

UK Advisory Forums – Scotland
20 March 2019
13:30 -16:00

General Medical Council
5th Floor, The Tun
4 Jackson's Entry
Edinburgh EH21 8QP

Agenda

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

Responding to Workforce Challenges in Scotland– the GMC perspective

Paul Buckley, Director of Strategy & Policy, will give a short update on our contingency planning around Brexit before setting out our 'workforce offer' as described in SOMEF 2018 – relevant chapter has been included at the end of the GMC Update Paper.

- 4 **Systems and collective assurance**

Workforce Supply in Scotland – the Scottish Government perspective

Dave McLeod, Senior Policy Officer, Scottish Government, will update on some of the priorities and challenges facing Scottish Government in achieving sustainability of the medical workforce in Scotland

Facilitated discussion of workforce themes raised

Nicola Cotter will seek members' views around how we can work more closely with key stakeholders to support workforce planning.

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

Maximising the collective effect of our Field Forces

Paul Reynolds, Director of Strategic Communications and Engagement will set out the principles behind our field forces review, focusing on how we can improve our services to stakeholders in Scotland and seeking their views. This will build on discussions we had around data at our October 2018 meeting.

- 6 Review of actions and AOB
- 7 Close

Report title: GMC Update Paper

Report by: Susan Goldsmith, Chief Operating Officer,
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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 2019. Key points for Advisory Forum Members to note in particular are:

- This will be the first UKAF meeting for our new Chair, Dame Clare Marx. Clare is looking forward to meeting UKAF members and hearing about issues and achievements across the health and care landscapes of the devolved nations.
- Our *Supporting a Profession Under Pressure* programme of work continues with a number of key workstreams beginning to draw together their recommendations on how to address issues raised with us in the context of the Dr Bawa Garba/Jack Adcock case.
- We are building on our collaboration with partners to further develop our intelligence and insight offer to support workforce planning on a four country basis. We have commenced pilots of our revised model for education Quality Assurance which aims to strengthen our relationships with education stakeholders, reduce the administrative burden in the assurance process, and provide continuous assurance that the *Promoting Excellence* standards are being met.

Recommendation:

Members are asked to consider this update in order to explore how we can work together to improve our collaboration on key areas of work as well as to highlight any queries, advice or concern.

Medical Workforce, Quality and Safety

Update on *Supporting a Profession Under Pressure*

- 1 We continue to progress this programme of work which was established to address the issues raised by the profession in the context of the Dr Bawa-Garba/Jack Adcock case.

Reflective practice

- 2 We published our *Reflective Practitioner* guidance in 2018 which was jointly developed with the Academy of Medical Royal Colleges, the Conference of Postgraduate Medical Deans, and the Medical Schools Council. We are now working with other healthcare workforce regulators to develop a joint statement on the benefits of becoming a reflective practitioner.
- 3 This statement will highlight the benefits of reflection, and encourage opportunities for multi-professional teams to come together and discuss openly and honestly what has happened when things go wrong; to build resilience, improve wellbeing and deepen professional commitment.

Wellbeing

- 4 The Co-Chairs of the Wellbeing Review, Dame Denise Coia and Professor Michael West, have met with a wide range of stakeholders from across the UK including the BMA, Medical Royal Colleges, and devolved governments and health departments.
- 5 In Scotland, the Health and Wellbeing Advisory Board is considering early intervention pilots in a small number of health boards to test some best practice interventions to support doctors and improve their wellbeing. Learning from these pilots will be shared across the UK.
- 6 Colleagues from the Northern Ireland and Wales offices continue to gather information on local wellbeing initiatives that support the NHS workforce and feed this back to the Review.
- 7 A roundtable event in January 2019 brought together Medical Royal Colleges at a UK level to explore possible recommendations the Review could make and promote collaborative working to implement these going forward. It is envisaged initial broad recommendations will be presented to the GMC Council with a view to the final action plan and recommendations being published later this year.

Raising and Acting on Concerns

- 8** We are improving and updating our online resources for doctors on our *Raising and Acting on Concerns* guidance. Alongside this, we recognise the growing body of evidence demonstrating the harmful impact of unprofessional behaviours, including bullying and undermining, on patient safety and the quality of education and training environments.
- 9** To build on our work supporting doctors to 'speak up' and challenge unprofessional behaviours, we are piloting new sessions for doctors across the UK in 2019; *Professional Behaviours & Patient Safety (PBPS)*. The PBPS project explores how the GMC can best help to improve professionalism to avoid adverse impacts on patient safety.
- 10** We continue to take a collaborative approach to this work, engaging the Medical Royal Colleges, BMA, Civility Saves Lives, National Guardian's office in England and other bodies that are active in this field; working in a reciprocal way to raise awareness of each other's work towards our shared goal.
- 11** Our stakeholder reach has extended to the US through recent collaboration with Vanderbilt University to better understand if and how their evidence-based model (which is a systems-based approach) could help inform progress in this field in the UK.

Human Factors

- 12** We are developing a programme of Human Factors training and advice on modifying investigation processes for all of the GMC's fitness to practice decision makers, case examiners and clinical experts. This work is in collaboration with Oxford University's Patient Safety Academy.
- 13** This training will help these staff to take into account how workforce pressures or systems may have affected a doctor's actions or decisions that lead to a concern being raised about them. While we already consider the context of a doctor's practice in our investigations, we want our teams to be trained to the highest standards, to deliver a balanced, consistent and fair approach in every case.

Gross Negligence Manslaughter / Culpable Homicide Review

- 14** The independent review into how gross negligence and culpable homicide are applied to medical practice is in its final stages.
- 15** The report is expected to be published in late-spring and will also include recommendations from the Scotland-specific Task and Finish Group, established to feed into the wider review on this issue in Scottish Law on Culpable Homicide.

Induction and Returners

- 16 We are committed to raising awareness of our Welcome to UK Practice programme and are working collaboratively with BAPIO in Scotland, the Department of Health and Social Care and employers in Northern Ireland and BAPIO in Wales.
- 17 In 2018 we delivered 11 of these sessions across the devolved countries to 80 doctors. In Northern Ireland, the CMO has endorsed mandatory inclusion of this programme into induction programmes for new doctors. Dr Madhu Kannan, our Welsh Clinical Fellow, is leading on the 'induction and returners' project for Wales. The Welsh CMO is aware of and positive about this area of work. In Scotland we have Welcome to UK Practice embedded into the Royal College Physicians Edinburgh MTI Programme.

Fairness

- 18 We expect the final report exploring why the GMC receives higher rates of referrals of BME and non-UK qualified doctors from employers to be delivered in the spring. The report will also consider what good practice looks like in local cultures and processes.
- 19 The researchers are engaging with a small number of key stakeholders to ensure the recommendations agreed on in the final report are challenging but realistic in their scope for implementation. On receipt of the report, the GMC will develop a programme of implementation in consultation with the organisation's Equality, Diversity and Inclusion Advisory Forum and the BME forum over the summer.

Upstream regulation: preventing harm and supporting professionalism

Workplace Cultures

- 20 We are working closely with key stakeholders including the Royal College of Surgeons of Edinburgh, Royal College of Physicians, and Royal College of Obstetrics and Gynaecology to develop our programme of work around Professional Behaviours & Patient Safety (see paragraph 9 above).
- 21 As part of our Harms Reduction Programme we are working closely with the Scottish Government and Scottish Public Services Ombudsman to deliver a programme of work looking at Reducing Harms and Tackling Poor Communication, with a workshop scheduled for March 2019 to develop further actions that can be taken.
- 22 We recognise that harms may stem from multiple issues at different levels, ranging from individuals to more systematic problems, which regulators may be well-placed to help alleviate. The programme seeks to learn how such harms occur, share our insights, and identify opportunities to intervene before harm occurs.

- 23** Medical Royal Colleges in Northern Ireland, led by RCGP NI, have collaborated to develop a set of Professional Behaviours and Communications Principles to strengthen clinical collaboration and working better together in the interest of patients. The principles, which are being launched on 20 March 2019, are designed to tackle issues at the interface between primary and secondary care.

Fitness to Practice reforms

- 24** We remain committed to working closely with health boards and trusts to overcome the challenges to achieving good quality investigations which are also relevant to our fitness to practise function. We are currently exploring options for a “Local First” approach to investigations to ensure that all complaints and concerns about doctors are dealt with in the right place and at the right time. We hope to pilot the new approach in 2020.
- 25** Following a successful two-year pilot, we’ve implemented a new process to reduce the number of full investigations we carry out in cases where a doctor has made a one-off mistake, while ensuring there is no ongoing risk to patient safety.
- 26** We now make ‘provisional enquiries’, where we look at information at an early stage of a case such as:
- whether a doctor understands what went wrong and if they have taken steps to make sure it won’t happen again; and
 - local investigation reports and the views of senior doctors from where the incident happened.
- 27** If we believe there is no future risk to patients, based on the evidence we have gathered, and the issue doesn’t require a formal regulatory response, we will close the case without opening a full investigation.
- 28** Our pilot showed that by taking these steps, we were able to review cases like this much more quickly and provide faster feedback to patients. We were also able to improve how we supported patients and/ or their representatives through the process, by offering a follow-up meeting and/or a phone call to those who wanted to discuss their case further.
- 29** By reducing unnecessary full investigations, we can target our resources on complaints that do need further in-depth work to protect patients, which is our absolute priority.

Better signposting of concerns

- 30** We are conducting research to better understand why we receive a high volume of concerns from the public that do not meet our investigatory threshold and how we could better support the public in directing their concerns to the right organisation. We expect to complete this research in early spring and will use these findings to consider how we can improve our service to patients and our work with stakeholders who provide advice and guidance to patients about their complaints.

Revised Consent Guidance

- 31** We have recently completed the consultation phase on the draft *Decision making and Consent* guidance. The draft guidance has been restructured with the aim of making it clearer and easier for doctors to apply in practice, providing more advice, and including steps to follow when making decisions in difficult circumstances.
- 32** GMC guidance reflects the law, policy and health care settings in England, Northern Ireland, Scotland and Wales and this has underpinned our consultation approach. In addition to including information about the consultation in our frontline *Promoting Professionalism* sessions with doctors, we delivered 20 workshops with stakeholders.
- 33** We expect to publish the revised guidance by the end of the year and are developing a range of resources to accompany this to support doctors to embed the guidance into their practice.

Revalidation

- 34** Our response to Sir Keith Pearson's independent review of revalidation was published in November 2018. In the report *Taking revalidation forward: Working with others to improve revalidation*, we set out the improvements we made in response to Sir Keith Pearson's recommendations and our next steps.
- 35** In December, we published *Effective Clinical Governance for the Medical Profession*. This revision of the previous Governance Handbook is a resource to support organisations to develop robust and effective clinical governance systems in designated bodies and other healthcare organisations to support revalidation. We worked with our stakeholders to ensure we captured learning and best practice from healthcare organisations since the introduction of revalidation in 2012.
- 36** As part of our ongoing work to support revalidation we are reviewing our patient feedback requirements for revalidation. We established a Patient Feedback Advisory Forum with stakeholders from across the four countries to inform this work and look forward to launching the consultation on the proposed changes in April 2019.
- 37** Changes we will be consulting on include:

- the format of feedback and whether alternative types should be available other than a questionnaire;
- what further advice could be provided in our guidance to doctors on collecting patient feedback; and
- whether there should be more local discretion on how patient feedback is collected and used.

Field Forces Review

- 38** An agenda item at the UKAF will be an overview of our Field Forces review. This review set out to establish how to meet our strategic aim of shaping our outreach teams that work with doctors on the frontline, healthcare providers, systems regulators and improvement bodies to align with local systems.
- 39** Complementing our existing national offices in Northern Ireland, Scotland, and Wales, we aim to establish a new seven-region model in England. This will help fulfil our corporate strategy aims to strengthen how we work with partners and meet the needs of health services across the four countries of the UK.
- 40** We want to integrate our outreach teams to get closer to doctors, patients and the healthcare economy, and ensure they support our functions and strategic ambitions in the best possible way.
- 41** We aim to have much greater influence on the ground and improve and share with others our insight and intelligence to improve patient safety. This will help us to better understand and support regional and national priorities.

Strategic Relationship Review

- 42** The changes outlined above will support the delivery of our re-focused approach to Strategic Relationships across the UK. Aimed at improving our relationships with key stakeholders and partners, our new approach will focus our resources on relationships with the highest strategic value, take a more proactive approach to relationships, and provide a framework to give relationships direction and structure.

Education Reforms

Quality Assurance

- 43** Our current Quality Assurance (QA) model involves us checking that medical schools and postgraduate organisations meet our standards through a series of periodically scheduled regional/national reviews. The current schedule of regional/national

reviews ended in December 2018 and in April 2018, GMC Council advised us to consider options for a future approach to QA. We have since undertaken a programme of research and engagement to inform our options.

- 44** We have begun to pilot a new QA model in Wales and in the West Midlands, designed to enable us to strengthen our relationships to gain more continuous assurance of compliance with our standards and outcomes. We intend that the new model will give us the opportunity to work more collaboratively and flexibly with medical schools and postgraduate organisations, to reduce burden and duplication, and to be more proportionate.
- 45** We also hope that the new model will be significantly 'lighter touch' than our current model. Our overall objective throughout the pilot is to ensure that the proposed model of QA would provide assurance that medical schools and postgraduate organisations meet the standards set out in *Promoting Excellence*.

Flexibilities

- 46** We have met a number of the commitments laid out in our report to UK Governments in March 2017 '*Adapting for the Future: a plan for improving the flexibility of UK postgraduate medical training*', and continue our work to:
- enable greater opportunities for doctors to move between specialties;
 - significantly reduce the need for the CESR/CEGPR combined route and improve opportunities for SAS doctors; and
 - allow doctors to step-off and then back on to training with recognition of training and experience taken into account towards a CCT.
- 47** We recognise there are risks in this work and are therefore testing ideas and exploring safeguards that might be required. We are also conscious of the need to reflect the needs of service providers in all four UK countries, and are also mindful of the impact that potential uncertainty could bring to those designing rotas, particularly where there are pre-existing workforce challenges.
- 48** We will continue to work closely with Postgraduate Deans, UK education bodies, employers, Medical Royal Colleges and trainees to address these concerns. In the meantime we will explore with GMC Council the issues which have emerged from discussions with stakeholders before considering next steps.

Credentialing

- 49** We continue to work to develop our credentialing proposals to formally recognise a doctor's knowledge and skills in a specific area of practice. Credentials will help the

profession to adapt to the current and future needs of patients and maintain consistent standards across the UK. Any credential introduced will have to show it will address significant patient safety issues, and/or offer opportunities to develop doctors flexibly to help support more effective service delivery.

- 50** We have held workshops in Northern Ireland, Scotland and Wales with key representatives to gain their feedback. We've also held specific workshops for doctors in training and provided opportunities for individual doctors in training to discuss credentialing with us.
- 51** We received a high volume of responses to our engagement exercise and we are finalising our recommendations on how credentialing would work for presentation to Council. If endorsed, a number of 'early adopters' will start the approval process in 2019 (subject to GMC Council approval). We are grateful for the feedback we have received including representatives of the four UK governments, Medical Royal Colleges and faculties, Postgraduate Deans, SAS doctors, doctors in training and patient representatives.

Medical Licensing Assessment (MLA)

- 52** The MLA will enable us to assess UK medical graduates and international medical graduates (IMGs) together, to ensure that they meet a common threshold for safe practise before registering for a licence to practise. It is focused on building on the current excellence in UK medical education, with the aim of offering patients, the public, and the wider healthcare system, increased confidence in the consistency and standard of care provided by doctors.
- 53** A two part model for the MLA was approved by GMC Council in December 2018. This was developed following extensive stakeholder discussion and consultation. The MLA model will consist of an Applied Knowledge Test and a Clinical Skills and Professional Assessment, and both will be bounded by the MLA content map which will set out what both assessments need to deliver. An expert reference group, drawn from across medical education and assessment, provides advice on the blue print and the two part assessments.
- 54** We have recently completed a series of meetings with medical schools in Northern Ireland, Scotland and Wales to provide us with an understanding of how the MLA will impact on their medical schools and students. Meanwhile the Medical Schools Council have, as well as providing feedback, proposed a different approach for the design and delivery of the Applied Knowledge Test. We are exploring this proposal with individual medical schools as well as the wider medical education community to identify the extent to which we can accommodate it whilst still delivering GMC Council's aim for the MLA. We are also carefully monitoring the Brexit process to understand the impact on EEA graduates.

Systems and Collective Effect

National Training Survey (NTS)

- 55 Our report on Training Environments, published in November 2018, provided in depth analysis of the NTS results. This report provides a unique perspective of the UK medical training environment, with over 70,000 trainees and trainers sharing their experiences. Findings show that trainee concerns are consistent across the four countries with very little variation.
- 56 The report makes clear that the vast majority of trainees say that they're satisfied with the teaching and supervision they receive, and that most trainers enjoy their roles. However, it is clear from the survey responses that postgraduate medical training continues to operate in an environment of intense pressure.
- 57 The survey helps us to influence system-wide change where it is needed most, including asking those responsible for allocating healthcare funding across the UK to make sure that suitable provision is made for education and training.
- 58 We also use the survey findings to feed into many of our work programmes set out in this update paper, and have used feedback from stakeholders on the 2018 NTS process and findings in our 2019 survey, which we hope to launch by the end of March.

SOMEPE

- 59 We have published our eighth annual report into the *State of Medical Education and Practice* which sets out some of the key challenges that our health systems, and those working in our health services, continue to face.
- 60 Drawing on the National Training Survey and the findings of two new pieces of research, *What it Means to be a Doctor and Adapting, Coping, Compromising*, we also explore the strategies that the profession are employing to cope with increasing demand, more complex cases, and pressurised environments.
- 61 We also set out the contribution that we can make to addressing issues that threaten a sustainable medical workforce. We note the need for long-term and joined-up planning to ensure that our health services have a workforce with the right skills, in the right places that can maintain the professional standards that they wish to achieve to deliver safe care to their patients.

Learning from Inquiries

- 62 We have restated our commitment to work collaboratively with Department of Health NI and other partners on the multiple inquiries and reviews with a specific NI focus.

Internally we have established a group with members from the NI team, Fitness to Practice, Regulation Policy and Media teams to ensure a co-ordinated approach to our engagement with these inquiries.

Zholia Alemi

63 We have taken a number of steps to address the circumstances surrounding Zholia Alemi's fraudulent registration with the GMC to ensure that no other individuals have been able to act in the manner that she was able to. These have included:

- an immediate review of all licensed doctors who joined the register via the route that Zholia Alemi used;
- checking the authenticity of qualifications for these doctors ; and
- liaising with the four UK governments to share information and ascertain how we can strengthen our regulatory arrangements for locum doctors.

Brexit

64 We will be updating UKAF members at our meeting on the work we have been undertaking with the four UK health departments to minimise any disruption to the medical workforce post 29 March. While we await clarity on the terms of the UK's exit from the EU, we are doing all we can to prepare for the various scenarios that we may face.

65 We are confident that our work over the past two years has put us in excellent place to be able to mitigate the challenges that may arise in the event of a 'no deal' EU exit. Our operational, policy, legal and Information Support teams have been working to ensure that our systems are prepared for whatever scenario we face in March 2019 in terms of registering EEA doctors.

66 The Department for Health and Social Care laid draft Medical Act amendments at Westminster legislating for a 'no deal' Brexit in a Statutory Instrument on 20 December. We have been working very closely with officials and lawyers over the past 18 months to make sure that the amended Act allows us to register EEA qualified doctors in a timely and streamlined way. In total we have submitted detailed legal and policy comments on 11 different iterations of the Act. We have also engaged closely with officials to ensure we are considering things appropriately from a four-country perspective.

67 We provided extensive briefing for both the Commons and Lords' stages of the Statutory Instrument debates. The amendments have been passed by the Commons and will be debated in the Lords in early March. Once passed, this will help to

manage any potential disruption to the NHS medical workforce in these circumstances.

Legislative Reform

- 68** We continue to seek reform of the legislative framework governing healthcare professional regulation to ensure it is fit for purpose and meets the needs of the public, professions, employers and wider health and care system. We believe this is achievable with secondary legislation.
- 69** We are aware that the Secretary of State is currently considering the response to the consultation on *Promoting Professionalism, Reforming Regulation (2017)*. This response will set out the broad direction of any proposed reform of the Medical Act.

Medical Associate Professionals (MAPs)

- 70** The UK Government consulted on behalf of the four UK health departments on bringing MAPs into statutory regulation and, if so, which regulatory body would be asked to take on this role.
- 71** In November 2018, the DHSC indicated that MAPs were likely to be subject to statutory regulation. Shortly afterwards the Department asked the GMC and the HCPC to submit a proposal as to how they might deliver on this commitment if asked to do so.
- 72** The consultation response from DHSC was published on 7 February 2019 confirming a decision to bring MAPs into statutory regulation, but the decision on who should take on the role has not yet been made.
- 73** We continue to make the case on a four-country basis that MAPs should be regulated alongside the medical profession so that evolving patient needs, medical science and medical practice can be taken into account in ensuring patient safety and confidence in the profession are upheld. We also believe that our role in the oversight of medical curricula would help ensure a coordinated and coherent approach to our key regulatory functions.



How we and others can build a sustainable workforce

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



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

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



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

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

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



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

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

A: Improving the supply of doctors

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

General practice

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

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

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

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

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

The GP Register and the Specialist Register

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

Enabling IMGs to access PLAB more quickly

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

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

Making training more flexible and relevant

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

Medical associate professions

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

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

Internationally based doctors treating patients in the UK

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

Strengthening oversight of the training environment

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

Medical Licensing Assessment

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

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

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

Incentivising good workforce culture and employment practice

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

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

B: Better support to retain and attract doctors

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

Supporting good workplace culture and wellbeing

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

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

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

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

Offering greater support to providers in enhanced monitoring

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

Credentialing

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

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

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

Enhancing insight into distribution of doctors across the UK

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

Strategic approach to front-line engagement on continuing professional development

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

Conclusion

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