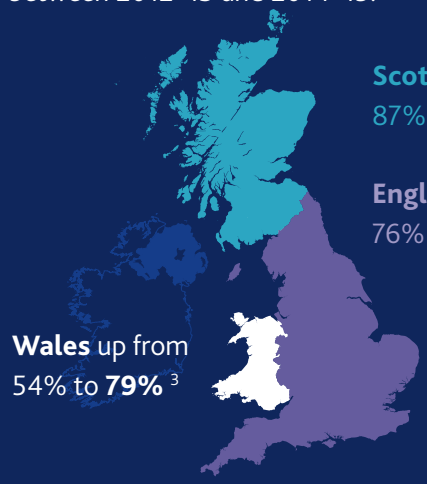
A number of investigations into tragic road accidents, including the Glasgow bin lorry crash in December 2014, have highlighted issues about patients not reporting concerns about their health to the DVLA (or DVA in Northern Ireland). They have also raised questions about whether doctors are doing enough to advise patients when they should not be driving and of their responsibilities to report.

As part of our consultation on revised guidance on confidentiality, we consulted on guidance on reporting concerns about fitness to drive, which received extensive media coverage and helped alert doctors and the public to this key safety issue. We also published a blog from the DVLA's medical advisor and held a meeting with key partners to explore and agree what more needs to be done collectively to make sure patients understand their responsibilities and that doctors are clear when they should report concerns directly.

05 Making sure every doctor can show they are competent and fit to treat patients

In 2012, we introduced a system of checks, known as revalidation, that require doctors to show they are competent and up to date. It has had a major impact on healthcare systems throughout the UK – most obviously increasing significantly the number of doctors who are subject to an annual appraisal.

Increase in doctors having an annual check between 2012–13 and 2014–15:



Scotland up from 87% to **93%** [4]

England up from 76% to **86%** [5]

Wales up from 54% to **79%** [3]

Appraisal rates have also increased in **Northern Ireland**, with some health and social care organisations now achieving **100%**.*

Four in ten

doctors say they have changed their clinical practice, professional behaviour or learning activities following appraisal.[6]

59%

of employers said doctors were more aware of how to apply the principles in our core guidance for doctors, *Good medical practice*, compared to the previous year.[10]

40%

of employers in England said the checking process of revalidation helped them identify concerns about doctors at an earlier stage.[7]

3 million

estimated contributions from patients giving feedback to doctors' appraisals. **Six in ten** doctors say that comments from patients have led them to reflect on and help them improve their practice.[8]

These are early days for the new system and there will be ways in which it can be improved – as well as being subject to independent research, we have commissioned a review of its impact over its first few years of operation.[9]

Fahed Youssef is the Responsible Officer for locum agencies ID Medical and Athona, looking after a large number of locum doctors.

"In my opinion, revalidation is more relevant to locum doctors than any other group, and I think they benefit more than anybody else…
Now in my own hospital, I see locum doctors asking for feedback, attending continuing professional development sessions, and using any learning opportunities they can."

* Further information on appraisal rates is expected to be included in the Regulation and Quality Improvement Authority's review of governance arrangements in health and social care organisations that support professional regulation, which is due to be published later this year.

06 Tackling problems that can arise in the way doctors are trained

Where a hospital department or GP practice has failed to meet our standards, we will place it under an enhanced monitoring process and require it to act to deal with patient safety and education concerns.

We work constantly with employers and local education agencies to improve the quality of training. Enhanced monitoring helps us to achieve this, though of course the important aspect is the action that follows.

74 sites are currently subject to enhanced monitoring.*

19 organisations have improved their education and training of doctors to the point where they were successfully moved out of enhanced monitoring, since we introduced the system.†

Case study: **Joint working helps to identify and quickly address patient safety concerns at a Scottish hospital**

NHS Education for Scotland identified concerns about safety of training in the emergency medicine department of a large teaching hospital. After consulting with us, the department was placed in enhanced monitoring in August 2014. The GMC and NHS Education for Scotland visited the department to explore the concerns.

We agreed an action plan and by May 2015 it was clear that significant progress was being made – this was confirmed by our annual survey of doctors in training. In June 2016, the GMC and NHS Education for Scotland agreed to take the department out of enhanced monitoring as the concerns had been addressed.

Using transparency to drive improvement

We now publish detailed information about how well training is delivered around the UK, including hospitals where we have ongoing concerns. Publishing this information helps create a culture in which information sharing and openness is the norm. Those who oversee and provide medical education at local level are publicly accountable for making sure doctors receive high-quality training – making information freely available underlines this accountability and means they can learn from each other.

* Figure correct on 19 July 2016

† Between launch of enhanced monitoring in early 2014 and May 2016.

07

Giving doctors relevant, accessible support to put standards into practice

We may be known for taking action against doctors, but most of our work is around education, training and support. As part of this, we organise events and produce learning materials to help doctors improve their practice.

96% of doctors who took part in our standards events found them helpful.

76% indicated that they would change their practice as a result.

400

doctors made enquiries about ethical matters in 2015, usually linked to a specific issue they were facing in clinical practice. Our professional standards team gave one-to-one responses and advice to each of them.

16,000

views, in August 2015, of our website advice on prescribing for friends and families. Our website gives regular advice on current issues that affect doctors.

10,000

doctors downloaded our new continuing professional development app in its first six months, registering **24,000** learning activities.

2,292

doctors attended events with our liaison teams in England in 2015.

1,928

doctors attended events with our liaison teams in Scotland, Wales and Northern Ireland in 2015.

Case study: **Standards team support a doctor with advice about data sharing and safeguarding**

A doctor contacted our Standards team for advice on good safeguarding practices and sharing information in multi-agency teams dealing with victims of child exploitation.

We answered the specific questions and examples raised in the enquiry, and explained our advice to doctors who receive requests for information from other agencies. We highlighted relevant paragraphs in our guidance, *Protecting children and young people: the responsibilities of all doctors*, and reminded the doctor that their first duty is to make the care of their patient their first concern.

The doctor thanked us for all the information we had sent, describing the service as 'helpful' and raising 'interesting points of principle'.

08 Helping future doctors to meet patients' needs

We've introduced a single set of standards that put patient safety, quality of care, and fairness at the heart of medical education.

In the past, postgraduate and undergraduate standards were separate. But our new, tougher standards, called *Promoting excellence*, apply through all stages of education. We've designed these standards to make sure doctors in training and medical students have assurance about the support they receive. And so they can be confident that they'll get the environment they need in which to learn and develop their medical practice.

To meet our standards, organisations need to demonstrate they have a culture where concerns about safety and standards can be raised without fear of adverse consequences. The standards also highlight the importance of leadership, making sure that those providing medical education are accountable for the quality of training.

Case study: **Rapid, concerted action helps to address patient safety concerns**

We placed the emergency department of a busy north London hospital under our enhanced monitoring process after it failed to meet our new standards for education. Doctors in training at the trust weren't getting the support they needed, which put patient safety at risk.

Working with Health Education England, we took steps to address the risks to patient safety and the lack of support for doctors in training. Among a range of measures taken as a result of this intervention, new clinical appointments were sped up, additional staff were brought in to treat patients and give support to doctors in training, and solutions to serious systems concerns started to be put in place.

Amy Butlin, is a fourth-year medical student at Cardiff University.

"The GMC's standards for education and training are your assurance that the medical school is keeping up their end of the bargain – that when you graduate you will have been given every opportunity to be a good doctor."

Robina Shah is the academic lead for patient experience and patient and public involvement at Manchester Medical School. She gave us advice on the development of our new standards for medical education and training.

"The new standards help to promote understanding of the wider aspects of working in multiprofessional teams and key elements of doctors' behaviour, such as patient safety. They also require medical schools and training providers to support an open and honest approach to patients – not just when things have gone wrong, but by involving patients in decisions about their care, being more compassionate and patient centred."

09 Using our data to drive improvements in education, training and care

To improve patient care, we're using data to inform our work and sharing data to inform others.

This work is helping us to identify trends and highlight areas of risk as well as areas of good practice. We are building links with other organisations, such as NHS trusts and systems regulators, to share data to help inform their work as well as our own.

What we do	Why
Run the **largest survey of doctors in training and their trainers in the world** (the national training survey) with 53,000 doctors and 23,500 trainers taking part 	To enable doctors in training to give feedback on the quality of their training and the safety of the systems they work in. The survey gives information about **the quality of training programmes** in every UK hospital department and GP practice – we can use this information to identify where improvements can be made
Share data with **Health Improvement Scotland and the Care Quality Commission in England** and other regulators and quality assurance bodies across the UK	Our data is used by system regulators **to inform inspections and oversight** and help to drive improvement. Individual organisations also use our data **to understand how well they are doing** and to compare their performance with others
Work in partnership with the **Medical Schools Council and others involved in medical education** to pilot a UK-wide medical education database (UKMED)	To **understand better how doctors progress through their education** and any barriers they may face
Publish an **annual report** on the state of medical education and practice in the UK	To provide an evidence-based overview of medical practice and education and to highlight **the opportunities and challenges facing doctors** and the systems in which they work
Publish data on locations or specialties where there is a **concern about patient safety** through our enhanced monitoring programme	To enable those responsible to **act on concerns**
Publish annual data and new research about the extent of **differences in attainment in medical education and training** and their underlying causes	To help medical educators and employers develop practical actions that could help to **narrow the gaps in progression and performance** experienced by some medical students and doctors in training
Publish the list of **registered and licensed doctors**, including who is responsible for their revalidation and fitness to practise decisions that affect their registration	To give a comprehensive, up-to-date, reliable and accessible source of who is registered and licensed to practise medicine in the UK, which lets **patients, employers and healthcare professionals check the medical background of any doctor**

10 Taking action to prevent doctors from putting patient safety at risk

Where there is a risk to patients or the doctor is putting trust and confidence in the profession at risk, we will act. We handle more than 9,000 complaints about doctors every year, although most of them are not serious enough for us to take action and reflect failures in local complaints systems. The most serious cases go before an independent tribunal of the Medical Practitioners Tribunal Service (MPTS).

73 doctors were banned from practice in the UK* – these were the most serious cases, such as doctors pursuing sexual relationships with patients, convictions for serious sexual offences and doctors who persistently refuse to address concerns about their ability to treat patients safely.

125 doctors who had restrictions on their licence were able to return to unrestricted practice in 2015. When we restrict a doctor's licence, we aim to give them time to return to unrestricted safe practice.*

212 doctors were given conditions or undertakings that restricted their practice.

522 new interim orders were imposed, restricting doctors' registrations to protect patients while we pursue our investigations.*

97 doctors were suspended, usually for periods of up to one year – these doctors include those who may have put patients at risk but have shown insight into their mistakes and modified their practise.

Case study: **Interim suspension used to protect patients from a GP who lacked insight into poor clinical knowledge and performance**

Following a performance assessment, Dr W, a GP, was found to be a risk to patients, due to potentially dangerous prescribing errors, a lack of skills in basic life support and inadequate mental health assessments. An interim orders tribunal of the MPTS suspended Dr W during the investigation and he was subsequently struck off the medical register.

Case study: **Meeting helps to explain decisions and reassure a complainant**

Mrs F complained to us when a doctor gave her daughter placebo treatment without consent and formed an inappropriate and dangerous action plan. The case concluded with advice to the doctor, and Mrs F attended a face-to-face meeting with us. Mrs F said: 'Being able to meet with the GMC stopped the process being so remote. I felt that the investigation had been done properly, and both my daughter and I are happy that the outcome is reasonable and proportionate. Knowing that this has been thoroughly looked into and hopefully lessons have been learnt makes a big difference.'

*1 July 2015–30 June 2016.

Reducing the number of cases going to a tribunal hearing unnecessarily

We have started meeting with doctors who are under investigation to see if we can reach agreement on the right way to protect patients without the need for a tribunal hearing.

So far, we have held **136** meetings with doctors about complaints where a hearing would otherwise have been the likely outcome.*

63% of these cases were resolved without a hearing – reducing stress for doctors, complainants, and witnesses.

Surendra Deo is one of our medical case examiners who make decisions at the end of an investigation

> "We're not out to punish doctors, and these meetings help us make sure our investigation is thorough and we are getting a fair outcome."

Reducing the number of tribunal hearings

When a doctor has their practice restricted or suspended, they must attend a review hearing before they can return to practice. Since January 2016, MPTS tribunals have been able to make decisions in these review hearings based on papers submitted by each side, where both parties agree.

123 cases have been decided this way already, removing the stress, cost and inconvenience of attending a full hearing at the MPTS hearing centre in Manchester.†

* September 2012–March 2016.

† Figure correct at 7 July 2016.

Giving value for money

Our work is funded by doctors and we are accountable to Parliament – we receive no money from the state. That is important in making sure our decisions are independent.

Despite taking on major new responsibilities – such as postgraduate education and revalidation – for the most part in recent years, the fee doctors pay us has been frozen or cut. It now stands just 1.1% above its level in 2010.

This year, we embarked on a major change programme to cut costs, which includes moving more than 100 posts from London to Manchester. This is projected to save £6 million a year from 2018.

Most of our resources are currently focused on managing fitness to practise cases – that will remain a key part of our work. But our ambition is to concentrate more of our effort on education, training and support, where we can help to improve practice and prevent harm, rather than just dealing with it once it has occurred.

References

[1] University of Manchester, University of Plymouth and University of York, April 2016, *Implementing medical revalidation: organisational changes and impacts*, available at www.gmc-uk.org/Implementing_revalidation___organisational_changes_and_impacts__FINAL.pdf_66033907.pdf.

[2] British Association of Aesthetic and Plastic Surgeons (Baaps) data as reported by BBC News www.bbc.co.uk/news/health-35501487.

[3] Information provided by Wales Deanery.

[4] Healthcare Improvement Scotland, October 2015, *Medical Revalidation in Scotland: 2014–15*, available at www.healthcareimprovementscotland.org/our_work/governance_and_assurance/medical_revalidation/overviewlocal_reports_2014-15.aspx.

[5] 2010–11 appraisal rates in www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/earl-ben-impact-mr-report.pdf; 2014–15 appraisal rates in www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2015/10/sro-report-med-revalidation-1415.pdf.

[6] UMbRELLA report p8 42.4% made changes to clinical practice, professional behaviour or learning activities as a result of their most recent appraisal. Most common reasons for not making changes were nothing being identified that required change, and doctors automatically reflecting and making changes.

[7] NHS Revalidation Support Team, March 2014, *The Early Benefits and Impact of Medical Revalidation: Report on research findings in year one*, available at www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/earl-ben-impact-mr-report.pdf.

[8] Estimate based on around 20 patients providing feedback to each of 155,403 doctors revalidated at 28 July 2016.

[9] UMbRELLA – 37.3+21.5% find patient feedback moderately/extensively helpful in supporting reflection on their practice.

[10] IFF Research, October 2014, *GMC Perceptions Study*, available at www.gmc-uk.org/about/research/26472.asp.

Email: **gmc@gmc-uk.org**
Website: **www.gmc-uk.org**
Telephone: **0161 923 6602**

General Medical Council, 3 Hardman Street, Manchester M3 3AW

Textphone: **please dial the prefix 18001** then **0161 923 6602** to use the Text Relay service

Join the conversation

@gmcuk **facebook.com/gmcuk**
linkd.in/gmcuk **youtube.com/gmcuktv**

To ask for this publication in Welsh, or in another format or language, please call us on **0161 923 6602** or email us at **publications@gmc-uk.org**.

Published August 2016

Code: GMC/IR2016/0816

General Medical Council