

UK Advisory Forums - Scotland

Agenda and papers for meeting
on
3 October 2018

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UK Advisory Forums – Scotland
3 October 2018
13:30 -16:00
GMC office in Scotland
Fifth Floor, The Tun
4 Jackson's Entry
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Agenda

- 1 Welcome and Chair's introductions
- 2 Review of actions from previous meeting
- 3 **Medical workforce, quality and safety**

Supporting a profession under pressure

The GMC will provide an update on this programme which was discussed at the last UKAF meeting. Opportunities for engagement and collaboration will be explored.

- 4 **Systems and collective assurance**

Insight, intelligence and collective effect

The GMC will give an overview of ongoing developments relating to data products, reports and publications. Discussion will focus on what these tell us about local issues and challenges, particularly in the context of workforce, and how insights and intelligence can best be shared to ensure collective effect.

- 5 **Upstream regulation: preventing harm and supporting professionalism**

GNM/CH review: responding to the specific interest in this issue in Scotland

Leslie Hamilton will provide an overview of the work of the GNM/CH review with Stewart Irvine providing an update on the work of the Scotland Task & Finish Group. There will be an opportunity for Forum members to ask questions of Leslie and Stewart.

- 6 Review of actions and AOB
- 7 Close

Report title: GMC Update

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Action: To consider

Executive summary

This paper provides an update on progress against a number of our priorities and key projects for 2018. Key points for Advisory Forum members to note in particular:

- We continue to develop the work we undertook earlier this year on our 'Supporting a Profession Under Pressure' programme, addressing issues that have been raised with us in the context of the Dr Bawa-Garba/Jack Adcock case. These include the application of GNM and Culpable Homicide; Reflective practice; Health and Wellbeing; Raising and Acting on Concerns; Induction and Fairness.
- We continue to find ways to share our intelligence and insight with partners for collective effect in the interests of patients and the profession. In England we have signed a multi-regulator agreement called the Emerging Concerns Protocol which facilitates a more upstream approach to identifying and acting on shared concerns.
- Our engagement with all four Governments in relation to the implications of Brexit and Legislative Reform continues. We continue to ask for a system which allows for the safe mutual recognition of professional qualifications post Brexit. We also continue to press the UK Government for fundamental reform of our outdated legislation so that we can make a greater contribution to the challenges facing our health systems.
- We continue to engage with key stakeholders on our range of education reforms, including the Medical Licensing Assessment (MLA), Credentialing, our Quality Assurance (QA) Review and Generic Professional Capabilities.
- Dame Clare Marx has been announced as the GMC's next Chair. She will succeed Professor Sir Terence Stephenson whose term finishes at the end of 2018.

Recommendation:

Members are asked to consider this update in order to share suggestions as to how our programme of work can best be delivered as well as any queries, advice or concerns.

Medical workforce, quality and safety

Supporting a profession under pressure

- 1 Earlier in the year, based on feedback from partners, the profession and patients, we commenced an ambitious [programme of work](#) to address the issues that have been raised with us in the context of the Dr Bawa-Garba/Jack Adcock case. We are extremely grateful for the engagement and support we have received from UKAF members in addressing these issues which have gone unaddressed for too long.

Reflective practice

- 2 [New guidance](#) to help doctors and medical students with reflection has been jointly published by the Academy of Medical Royal Colleges, the Conference of Postgraduate Medical Deans, the General Medical Council and the Medical Schools Council.
- 3 The guidance aims to help medical students and doctors meet expectations around reflective practice for revalidation, education and training. It also aims to address the concerns and misunderstandings we've heard about the use of reflective notes, following the case of Dr Bawa-Garba. The guidance comes following a clear desire from the profession for greater clarity on reflection and reflective practice, with a focus on values rather than ticking boxes.
- 4 We are also working on a suite of learning materials to support medical students and doctors in applying the guidance in practice, and to support them to become confident reflective practitioners. This will be supported on the frontline by our Liaison Advisers in each country who currently engage with over 40,000 doctors, educators, employers and medical students each year, so that the principles of reflective practice and the culture systems required to support it are embedded.

Wellbeing

- 5 A UK wide review led by Professor Michael West and Dame Denise Coia has been commissioned to identify factors that impact on the wellbeing of medical students and doctors. Findings from this review will enable us to work together with relevant organisations to agree priority areas for collaborative action that can help tackle the causes of poor wellbeing.
- 6 The current focus of this work is to review all existing research in this area and identify any evidence gaps, which may need to be explored further. Existing initiatives that support wellbeing will also be reviewed to ascertain if these might be applied or implemented across the UK.

- 7 An important part of this project will involve seeking views from relevant stakeholder organisations, groups and individuals. To enable us capture this information we have arranged meetings for education providers in each of the countries during September and October, which will allow an opportunity to inform the review.

Raising and Acting on concerns

- 8 We signed a cross regulator [Emerging Concerns Protocol](#) that facilitates a more agile and upstream approach to identifying and acting on shared concerns about the environments in which healthcare professionals work and train in England. This has already been used in a number of incidents where we have been able to address potential risks to safety in real time without recourse to formal regulatory action.
- 9 A concern that has been consistently identified in our engagement with stakeholders and our National Training Surveys (NTS) is the issue of rota gaps. We also know from our initial analysis that burnout is a serious concern among the profession and poses a risk to patient safety. This year's NTS found that around a third of doctors in training and trainers said that training opportunities are lost due to rota gaps.
- 10 In Scotland and Wales we have worked with the British Medical Association (BMA) and others to engage publicly with employing organisations to improve rota management and monitoring, in order to promote the quality and safety of the working environment for doctors in training.
- 11 In Northern Ireland, we have agreed to join the Department of Health's Junior Doctor Management Reference Group which will focus on non-contractual issues affecting the morale and well-being of post-graduate doctors in training in Northern Ireland.
- 12 In England we have also launched [a joint programme of work](#) with NHS Improvement (NHSI), Quality Care Commission (CQC), the BMA and NHS Employers to improve how doctors can 'exception report' on rota gaps.
- 13 We are working with partners across the UK including RCS Ed, AOMRC, RCOG and the BMA to develop a training programme focusing on helping doctors to challenge unprofessional behaviours. 'Speaking up' can often be a daunting experience so we aim to equip doctors with techniques so they can address concerns more confidently. We will be piloting this new programme in organisations across the UK in the next few months as part of our commitment to supporting just cultures.

Human Factors

- 14 In accordance with the [Human Factors Concordat](#), to which we are signatories, our Generic Professional Capabilities (GPC) framework defines Human Factors as: *The environmental, organisational and occupational factors, and human and individual*

characteristics, which influence behaviour at work in a way that can affect health and safety.

- 15** These themes are prioritised in the GPC framework, which also states that Human Factors training must be incorporated into all curricula: *Doctors in training must... demonstrate and apply basic Human Factors principles and practice at individual, team, organisational and system levels.*
- 16** To assure ourselves on how Human Factors are being taught, we are considering whether questions regarding this training should be included in our National Training Surveys from next year.
- 17** We are currently also exploring how we can incorporate Human Factors Training into the training of our fitness to practise Case Examiners, and the medical experts used in our processes.
- 18** As an extension of this we are also exploring how we can help Responsible Officers apply Human Factors methodology in their investigations, supporting our objective that only the most appropriate cases are referred to us. This builds on our existing reforms including Provisional Enquiries, which has resulted in a 54% reduction in the number of complaints about single clinical incidents being referred for investigation.

Gross Negligence Manslaughter and Culpable Homicide

- 19** The independent review into how Gross Negligence Manslaughter (GNM) and Culpable Homicide (in Scotland) are applied in the medical profession has been underway for six months. A working group of 10 people with a range of perspectives, experience and expertise are leading the review chaired by Dr Leslie Hamilton who is a consultant cardiac surgeon.
- 20** Given the different health and legal system in Scotland, this working group is being supported by a Scottish Task and Finish Group looking at these issues in the Scottish context.
- 21** The working group invited written submissions from doctors, patients and anyone with experience, expertise or an interest in this area and have been meeting with both individuals and organisations that made suggestions about how the system can be improved. All of this evidence will contribute towards their report.
- 22** In September and October the working group will gain further understanding of the views of doctors, their representative organisations and others by running workshops and oral evidence sessions in London, Manchester, Cardiff, Belfast and Edinburgh.

- 23** The Health Select Committee at Westminster has announced an Inquiry focusing on Sir Norman Williams' review of GNM which was published in July this year. We will be appearing in front of the Committee to provide evidence on this issue.

Induction and returners

- 24** We continue to expand our Welcome to UK Practice programme to support the induction of doctors who qualified outside the UK and are new to practice here. Our attendance figures have increased by over a third over the last year.
- 25** We are working with British Association of Physicians of Indian Origin (BAPIO) in Wales on how our Welcome to UK Practice programme can be adapted to support the induction of those recruited to the Medical Training Initiative (MTI). Similarly, we are supporting Health Education England (HEE) and NHS England with their overseas GP recruitment programme.
- 26** Currently we are running a survey of healthcare providers to understand how many overseas qualified doctors will be recruited over the next 12 months so that we can plan our resources to deliver this most effectively. We are seeking innovative ways to deliver the programme incorporating webinars as part of a blended approach.
- 27** We are considering the value of GMC commissioned research into the specific issue of induction and support for doctors returning to practise after a period of absence. We are working with partners to determine what is already known about this issue and the value of additional GMC work in this area.

Fairness

- 28** It's well established that some groups of doctors are referred to us for fitness to practise concerns more or less than others. Earlier this year we commissioned Roger Kline to take forward a major, independent research programme to help us understand what drives this disparity, which will analyse data and undertake case studies across primary and secondary care in all four countries of the UK.
- 29** The research team have been writing to employing organisations across the UK as part of this study. We hope the research will give practical recommendations for the GMC and others to act on if changes are required to ensure fairness in our processes.
- 30** We have commissioned a number of independent audits of fairness over the years which have not found any evidence of bias in our processes. However we are in no way complacent about the possibility that bias – subconscious or otherwise – could exist in our processes and as such we are exploring how we might more regularly independently assure ourselves and the profession in this area.

Fitness to practice reforms

- 31** Our Corporate Strategy commits to a pilot of a 'Local First' approach by 2020, to ensure that concerns about doctors are dealt with at the right level and locally where appropriate. We are currently carrying out a programme of research to help us understand and map out how this would work, what the challenges, risks and benefits are and how we can work with our key partners to achieve this ambition within our current legislation.
- 32** We are completing a pilot to extend provisional enquiries to cases that involve single clinical incidents and expect to have this rolled out by the end of 2018. We continue to explore how we can expand the use of provisional enquiries in more types of cases, and aim to have a further pilot developed and launched in 2019. As described above, the success of this approach is evident in the 54% reduction in the number of complaints about single clinical incidents which we decide require investigation.

Education reforms

Credentialing

- 33** We continue to progress our work on credentialing and held a workshop on 18 July, with members of the UK Medical Education Reference Group (UKMERG) who represent four-country government and statutory education bodies. We returned to UKMERG on 5 September and agreed a draft credentialing framework.
- 34** From September to November we will undertake a wider stakeholder engagement process to seek views, which will include discussions as part of the education provider meetings planned for the autumn. We will then refine the framework and plans for how it will operate in practice, ensuring alignment with the wider Education Quality Assurance (QA) review. We plan to return to GMC Council in April 2019 with finalised proposals, prior to launching the framework.
- 35** Any stakeholders who are not attending the education meetings may contact us directly (rose.ward@gmc-uk.org) so we can share the draft and arrange a discussion or to get written feedback.

Medical Licensing Assessment (MLA)

- 36** We continue to make progress with our ongoing programme of meetings with medical schools to enable us to gain an in-depth understanding of the impact of the MLA for them. This includes:

- a** Publishing an updated list of practical procedures to accompany the updated Outcomes for Graduates; further drafting of requirements for the Clinical and Professional Skills Assessment (CPSA).
- b** Establishing processes and structures for developing Applied Knowledge Test (AKT) questions and papers; developing an initial version of MLA delivery software for use in trialling.
- c** Supporting a programme of activity and materials to support medical schools in introducing the MLA.
- d** Undertaking an equality assessment.

Education provider meetings

- 37** We held a meeting for education providers in Northern Ireland on 26 September and have scheduled one in Wales on 16 October and one in Scotland on 30 October. These events provide an opportunity to update and seek feedback on a number of key areas of our education reforms, including the MLA, credentialing, the Welcomed and Valued consultation, our QA Review and the mental health and wellbeing programme.

Systems and collective effect

Intelligence, insight and collective effect

- 38** We continue to develop our products to ensure the data we hold can be shared with others appropriately, building on the successful roll out of [Data Explorer](#) and the Designated Body dashboard.
- 39** We publish regular reports to share the insights we have gained from our data and from other engagement, so that we can work collectively with others to achieve our mutual strategic aims and make improvements wherever possible. We have recently shared with Medical Schools and Deaneries data relating to [differential attainment](#), and have published a range of reports highlighting what the insights we gain from doctors tell us about the quality and safety of education and training, including the [training progression and pathway reports](#) and the report of our initial analysis of the 2018 [National Training Surveys](#).
- 40** We have a survey underway seeking views on what it means to be a doctor, what motivates the profession and how doctors envisage their career pathways. We anticipate that these survey findings (scheduled to be published early in 2019), alongside our annual review of the [State of Medical Education and Practice](#), will

provide useful intelligence relating to the likely future development of the medical workforce which will inform our ongoing collaborative work in this respect.

- 41 The GMC Strategy Team's Collective Effect review is exploring how the GMC interacts with external organisations. As a critical part of this, we are working closely with our colleagues in the devolved offices – initially in Wales, and then more broadly – to establish where and how we collaborate, and where there may be opportunities to work even more collaboratively in future.
- 42 We also made a submission to NHS England consultation on the [long term plan for the NHS in England](#). We have focused our contribution on the future shape of the medical workforce, attracting and retaining doctors, health and wellbeing and how our unique data and insights can contribute to a more strategic approach to workforce planning and delivery. We have been engaging with partners from across the UK on these ideas and will continue to consider the implication and applicability of our contribution on a UK wide basis, recognising that many of the challenges are common across the UK.

Learning from inquiries

- 43 In May 2018 we [responded](#) to the Independent Inquiry Hyponatraemia [report in Northern Ireland](#). Although none of the report's 96 recommendations are directed specifically at the GMC, we are committed to learning lessons from what occurred and to making sure that patients are protected.
- 44 Also in May 2018, the Department of Health in Northern Ireland [announced](#) the establishment of an Independent Inquiry to review the recall of neurology patients by Belfast Health and Social Care Trust. We are currently monitoring developments and conditions have been imposed on the registration of the doctor whose practice is central to this Inquiry.
- 45 The Independent Inquiry into Child Sexual Abuse (England and Wales) published its [interim report](#) in April, 2018. Although recommendations were not directly made concerning our role it did recommend that the Home Office ensures that, where a fitness to practise hearing has been conducted by the keeper of a relevant register and has resulted in removal of a practitioner from that register for reasons relating to harm or risk of harm to children, the keeper of the register has a duty to refer that information to the Disclosure and Barring Service (amending the Vulnerable Groups Act 2006). Where legally permitted, this is already our standard practice. We are now preparing our formal submission to the Inquiry in England and Wales and in Scotland.

Brexit

- 46** The UK Government has reached provisional agreement with the European Commission on the transition period which will begin once the UK formally leaves the EU on 29 March 2019. Nevertheless, considerable uncertainty remains and it is possible that the agreement won't be formally confirmed until the end of the year.
- 47** We have corresponded with the Secretary of State for Health and Social Care (England) and senior Department for Health and Social Care (England) officials seeking clarity on a range of issues. In particular we have asked whether or not we need to make contingency plans to treat doctors from the European Economic Area (EEA) coming to work in the UK as International Medical Graduates (IMGs) from 30 March 2019, or at the end of a legally defined transition period. These exchanges have been copied to Ministers and officials in Northern Ireland, Scotland and Wales. In light of the continued uncertainty, our operational planning has been stepped up to prepare for a 'no deal' Brexit in March 2019.
- 48** We continue to provide detailed legal comments on the draft Medical Act amendments that the Department of Health and Social Care (England) plan to introduce under the EU Withdrawal Bill when it is passed. We are also seeking to meet with the Department of Business, Energy and Industrial Strategy to discuss drafting of the regulations that deal with the general system for EEA applicants.
- 49** Over the summer the UK Government published its White Paper which sets out its negotiating position for the future relationship between the UK and EU. This confirmed that the UK will seek to continue to have a system for the mutual recognition of professional qualifications, enabling professionals to provide services across the UK and EU post Brexit.
- 50** To note, the Health Select Committee at Westminster will be holding an evidence session in October on the impact of a no-deal Brexit on health and social care:
[Inquiry: Impact of a no deal Brexit on health and social care](#)

Legislative Reform

- 51** As Forum members are aware we believe that the legislative framework governing healthcare professional regulation is not fit for the needs of the public, professions, employers, or the wider health and care system. We would like to see a framework which provides regulators with the flexibility and autonomy that is needed to meet current demands, as well as adapt to the changing needs of patients and health services over the next 20-30 years, accompanied by enhanced accountability to the parliaments across the UK and to their key interest groups.
- 52** As we see it, the current climate creates a pressing need to improve patient safety and support UK workforce ambitions. In particular we need to refine the processes

for equivalent application to our register (Certificate of Eligibility for Specialist Registration – CESR - and Certificate of Eligibility for the General Practice Register - CEGPR), streamline fitness to practise processes, and futureproof other systems including potential regulation of Physician Associates. We continue to call on the UK Government to deliver on its commitment to legislate in this area.

- 53** We look forward to further information on next steps from the UK Government, led by Department of Health England (DHE), following last year's consultation on the reform of Professional Regulation. We expect that all three governments in Scotland, Wales and Northern Ireland will be engaged at every stage by colleagues in England and will also do what we can to ensure that partners are sighted and engaged with throughout this process.

Upstream regulation: preventing harm and supporting professionalism

Consent

- 54** The final report from the research we commissioned earlier in the year to explore patient attitudes to consent is due to be released in the autumn. This follows research we released in October 2017 exploring [doctors' attitudes to consent and shared decision making](#).
- 55** In September we held a Task and Finish Group where we shared the findings of the report and finalised plans for the consultation, which is scheduled to be launched this autumn.

Taking revalidation forward

- 56** In September we closed our programme of work to implement the recommendations from Sir Keith Pearson's independent review of revalidation.
- 57** Since the last round of UKAF meetings we have launched a number of programme outputs including: updated guidance on supporting information required for appraisal; improved revalidation information on our website for both doctors and patients; guidance relating to licences to practice; measures for tracking the impact of revalidation and a set of principles to govern the sharing of concerns where doctors work in multiple locations. The updated clinical governance handbook will be published before the end of the year.
- 58** There are two ongoing projects in support of revalidation that will continue beyond the close of the programme, including a consultation on patient feedback and expanding the information we collect about deferrals.

Report Title: **Insight, intelligence and collective effect**

Report by: **Susan Goldsmith**, Corporate Directorate, susan.goldsmith@gmc-uk.org, 020 7189 5124
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Action: **To discuss**

Executive summary

- 1** We will give an overview of ongoing developments relating to GMC data products, reports and publications with a focus on how these are used currently, and what they tell us about the local medical workforce and system pressures.
- 2** The presentation will be supported by a table pack providing some of the data in more detail.
- 3** Discussion will focus on what the data and intelligence tells us about local issues and challenges particularly in the context of workforce, and how these can best be shared and used to achieve our collective strategic priorities – supporting employers and doctors to protect patients.
- 4** Any specific questions relating to the data will be referred back to our data teams for ongoing advice and discussion outside the meeting.

Recommendations:

- 5** Forum members consider their own understanding and use of GMC data, reports and publications, alongside their own organisational data and intelligence, and how this might be enhanced for better collective effect.

Forum members come prepared to share examples and suggestions to inform the discussion.

Aims of this session

6 This session builds on previous discussions at Advisory Forum meetings and aims to demonstrate how our data products and reports have developed, with a particular focus on availability of data and intelligence on a four country basis.



7 This time last year, we had only a fraction of data available at country level. By this time next year we aim to have used your suggestions to improve it even further.

8 We will also share how we use insights from our work with doctors, medical students, patients and key stakeholders within our country to best effect, considering what the emerging insights tell us about the current medical workforce and pressures affecting the systems in which they work.

9 This will be an interactive session with opportunities to discuss what the data and emerging evidence tells us, how it relates to other data and intelligence you might be aware of, and if and how this might be used to inform our collective work to build on opportunities and address issues relating to education, training, employment and medical practise.

10 This is not intended to be an in-depth data analysis session and we will not have data experts in the room. If there are specific questions regarding the data, or further data is required, we will pass these on to our data teams so that they can continue this conversation with you outside the meeting.

What will be considered?

11 In addition to our presentation, a table pack will be provided giving greater detail on many of the areas for discussion. You will be able to take this pack away with you for ongoing consideration.

GMC Data

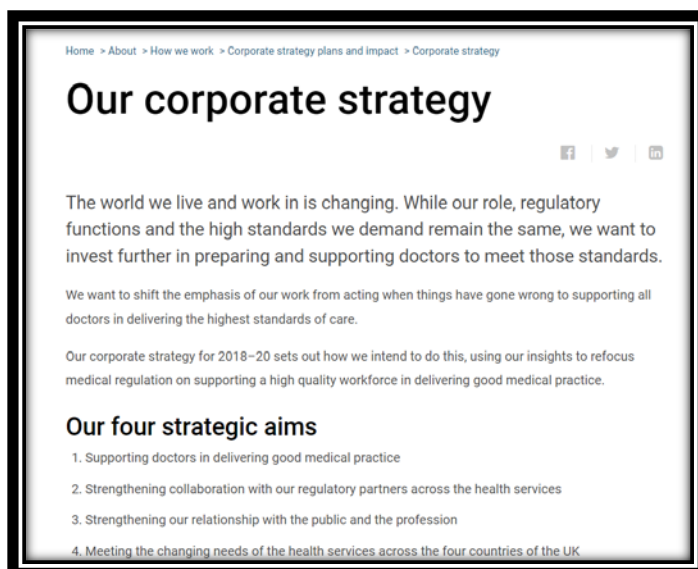
12 Our datasets have been developed over the last 12 months to bring a new level of detail to four country reporting. Much of this data is already available in the publicly accessible [Data Explorer](#) and the Designated Body dashboard, which is accessible to Responsible Officers and system regulators. We will be making further improvements to Data Explorer in the future to improve the four country reporting functions.

Intelligence and insight

- 13 We publish regular reports to share the insights we have gained from our data and from other engagement, so that we can work collectively with others to achieve our mutual strategic aims and make improvements wherever possible. We have recently shared with Medical Schools and Deaneries data relating to [differential attainment](#), and have published a range of reports highlighting what the insights we gain from doctors tell us about the quality and safety of education and training, including the [training progression and pathway reports](#) and the report of our initial analysis of the 2018 [National Training Surveys](#).
- 14 Alongside these previously published reports we will share insights arising from our engagement with doctors, medical educators and others, and early findings from two new research products (*What It Means To Be A Doctor*, and *Adapting, Coping, Compromising*).

Collective effect and GMC strategy

- 15 One of the GMC's strategic aims for 2020 is to collaborate more effectively with our regulatory partners and share data and intelligence more effectively so that we can support risk-based regulation. A strategic review of collective effect is underway to identify how effectively we work with our partners to deliver on common areas of strategic priority.



- 16 During the session we will be sharing examples of where we feel this has worked effectively in the past, and would welcome your thoughts both on what has worked well and how this might be improved.

Outcomes and outputs

- 17 Feedback and suggestions made during the session will be noted and shared with our data and other teams as appropriate to inform ongoing development of our products. They will also be shared with the collective effect strategic review team, who may wish to follow up with Forum members on specific aspects.
- 18 We welcome other feedback and comments, either at the end of this session or after the meeting, and will provide some feedback sheets for you to capture thoughts as they arise during the discussion.