

Understanding the Role of Resident Medical Officers in the Independent Healthcare Sector

Prepared by IFF Research for the General Medical Council

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Snapshot summary

- The GMC commissioned IFF Research to conduct a survey of Resident Medical Officers (RMOs) currently working in the UK, as part of a wider project to further understand medical practice within the independent sector. The research aimed to inform the GMC whether RMOs require additional support and guidance from the GMC to deliver good clinical care. A total of 138 RMOs took part in the survey online or by telephone, representing around a fifth of all RMOs estimated to be currently working in the UK.
- The population of RMOs currently working in the UK independent sector appears to be mostly made up of younger male doctors who completed their medical training outside the UK. Almost three-quarters of survey respondents were male (72%), six in ten (57%) 35 or under, and nine in ten (93%) achieved their primary medical qualification (PMQ) outside the UK.
- Most RMOs (86%) were practising medicine outside the UK immediately before starting in the role. Many viewed the role as a pathway into practising medicine in the UK following difficulty gaining employment in the NHS. Other attractive aspects of the role included the working pattern allowing for extended time off, and a good salary.
- In line with motivations to take on the role, many RMOs continue to view the role as transitional: only a fifth (21%) expect to still be in the role one year from now.
- Feedback on performance for RMOs is fairly infrequent. Over half of RMOs (56%) reported that they receive feedback from senior colleagues less than once a month, and three in ten (28%) never receive such feedback.
- Most, but not all, RMOs feel they have sufficient access to training: almost two-thirds (64%) agreed that they are given the opportunity to keep their skills up to date via training, and a similar proportion (68%) have attended at least one training session in the last year. However, only a fifth (20%) reported that their job plan contains regular Supporting Professional Activity sessions.

- The research asked RMOs about the supervision and mentoring they received as part of their role. They were asked to reflect on this at a general level, rather than with reference to specific individuals or organisations who may have provided the supervision or mentoring. Bearing this in mind, RMOs do not fully endorse the quality of supervision and mentoring they receive: only half (49%) rate supervision by senior colleagues as good or excellent, and only a third (33%) rate mentoring they receive as good or excellent (while more feel mentoring is poor – 39%).
- RMOs face challenges in the form of high workloads, struggling to reach senior colleagues for support with patients, lack of time for training, and high levels of responsibility. To help them with these challenges, RMOs would appreciate more contact with senior doctors via regularly scheduled meetings, employment of more RMOs to share responsibilities, and more support with managing workloads and personal wellbeing.
- RMO awareness of the GMC's role is high: over four in five are aware of the GMC's core responsibilities, such as setting the standards for medical practice in the UK (84%) and providing ethical and professional guidance for the medical profession (83%), although there were also some incorrect assumptions held such as the GMC being an independent membership body for doctors (45%). On the whole, RMOs feel the GMC is relevant to their day to day work (75%).
- RMOs mostly engage with the GMC online: the main channel of contact is via GMC online (66%) and the most common way of finding out about GMC-led training and guidance is online (65%).
- While RMOs generally feel supported in some of the most crucial aspects of patient care - e.g. eight in ten (84%) were confident they knew, or could find out, how to escalate a concern about patient safety - there are clear support needs which the GMC may want to consider how to address, whether this be through working with others, engaging directly with RMOs or both.

1 Introduction



Background and objectives

The General Medical Council's (GMC's) mission is to prevent harm and drive improvement in patient care by setting, upholding and raising standards for medical education and practice across the UK. An important part of achieving this is providing support and guidance to all UK doctors to help them reach and maintain these high standards.

There is evidence to suggest that support and supervision for Resident Medical Officers (RMOs) working in the independent sector is inconsistent, both in terms of who is responsible for providing support to them and how it is administered (CHPI, 2017).¹ RMOs perform a unique role, requiring them to be on site at their contracted hospital at all times during a shift and they are often the only doctor on-site outside office hours. Because of this, RMOs usually work extended shifts followed by an extended period of time off (for example a week-long shift, followed by a week off). Independent hospitals rely on RMOs to provide continuous qualified patient care. Their varied clinical work includes ward rounds, communicating changes in patient condition to consultants, dealing with emergencies such as cardiac arrests, and sometimes assisting in theatre.

The GMC commissioned IFF Research to conduct a survey of RMOs currently working in the UK, as part of a wider project to further understand medical practice within the independent sector. This research will inform the GMC whether RMOs require additional support and guidance from the GMC to deliver good clinical care.

The objectives of the research were to:

- Identify who RMOs are in terms of their background and pathway into the role, including:
 - RMOs' demographic characteristics and where they trained;
 - Typical routes into the role and 'pull factors' that motivated individuals to enter it.
- Identify the current situation around access to support and guidance:
 - Access to and uptake of training;
 - Levels of support available, who is providing this and how this support is accessed (including supervision and/or mentorship specifically).
- Identify challenges that might indicate current or future need for support and guidance:
 - Experience of barriers to providing good medical practice
- Establish awareness of, and engagement with, the GMC including the extent to which, as the regulator, the GMC is effectively reaching and communicating with RMOs.

¹ <https://chpi.org.uk/papers/reports/no-safety-without-liability-reforming-private-hospitals-england-ian-paterson-scandal/>



Research approach

Fieldwork took place between 5th October and 8th November 2020. A total of 138 RMOs completed a survey online or by phone. Sampling and recruitment methods are detailed below. Based on the information available to them, the GMC estimates the total population of RMOs working in the UK to be around 650. Based on that, the survey completes represent just over one fifth of the total population of RMOs (and the response rate is likely higher given that it is unlikely that all RMOs will have had sight of the survey, given exploratory sampling and recruitment methods).

Sampling

A full list of organisations which employ RMOs does not exist, so the sampling process for the survey was exploratory and designed to get as close as possible to comprehensive on a 'best attempt' basis.

The GMC provided databases of independent healthcare providers from each UK nation's respective system regulator. For England, this was taken from the Care Quality Commission's (CQC) records, the Regulation and Quality Improvement Authority (RQIA) for Northern Ireland, Healthcare Improvement Scotland (HIS) and Healthcare Inspectorate Wales (HIW).

These were then filtered and cross-checked in a number of ways, against existing information – such as lists of designated bodies² and their associated providers – and through desk-based research, to ensure those invited to take part in the survey were those likely to provide overnight stays on-site to patients (and therefore to have RMOs on-site).

Recruitment and fieldwork

We used a number of recruitment approaches to reach as many RMOs as possible. A lack of direct email addresses or telephone numbers, and the fact that there are multiple RMOs at many sites (but it was unknown how many would be located at each site), meant that a recruitment strategy using multiple avenues had the best chance of maximising response. In summary:

- A hard copy letter was sent to headquarters (HQs) of groups of sampled independent hospitals and clinics prior to the launch of the survey to inform them that we would be contacting their RMOs shortly and seed awareness of the survey.
- A hard copy letter containing the link to the online survey was sent directly to sampled independent hospitals and clinics, addressed for the attention of RMOs;
- The GMC contacted their Employment Liaison Advisers (ELAs) by email to ask them to forward the link to the online survey to designated bodies that had doctors connected to them who were working as RMOs;
- The GMC contacted the Independent Healthcare Providers Network (IHPN), the representative body for independent sector healthcare providers that aims to represent their

² A designated body is an organisation that has responsibility for carrying out appraisals for all doctors employed by them. Some designated bodies are recruitment agencies, meaning that they employ doctors working for a range of providers.

interests and support in the delivery of care to patients, to ask them to include the link to the online survey in relevant communications with RMOs:

- The GMC contacted RMO International, an employer that specialises in supplying RMOs to hospitals, to ask them to share the survey link directly to their doctors currently working as RMOs;
- Between 29th October and 8th November, IFF interviewers contacted sampled independent hospitals and clinics, asking to be transferred to an RMO. Interviews were then scheduled and completed over the telephone (or, in some cases, RMOs were sent the online survey link, where this was their preference).

In total, 98 surveys were completed online and 40 by phone and took an average of 20 minutes to complete. Table 1.1 summarises the number of surveys completed via each route:

Table 1.1 Summary of survey response by recruitment method

	Number of survey responses	Proportion of overall responses
Hard copy letter, with link to online survey	37	27%
Emails from ELAs (including RMO International) containing link to online survey	55	40%
Communications from IHPN containing link to online survey	6	4%
Telephone interview	40	29%
TOTAL	138	-



Questionnaire design

The questionnaire covered a brief section on RMOs' experiences of working through the COVID-19 pandemic, their career background, how and why they became an RMO, the support they receive in their current role, their views on the GMC, and any additional support the GMC could provide.

Some of the questions were adapted from questions asked to doctors in previous GMC research. Where questions from previous research were included in such a way that allows for comparison, these comparisons have been made in this report where appropriate and are caveated as necessary.



Data analysis and reporting

The exact characteristics of the wider population of RMOs is unknown, so for this reason responses to this survey have not been weighted.

Throughout this report, differences between types of respondent that are reported are always statistically significant (i.e. we can be 95% confident that these are 'real' differences in views between

different types of respondent, rather than these apparent differences simply being due to margins of error in the data). Differences which are not statistically significant have not been reported.

Percentages shown throughout the report may not total to exactly 100% or to a summary statistic given, due to rounding to the nearest whole number or respondents being able to choose more than one response option at a particular question.

A note on terminology

RMOs are generally employed by organisations which then provide the RMOs to the hospital where they work. The organisations providing the RMOs are referred to as 'agencies' in the report. This reflects the wording that we used in our research questions and how they are referred to by RMOs who took part in the research. The use of the term 'agencies' should be understood in this context.

2 Profile of RMOs

This chapter summarises the demographic profile of the RMOs that participated in the survey.

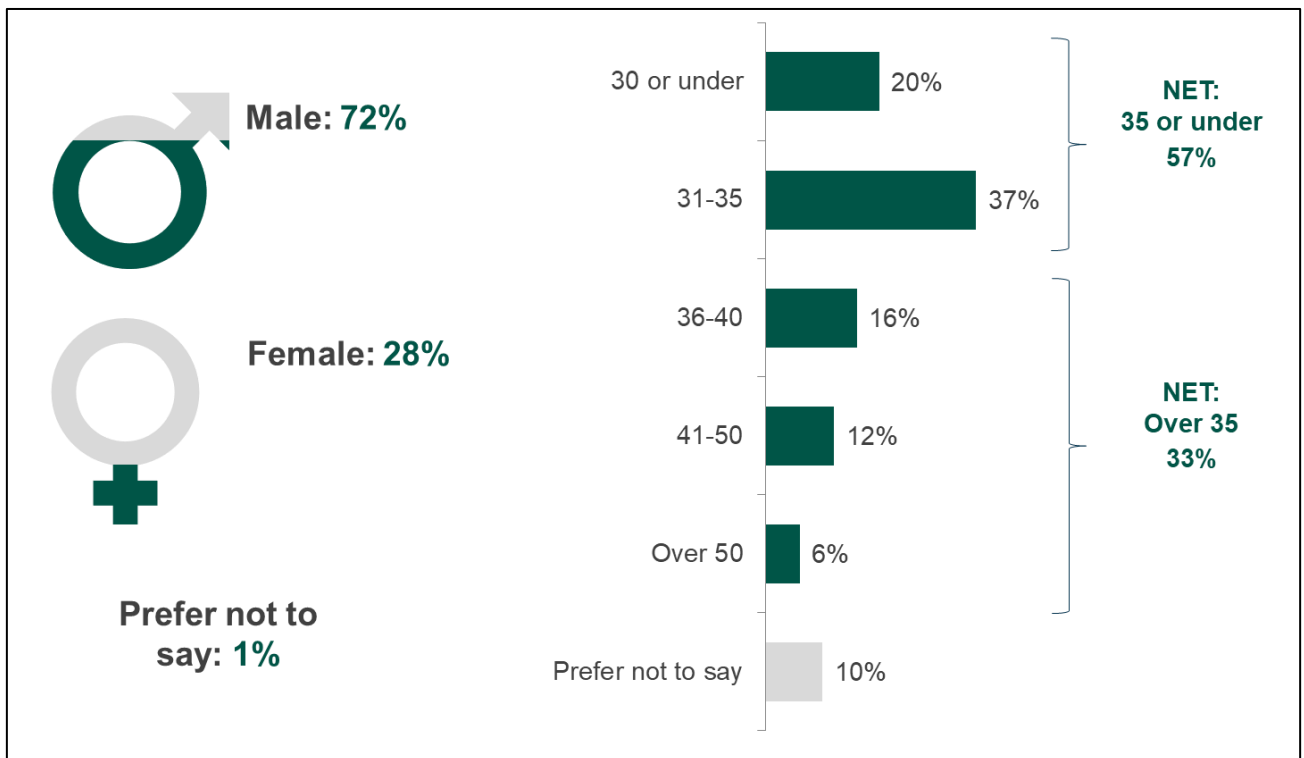


Demographic profile

The population of RMOs currently working in the UK appears to be mostly made up of younger male doctors who completed their medical training outside the UK.

Almost three-quarters (72%) of survey respondents were male, compared to just over a quarter (28%) female (Figure 2.1). Almost six in ten (57%) were 35 or under, although some older RMOs also took part: 6% were over 50 years of age.

Figure 2.1 Gender and age



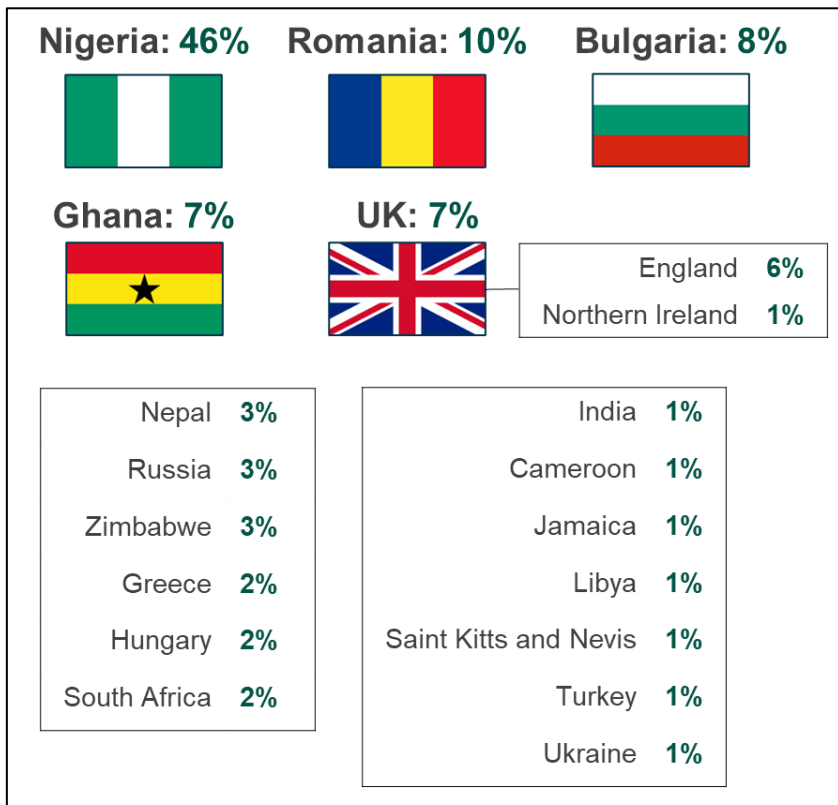
F1. Are you...?³; F2. How old are you? Base: All RMOs (138)

Over nine in ten (93%) survey respondents achieved their primary medical qualification (PMQ) outside the UK. RMOs were most likely to have achieved their PMQ in Nigeria, with almost half (46%) of survey respondents having done so (Figure 2.2). Other common countries for RMOs to have achieved their PMQ in were Romania (10%), Bulgaria (8%) and Ghana (7%).⁴

³ Respondents were also provided with the option 'I identify in another way'.

⁴ In the analysis, RMOs were grouped by continent as a way of identifying differing experiences. However, because IFF Research and the GMC recognise the broad variation across continents, when these differences are referenced in the report the countries represented in the groups have been listed out.

Figure 2.2 Country of PMQ

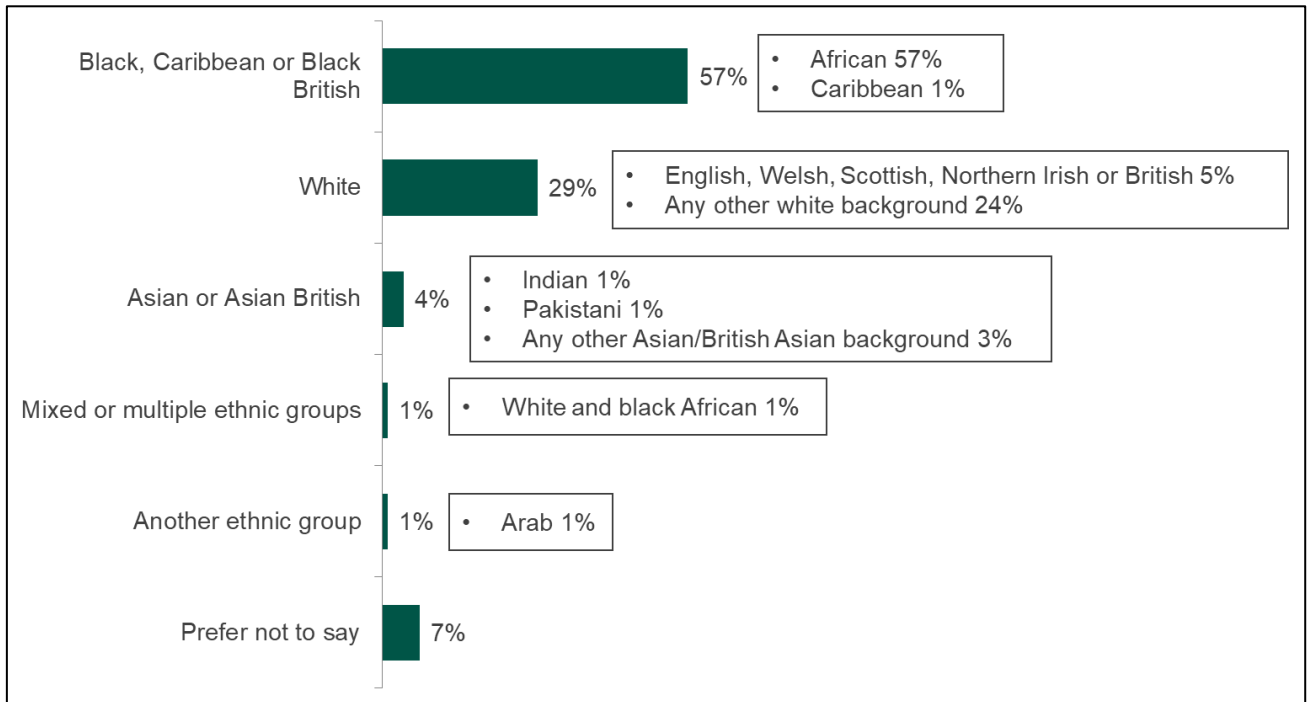


B2. Where did you gain your primary medical qualification (PMQ)?; B3. Where outside the UK did you receive your PMQ? Base: All RMOs (138)

In line with the distribution of country of PMQ, almost two-thirds (64%) of respondents identified as black or minority ethnic (BME), including almost six in ten (57%) who were of black African ethnicity. Three in ten RMOs (29%) were of white ethnicity, with most of these (24% of all RMOs) having a non-British white background.

Figure 2.3 shows the proportions of overarching ethnic groups, and the more detailed ethnic groups within each that RMOs selected.

Figure 2.3 Ethnic group



F1. What is your ethnic group? Base: All RMOs (138)

Age, PMQ and ethnicity were closely correlated. RMOs under 35 were more likely to be BME (71%) and have achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe (71%), while those over 35 were more likely to be of white ethnicity (60%) and to have achieved their PMQ in Bulgaria, Greece, Hungary, Romania, Russia, Turkey or Ukraine (65%).

Only a small minority (3%) had a disability, long term illness or health condition.

Nine in ten (89%) worked in England, while 3% worked in Scotland, 2% in Northern Ireland and 1% in Wales.⁵

⁵ The remaining 5% preferred not to say which nation they worked in.

3 RMO background and careers

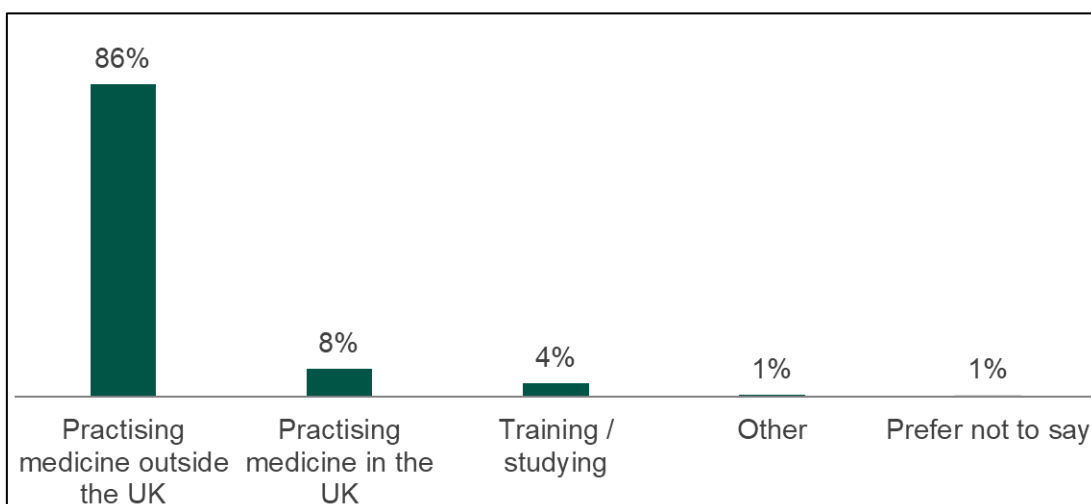


This chapter explores RMO backgrounds and career progression. First it covers the professional experience that RMOs had prior to starting in their current role. Next, it explores how RMOs were recruited, what attracted them to the role, and what concerns they had about working as an RMO. Finally, it looks at the plans that RMOs have for their future.

Experience before becoming an RMO

Most RMOs were practising medicine outside the UK immediately before starting in the role, reflecting that for many this is their first experience of working in the UK. Over four in five (86%) reported that they were practising medicine outside the UK, while 8% were practising medicine in the UK before becoming an RMO (Figure 3.1). A minority of RMOs (4%) were in training or studying.

Figure 3.1 What RMOs were doing immediately prior to becoming an RMO



B4. Immediately before becoming an RMO, what were you doing? Base: All RMOs (138)

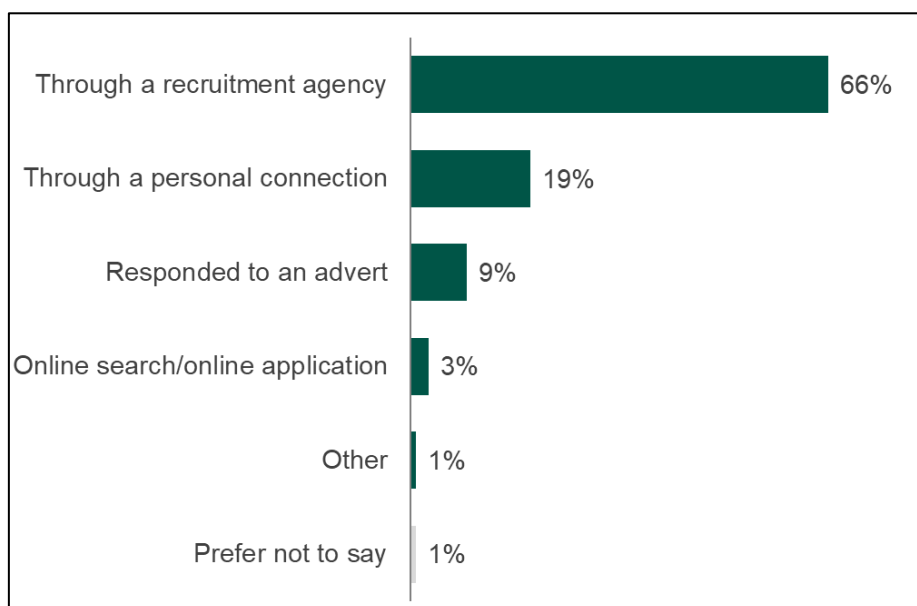
Among those RMOs who were previously practising medicine in the UK, five out of ten⁶ were working as a SAS doctor (including a staff grade, associate specialist or specialty doctor), while two were working as locums, two as doctors in training, and one as a General Practitioner (GP).

Recruitment to current role

Most RMOs were introduced to their current role through a recruitment agency. This route was taken by two out of three RMOs (66%) (Figure 3.2). One in five (19%) were recruited through a personal connection, while 9% responded to a job advert, and 3% found their current role through an online application.

⁶ Results are reported as numbers instead of percentages due to a very low base size of RMOs working in the UK prior to their current role (n=10)

Figure 3.2 Ways in which RMOs were introduced to their current role⁷



B6. How were you recruited to your current RMO role? Base: All RMOs (138)

RMOs who achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe are significantly more likely to have been introduced to their role through a recruitment agency than RMOs who achieved their PMQ in Bulgaria, Greece, Hungary, Romania, Russia, Turkey or Ukraine (79% vs. 46%) and less likely than the latter group to have been recruited through a personal connection (11% vs. 32%) or to have responded to an advert (4% vs. 16%).

Appeal of the role and initial concerns

RMOs were asked to explain in their own words how and why they applied to and started working in the role, including what appealed about working as an RMO and any initial concerns they may have had. Due to the exploratory, open nature of this question, these findings are reported qualitatively.

Many RMOs first thought about becoming an RMO through conversations with friends or other contacts who had experience of working in the role or knew of it through working in the healthcare sector. For some RMOs who achieved their PMQ outside the UK and had experienced difficulties gaining employment in the NHS, the role was suggested by friends or contacts as a pathway to practising medicine in the UK and as a way to gain relevant experience of the UK health system. It is not clear from the RMOs' comments why they struggled to find a role in the NHS, although a few did mention the difficulty of applying with a non-UK PMQ, suggesting there are fewer barriers for those without UK-based medical experience to gain employment in the independent sector than in the NHS.

The working hours were seen as attractive by some due to the pattern of working for one to two weeks and then having one to two weeks off. Some of the positives of this working pattern mentioned by RMOs include that their time off allows them to study for exams, spend time with family, focus on personal development, and adjust to life and work in the UK for those who had not lived in the country

⁷ The question text formulation of 'recruited to' and response option of 'recruitment agency' were agreed between GMC and IFF as part of this exploratory research. In retrospect, ideally this question would have been formulated as 'introduced to' and 'recruited to' responses should be read in this light.

previously. In addition to the work schedule, the RMO salary was seen as an attractive feature of the role compared to similar roles in the NHS.

"I learnt about the role through friends and colleagues who had been in similar roles. I liked the extra free time off work it would provide me to enable work on my other commitments. I also liked that it would help me settle into the UK health system more subtly than working straight in the NHS"

Nigeria PMQ, 35 or under

"The flexible rotas appealed to me - the hours can be draining sometimes but you get more time to yourself - also the pay is better compared with similar roles in the NHS"

Pakistan PMQ, 35 or under

"I was training to become a surgeon in my country and I wanted to migrate to UK and I needed a place to help learn the UK health system before I seek to continue my training. RMO in a private surgical hospital provided me with such opportunity"

Nigeria PMQ, 35 or under

Some RMOs mentioned having concerns about the role prior to starting. One of these concerns was around the perceived isolated nature of the role. Some RMOs were concerned about a lack of support from senior colleagues and the availability of consultants, while others worried about a lack of colleagues working at a similar level to them in the hospital. Although working hours were seen as attractive by some, other RMOs had concerns about the demands of being on duty for long periods, on call 24 hours a day for up to two weeks at a time and the impact this could have on their wellbeing. Lack of opportunity for career progression was also mentioned, although this was less of a concern for those RMOs who viewed the role as a stepping stone to employment elsewhere in the UK healthcare sector.

"The main concern was the lack of peer support. Most RMOs end up being the only junior doctors on-site. Consultants are always available to reach but the lack of peer interaction and support makes one feel extremely lonely during these long weeks"

Russia PMQ, 35 or under

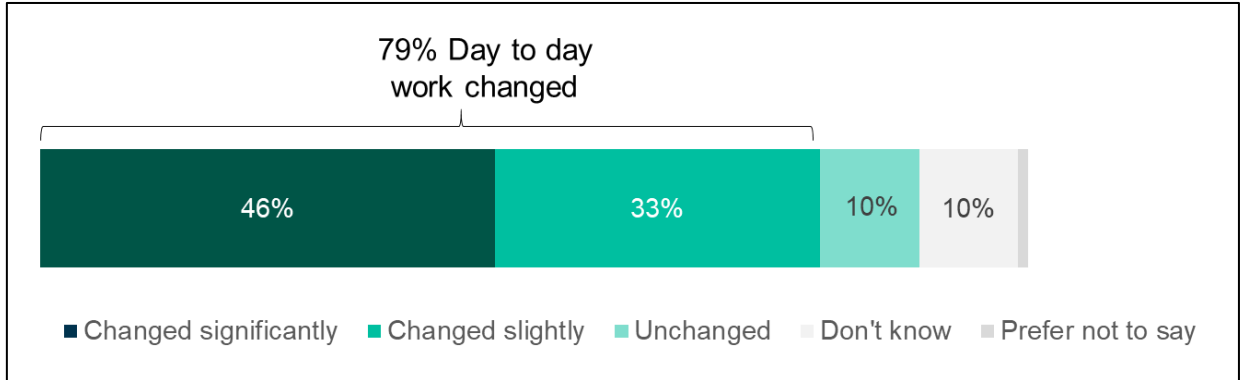
Experience of working during the COVID-19 pandemic

Most RMOs (79%) felt their day to day work had changed as a result of the COVID-19 pandemic, with almost half (46%) feeling that it had changed significantly (Figure 3.3). This is much lower than comparable findings for the overall population of doctors,⁸ which reported that 99% felt their day to day work had changed, including 81% who felt it had changed significantly. This suggests that

⁸ State of medical practice and education (SoMEP) barometer survey 2020: <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/the-state-of-medical-education-and-practice-in-the-uk>.

while changes for RMOs were widespread, their day to day work remained relatively stable during the pandemic compared to doctors working in different roles.⁹

Figure 3.3 Extent day to day work changed by the COVID-19 pandemic¹⁰



A1. To what extent has your day to day work been changed by the COVID-19 pandemic? Base: All RMOs (138)

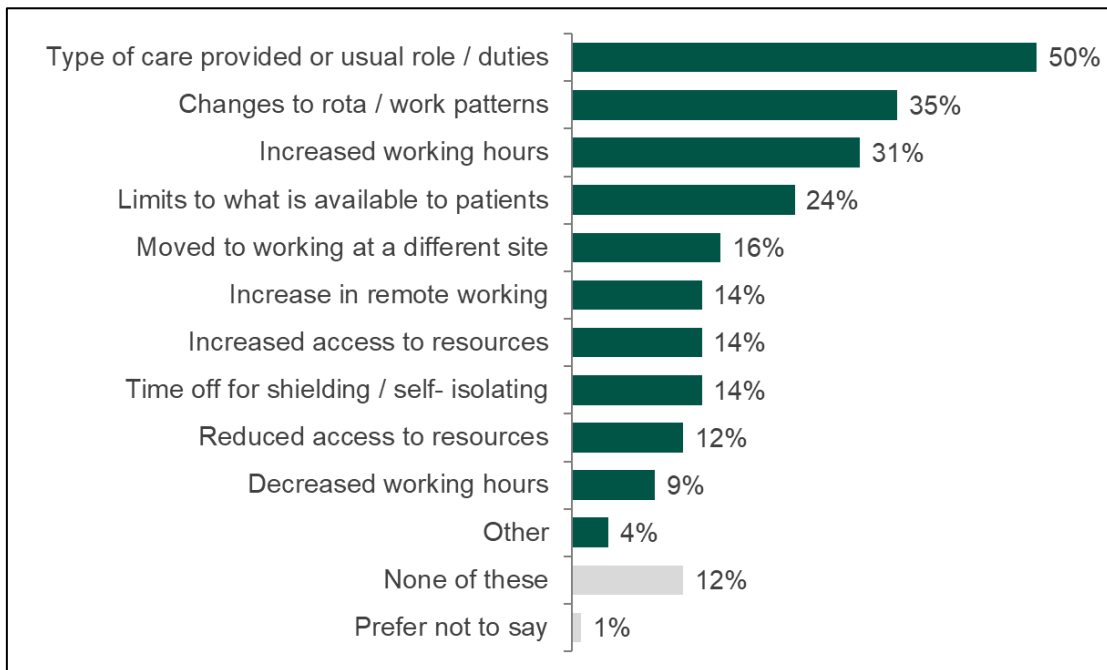
The type of change most commonly experienced by RMOs (50%) over the course of the COVID-19 pandemic was a change to the type of care provided or duties performed, with half (50%) of doctors experiencing this (Figure 3.4). Around a third experienced changes to rotas or work patterns (35%) and three in ten increased working hours (31%). A quarter (24%) noted that there were limits to what was available to their patients e.g. urgent cases only.

When prompted with specific types of change they may have experienced, twelve per cent reported that they had not experienced any changes.

⁹ Looking specifically at the findings for SAS/LE doctors in the same research (arguably a role most similar to that of RMO), these were similar to the overall findings of the SoMEP survey: amongst SAS/LE doctors 80% reported a significant change and 20% a slight change

¹⁰ It is worth noting that responses may not include RMOs who had been furloughed or lost their jobs due to the COVID-19 pandemic and so not working at the time of the survey.

Figure 3.4 Changes experienced over the course of the COVID-19 pandemic (prompted)⁸

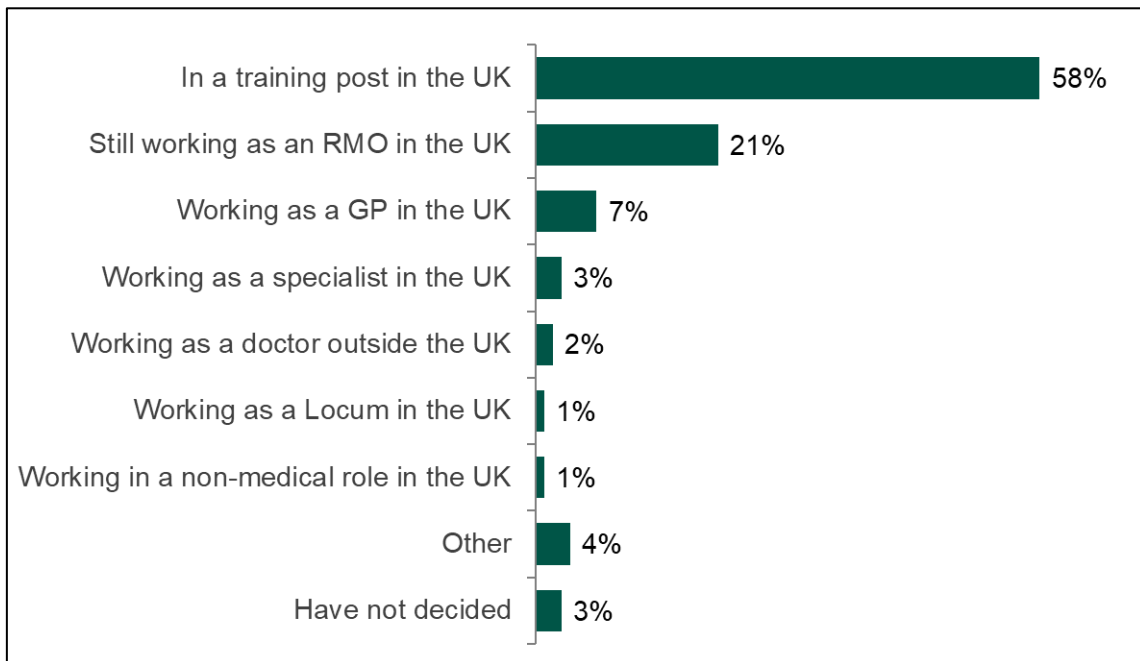


A2. Which of the following changes to your role have you experienced over the course of the COVID-19 pandemic? Base: All RMOs (138)

Plans for the future

In line with initial motivations to take on the role, many continue to view the role of an RMO as transitional. Only one in five RMOs (21%) feel that they will still be working as an RMO in the UK one year from now, while most RMOs (58%) expect to be working in a training post in the UK (Figure 3.5). Fewer RMOs expect to be working as a GP in the UK (7%), working as a specialist in the UK (3%), or working as a doctor outside the UK (2%).

Figure 3.5 What RMOs see themselves doing one year from now



B7. Which of the following best describes what you see yourself doing one year from now? Base: All RMOs (138)

As could be expected, the view of RMO as a transitional role is more common amongst younger RMOs. Those aged 35 or under are more likely to see themselves in a training post one year from now (68% vs. 39% of older RMOs), while those aged over 35 are more likely to expect to still be working as an RMO in a year's time (41% vs. 8% of younger RMOs). This suggests that older RMOs are more likely to view the role as a longer-term post or career choice.

4 Support in current role

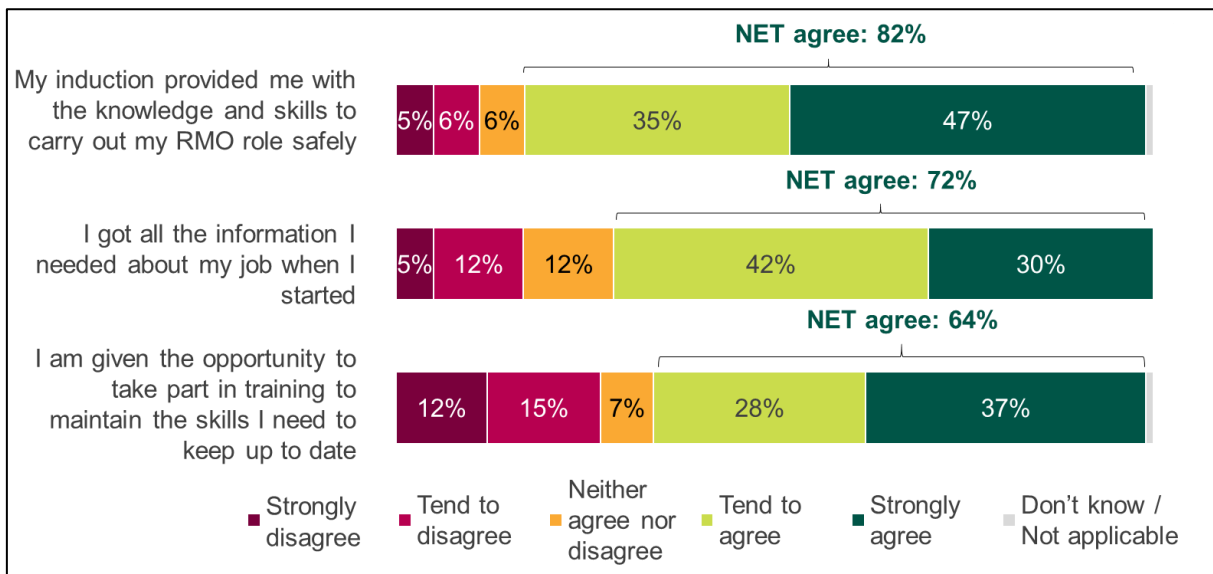


This chapter explores the ways RMOs are supported at work. Firstly, it explores the extent to which RMOs participate in training. It then examines RMOs' perception of the support they receive from colleagues, including feedback, supervision and mentoring. Finally, it looks at the extent of RMOs' experience of compromises to patient care and common reasons behind those, and whether RMOs feel confident in escalating concerns about patient safety. Experiences of these for RMOs in the independent sector are all important to examine, given they do not have access to the more structured processes available to those working in the NHS.

Induction and training

Positively, most RMOs felt that they were sufficiently prepared when they started their role. Four in five (82%) RMOs agreed that their induction had provided them with the knowledge and skills needed, and almost three quarters (72%) felt that they had been given all the information needed when they started their job (Figure 4.1). This experience compares favourably to previous research conducted by the GMC in 2019 with Specialty, associate specialist (SAS) and locally employed (LE) doctors (working in both NHS and independent roles) which found that six in ten (59%) SAS/LE doctors felt they had been given all the information they needed.¹¹

Figure 4.1 Agreement with statements about induction and training



C5. To what extent do you agree with the following statements about your current role as an RMO? Base: All RMOs (138)

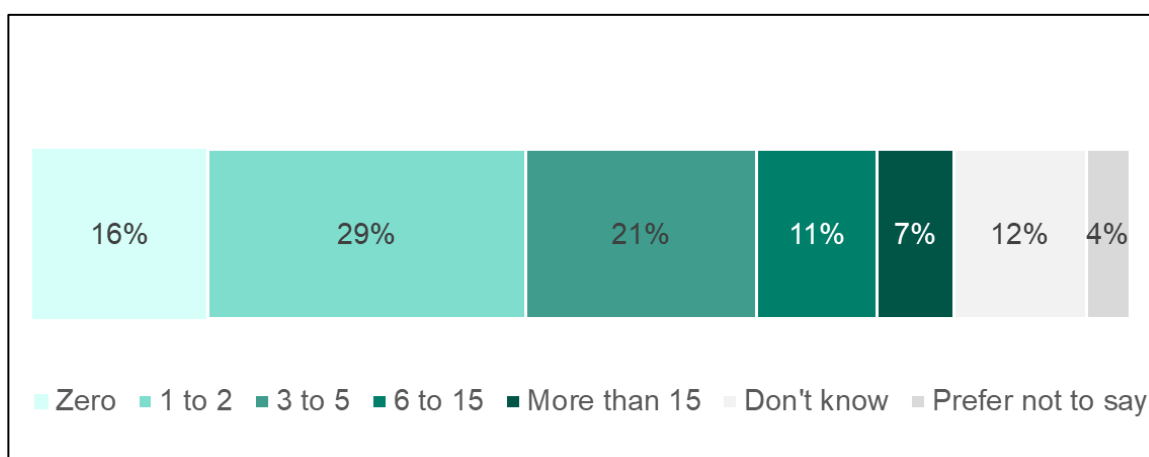
Slightly fewer, but still most, RMOs feel that this preparation continues following the induction. Almost two-thirds (64%) agreed that they are given the opportunity to take part in training to keep their skills up to date, while around a quarter (27%) disagreed. This is broadly in line with findings from previous research with SAS/LE doctors conducted by the GMC (68% agreed).¹¹

¹¹ <https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/survey-of-specialty-and-associate-specialist-and-locally-employed-doctors>

Two-thirds (68%) of RMOs have participated in training at least once in the last 12 months, with three in ten (29%) doing so one or two times, a fifth (21%) between three and five times and slightly fewer (18%) doing so 6 or more times (Figure 4.2). One in six (16%) did not recall taking part in any training sessions in the last 12 months. This variation suggests there is not a consistent structure of training provided to RMOs across hospitals.

Older RMOs were more likely to have attended a higher number of training sessions: a quarter (24%) of over 35s participated six to fifteen times, and over one in ten (13%) had done so over fifteen times (compared to 5% and 3% respectively of those aged under 35).

Figure 4.2 Number of times participated in training in last 12 months

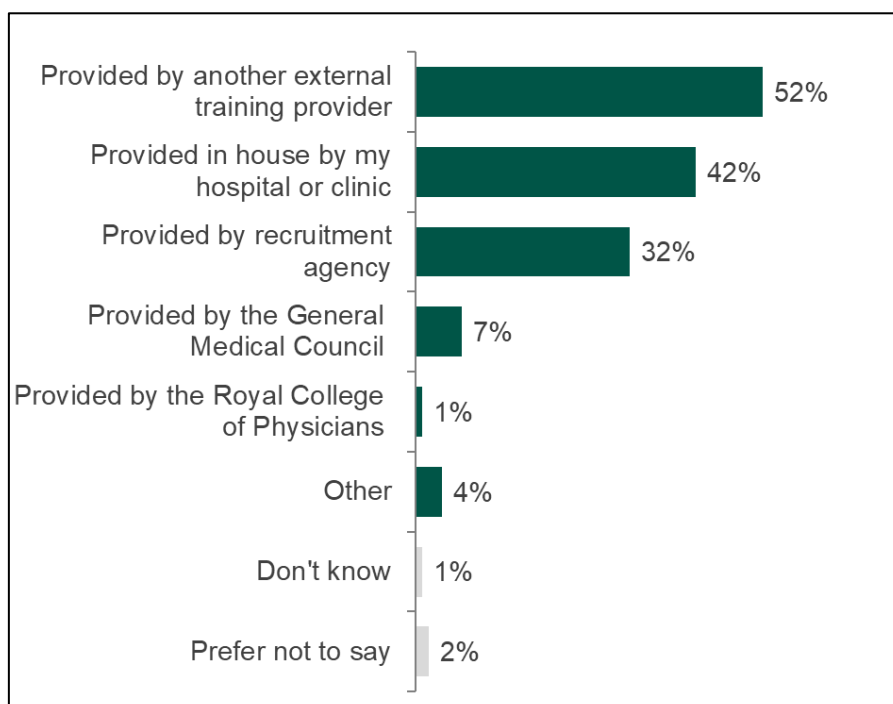


C6. In the past 12 months, how many times have you taken part in training to maintain your skills? Base: Those able to answer agreement about opportunity to take part in training (136)

This training was most commonly provided by external training providers (52%) or the hospital or clinic the RMO is based at (42%). A third (32%) of RMOs reported that their recruitment agency provided training (Figure 4.3).¹²

¹² Recruitment agency was not a pre-coded response option but rather was mentioned unprompted by RMOs, so it's likely that the proportion would be higher if all RMOs had been prompted with it (some of those who would have chosen recruitment agency if the option had been shown may have chosen 'another external training provider' instead).

Figure 4.3 Organisations that provide training to RMOs



C7. Who provides the training to maintain your skills? Base: RMOs who had taken part in training (92)

Alongside training sessions, it was of interest how much Supporting Professional Activity (SPA) time RMOs are expected to spend. SPA time is non-clinical time for activities such as teaching, governance, appraisal or CPD. Only a fifth (20%) of RMOs reported that their job plan contains regular Supporting Professional Activity (SPA) sessions each week. One in six (15%) have one to two, and 4% more than two each week (Figure 4.4). A third (35%) reported that they do not have any SPA sessions each week, while four in ten (41%) reported that they did not know.

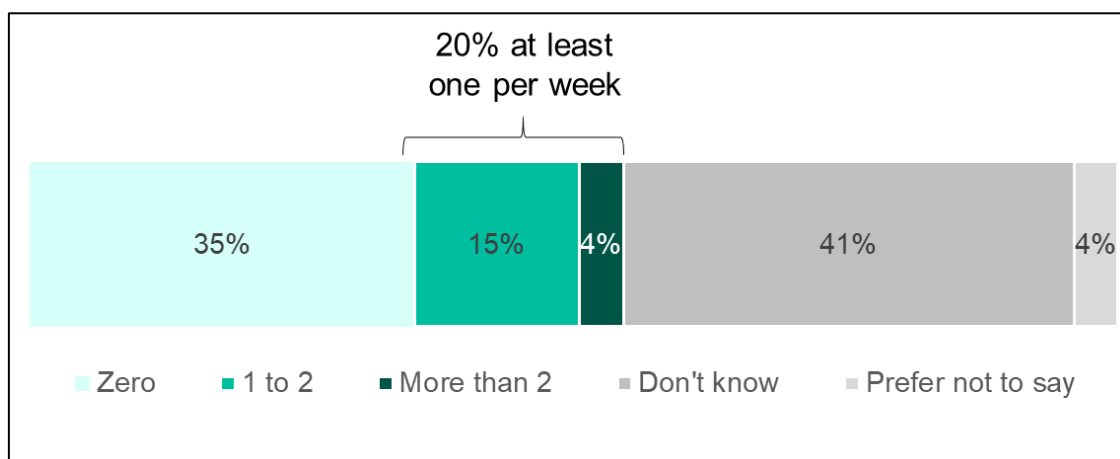
The findings differ widely from previous research conducted by the GMC with SAS/LE doctors, where it was found that four in five (80%) of SAS/LE doctors have at least one SPA session per fortnight, and seven in ten (70%) at least once a week.¹³

There are likely to be a couple of reasons for this difference:

- Doctors in the independent sector are not entitled to SPA sessions in the same way as those in the NHS, because their employers are not obliged to include them in job plans, unlike NHS employers;
- RMOs are expected to be available 24/7 during their shifts so SPA time cannot always be 'built in' to weeks where the RMO is working (with some RMOs expected to cover SPA sessions in their weeks off instead).

¹³ <https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/survey-of-specialty-and-associate-specialist-and-locally-employed-doctors>

Figure 4.4 Number of SPA sessions job plan contains per week



C4. How many Supporting Professional Activity (SPA) sessions does your job plan contain per week? SPA time is non-clinical time for activities such as teaching, governance, appraisal or CPD Base: All RMOs (138)

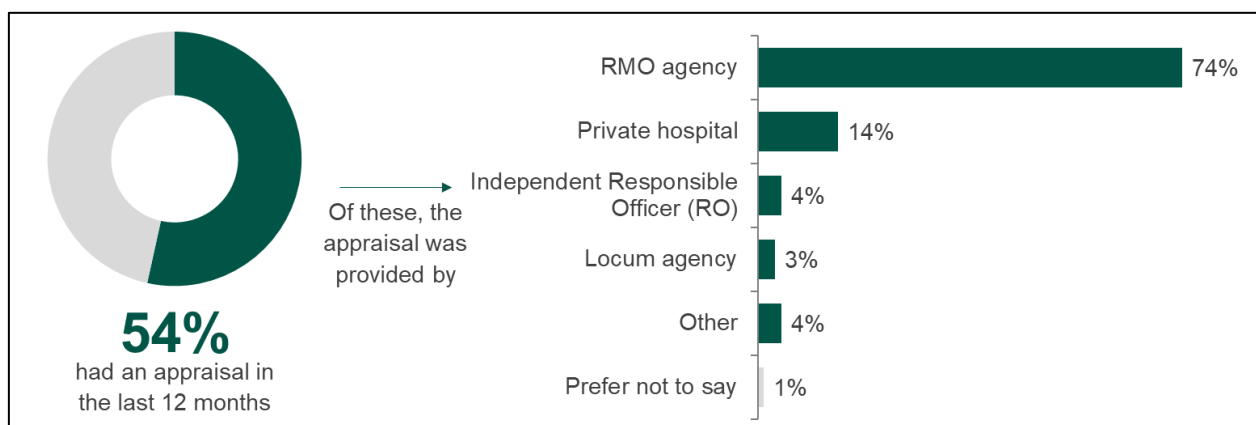
Support from colleagues

Appraisals and feedback

All doctors working in the UK are required to have an appraisal once a year. These appraisals are one way in which RMOs can receive feedback about their performance in order to identify development opportunities.

Slightly over half (54%) of RMOs recalled having an appraisal in the last 12 months (Figure 4.5). These appraisals were most commonly provided by the RMO agency / provider (74%) or by the hospital at which the RMO works (14%).

Figure 4.5 Whether had appraisal in last 12 months and who conducted the appraisal



C1. Have you had an appraisal within the last 12 months? Base: All RMOs (138); C2. Who provided your most recent appraisal? Base: RMOs who had an appraisal (74)

For most of those who hadn't had an appraisal (45%¹⁴), this is less concerning than it initially appears because two-thirds (63%) of these RMOs had simply been licensed for fewer than 12 months.

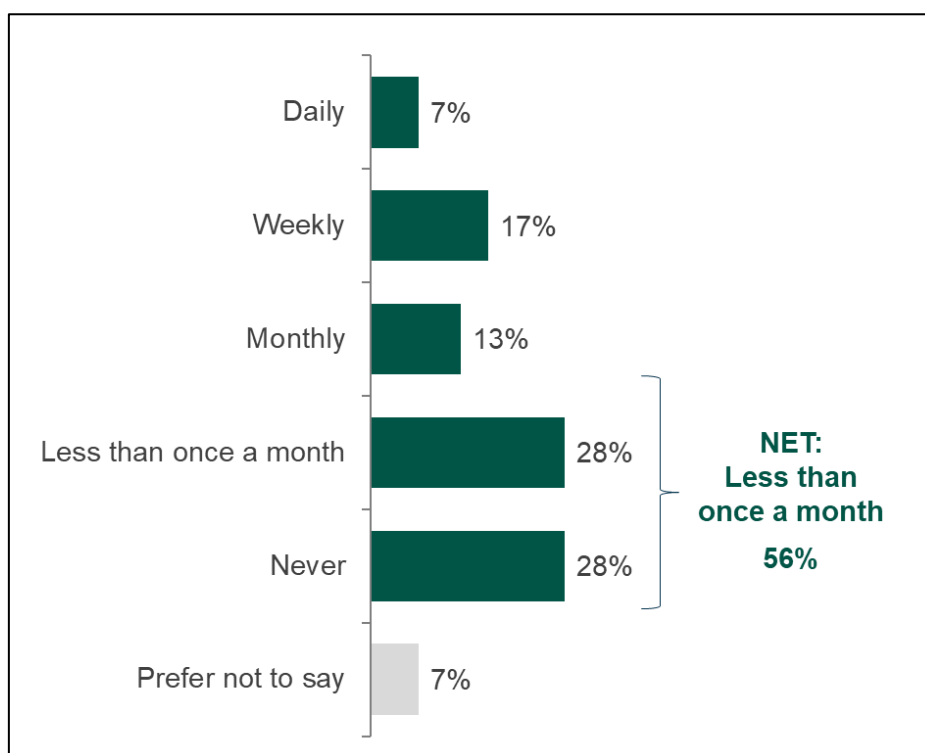
¹⁴ The remaining 2% either responded that they did not know or preferred not to say.

However, a quarter (26%) of RMOs who had not had an appraisal reported that their appraisal had been delayed due to the COVID-19 pandemic.

Ongoing feedback on performance was also lacking for many RMOs: over half (56%) reported that they receive feedback from senior colleagues, whether formal or informal, less than once a month, including three in ten (28%) who never receive it (Figure 4.6). RMOs that achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe were more likely to report never receiving feedback than RMOs that achieved their PMQ in Bulgaria, Greece, Hungary, Romania, Russia, Turkey or Ukraine (34% vs. 16%).

Of those who receive feedback more frequently, 13% do so on a monthly basis and a quarter (24%) at least once a week (7% daily; 17% weekly).

Figure 4.6 Frequency RMOs receive formal or informal feedback about performance from senior colleagues



C8. In your current post, how often (if at all) do you receive formal or informal feedback from senior colleagues about your performance? Base: All RMOs (138)

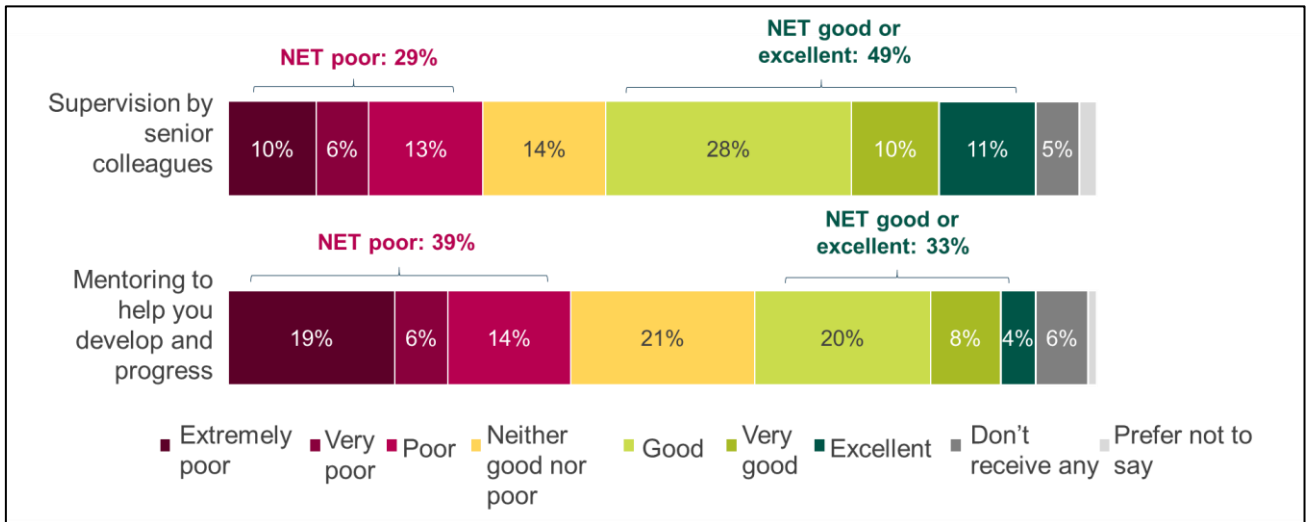
Supervision and mentoring

The research asked RMOs about the supervision and mentoring they received as part of their role. They were asked to reflect on this at a general level, rather than with reference to specific individuals or organisations who may have provided the supervision or mentoring.

Given that this was often their first experience of UK medical practice, supervision and mentoring could potentially be very valuable to RMOs. However, RMOs do not fully endorse the quality of supervision and mentoring they receive. While half (49%) feel the supervision they receive from senior colleagues is excellent or good, a sizeable minority (29%) feel that supervision is poor (Figure 4.7). Additionally, a higher proportion of RMOs feel the quality of mentoring they receive is poor (39%) than the proportion that feel it is good or excellent (33%).

RMOs that achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe are more likely than average to rate both factors as poor (39% for supervision and 46% for mentoring), while those that achieved their PMQ in Bulgaria, Greece, Hungary, Romania, Russia, Turkey or Ukraine are more likely to rate both factors as excellent or good (68% for supervision, 51% for mentoring).

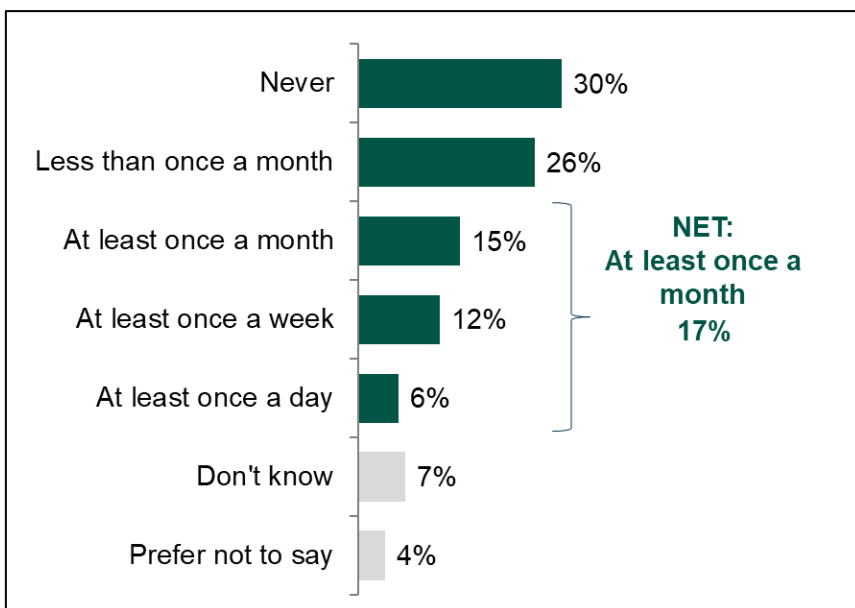
Figure 4.7 Rating of quality of support and mentoring in role



C10. How would you rate the quality of the following in your current role as an RMO? Base: All RMOs (138)

More positively, most RMOs do not feel unsupported on a regular basis. While over half of RMOs (59%) have felt unsupported at some point in the last year, for most this took place less than once a month (26%) and only around a sixth (17%) on a weekly basis (Figure 4.8).

Figure 4.8 Frequency felt unsupported in the last year

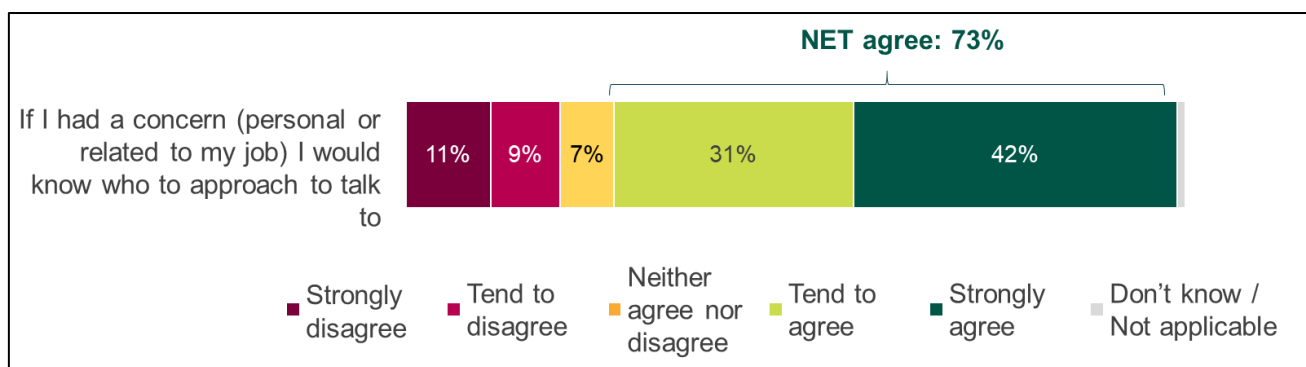


C11. How frequently, if at all, have you felt unsupported in the last year? Base: All RMOs (138)

Again more positively, the majority (73%) of RMOs feel they know who they could approach if they had a personal or job-related concern (Figure 4.9). This is in line with findings from previous research with SAS/LE doctors conducted by the GMC (73%).¹⁵

However, similarly to the findings about supervision and mentoring, RMOs that achieved their PMQ in Bulgaria, Greece, Hungary, Romania, Russia, Turkey or Ukraine are more likely to agree that they know who to approach (86%) than those that achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe (68%).

Figure 4.9 Agreement that know who to approach if had a concern



C9. To what extent do you agree with the following statements about your current role as an RMO? Base: All RMOs (138)

Patient care and safety

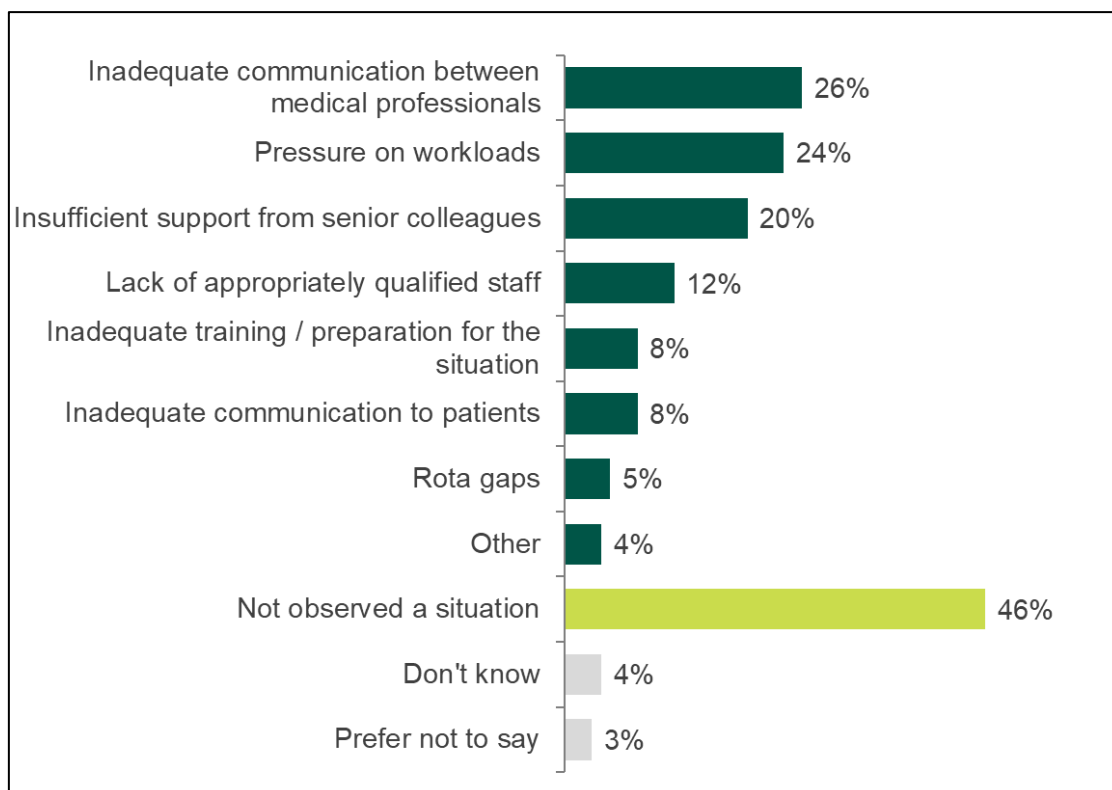
Around half (47%) of RMOs could recall witnessing a situation in which they believe a patient's safety or care was being compromised when being treated by a doctor.¹⁶ BME RMOs were less likely to be able to recall such a situation (43%).

The most common factors that RMOs reported having contributed to the most recent situation they had witnessed (Figure 4.10) were inadequate communication between medical professionals (26%), pressure on workloads (24%) and insufficient support from senior colleagues (20%). These factors reflect the top three challenges of the role that RMOs identified in their own words: high workloads; difficulty communicating with senior colleagues; and lack of support from senior management and colleagues (this is explored in more detail in Chapter 5).

¹⁵ <https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/survey-of-specialty-and-associate-specialist-and-locally-employed-doctors>

¹⁶ While this initially appears higher than findings from the SoMEP barometer survey 2020 where 26% of doctors (27% of SAS/LE doctors) had witnessed a compromise to a patient's safety or care, it is not possible to compare the two because the barometer survey asked doctors to think about the period January-June/July 2020. The question was also asked in a slightly different way.

Figure 4.10 Contributing factors to most recent patient safety/care compromise witnessed (prompted)



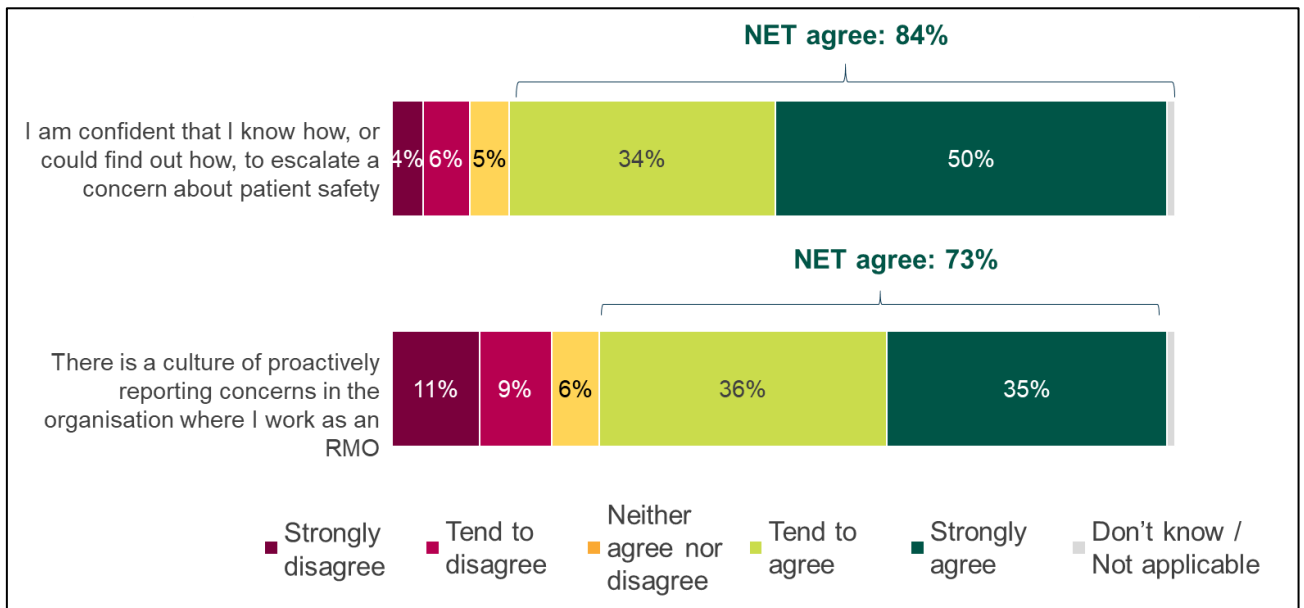
C12. Thinking of the most recent situation in which you believed that a patient’s safety or care was being compromised when being treated by a doctor, which of the following do you believe were contributing factors?
 Base: All RMOs (138)

Reassuringly, even though there may not necessarily be the same structures in place as in traditional NHS roles, the majority of RMOs feel confident in their own and in colleagues’ abilities and willingness to report such compromises to patient safety. Over four in five (84%) feel confident that they know, or could find out, how to escalate a concern about patient safety, with half of RMOs strongly agreeing that this was the case (Figure 4.11). Equally, around three quarters (73%) feel there is a culture of proactively reporting concerns in their organisation. This is a similar proportion to that found for SAS/LE doctors in previous research conducted by the GMC (70%).¹⁷

RMOs that achieved their PMQ in Bulgaria, Greece, Hungary, Romania, Russia, Turkey or Ukraine are more likely to strongly agree with both statements (70% and 54% respectively) than those that achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe (39% and 28% respectively).

¹⁷ <https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/survey-of-specialty-and-associate-specialist-and-locally-employed-doctors>

Figure 4.11 Agreement with statements about reporting concerns about patient safety



C9. To what extent do you agree with the following statements about your current role as an RMO? Base: All RMOs (138)

5 Additional support needs



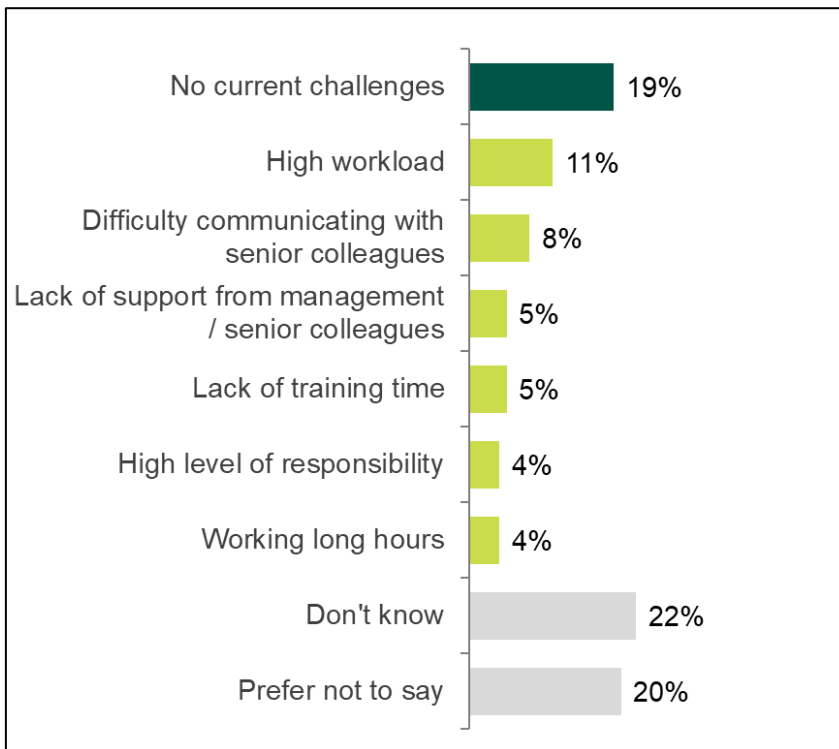
This chapter explores the challenges faced by RMOs and what form additional support to help them with these challenges could take.

Qualitative analysis has been used to give detail and interpret quantitative findings.

Challenges encountered and support needs

While only four in ten (39%) RMOs reported encountering challenges in delivering good medical practice there do still appear to be a variety of challenges associated with being an RMO (Figure 5.1). Additionally, it is hard to conclude about the remaining proportion because only a fifth (19%) of RMOs reported they faced no current challenges in delivering good medical practice, with the remaining RMOs either unsure of challenges (22%) or preferring not to say (20%). As mentioned above, the main challenges reported here reflect the reasons RMOs identified for compromises to patient safety or care.

Figure 5.1 Challenges encountered in delivering good medical practice (unprompted)



E1. Challenges encountered trying to deliver good medical practice Base: All RMOs (138)

Around one in ten (11%) struggle to keep on top of high workloads, sometimes in combination with finding the long working hours challenging (4%). Further illustrated through unprompted responses, support through reducing workloads is a common request among RMOs. Some said the level of work is too great for one on-site RMO, with a few saying the high stress and lack of rest is negatively impacting their mental health and/or patient care. Among this group of doctors, they typically suggested increasing the number of on-site RMOs and dedicated hours to have undisturbed sleep or time to study.

“The main issue is working hours. More times than not, you see the RMO busy throughout the week shift including over the night with little or no time to rest. I feel mistakes can be made in this high stress situations and this could gravely impact on patient’s health. As a recommendation, more hands at a particular shift can help solve this.”

PMQ Nigeria, 35 or under

Some RMOs also feel they are required to take on too much responsibility (4%). Based on the verbatim responses there was a connection between having too much responsibility, difficulties communicating with senior colleagues (8%), and not feeling supported by management and/or senior colleagues (5%). When they had a question about the appropriate care for a patient, RMOs typically outlined the enquiry process as contacting consultants initially and - if they are unavailable - approaching senior members of staff, such as senior nurses, registrars or ward/hospital management¹⁸. If both these routes were unavailable, RMOs would then look to their agency. For RMOs who felt they had too much responsibility, this standard support pathway did not appear to be in place. If consultants and senior colleagues are unavailable, diagnosing is left up to RMOs and, being junior doctors, some felt was too much responsibility.

“When there are patients with deteriorating conditions no one provides support. They all expect to know how things work in NHS Trusts when I have not worked there”

PMQ Nigeria, 35 or under

“It would be nice to have someone to call on for help if something goes wrong in the middle of the night when I am the only one covering the hospital as this would afford me assistance with difficult cases”

PMQ Norway, 35 or under

The solution of talking over the phone to senior doctors, for some, did not leave them feeling fully supported. This is because they feel it is not possible for senior staff to provide the help needed without seeing the patient themselves. This results in RMOs feeling they have not been given sufficiently accurate or in-depth information before making calls on patient diagnosis or treatment.

“I can phone consultants but without having seen the patient themselves it’s difficult for the consultant to decide how to treat the patient over the phone so escalating patients is left up to me.”

PMQ, South Africa, Under 35

Some RMOs also mentioned they had experienced difficulties in raising concerns or challenges they face. A few RMOs have observed that the relationship between their agency and hospital can negatively impact the support they receive, because the agency prioritises the hospital’s perspectives and needs over the RMO’s. A couple also felt that there could be better systems in place to enable complaints to be made confidentially to the senior doctors.

¹⁸ This tallies with routes outlined on p4-6 and in Appendix 1 of the instructions outlined by one of the largest recruitment agencies - RMO International – in their Clinical Handbook: <https://rmointernational.co.uk/wp-content/uploads/2016/04/RMO-International-Clinical-Handbook-Revised-JT-07.03.2017.pdf>

“Having a clear pathway where I could complain confidentially about patient safety. Preferably to a doctor because there are a number of leadership and management staff who are nurses but I don't feel I have a safe doctor who understands challenges faced by doctors who I can complain to and for after advice..”

PMQ England, 35 or under

“Challenges are never addressed or sorted out and even on telling the agency, these challenges are swept under the carpet to please client hospital. There are no means to escalate an unresolved challenge whether at client hospital level or through the employer (agency)”

PMQ Nigeria, 35 or under

Despite the challenges described above, the majority of RMOs feel supported in delivering good medical practice. When treating patients most felt comfortable with the support pathway outlined above, including talking to senior staff over the phone. Many said they were able to involve senior team members in their decision making or reallocate complex cases as required. It was also common among RMOs to mention their concerns were addressed promptly, describe positive relationships with senior staff and healthy team dynamics.

“The staff and consultants are very supportive. I can always call them to say I need help with this and this and this and I can always have a second opinion which is very good”

PMQ Romania, Over 35

“I have good relationships with senior staff members of my hospital. They are usually happy to help me if I need. If I need external support I contact my agency, which are always able organize appropriate support and provide necessary information regarding any patient care issue”

PMQ Ukraine, Over 35

While most RMOs feel supported enough to deliver good medical practice, concerns over a lack of training time (5%) led to a number of requests for additional support. Many mentioned more could be done to provide learning opportunities such as greater contact with senior doctors and regularly scheduled meetings to create dialogue on performance, queries, and learn from the experience of other doctors. As well as more contact with senior medical staff, increased time for training was a common request. Suggested formats for the training were through refresher courses to keep up with guidelines and medical developments or having discussions to talk about different situations and how challenges were overcome.

“Mentorship and regular feedback and support from senior colleagues we work with directly. They could just set some time to meet us, talk to us to see if we have any areas, we need support or guidance. It would help me develop professionally, navigate challenges, and become more confident in my job”

PMQ Zimbabwe, 35 or under

“Feedback from colleagues, opportunities to review patients with the consultant, opportunities for training regarding common issues on the ward e.g. post-op analgesia. This should be provided by the hospital in the form of development of pathways that are shared with the team, and formal ward rounds with consultants”

PMQ England, 35 or under

There were also a few RMOs who wanted greater clarity in their role so that prospective RMOs could be clear as to what the day to day work, responsibilities and T&Cs are before taking up a post, and so that current RMOs would know what they should be doing and what they can reasonably say is out of scope for them (which may be needed as a handful of RMOs' colleagues do not widely understanding the RMO role either).

"In some hospital/clinics, the RMO position is misunderstood by the other staff, because there are no clear rules/attributions in place. The amount of work may be huge"
PMQ Romania, 35 or under

"RMO role is most times not clearly explained to the immigrant doctor taking up the role and the agency is deceptive about indemnity for the doctors. It will be good if the job role is clearly explained to the doctor taking up the task as well as the working hours"
PMQ Nigeria, 35 or under

6 Views of the GMC



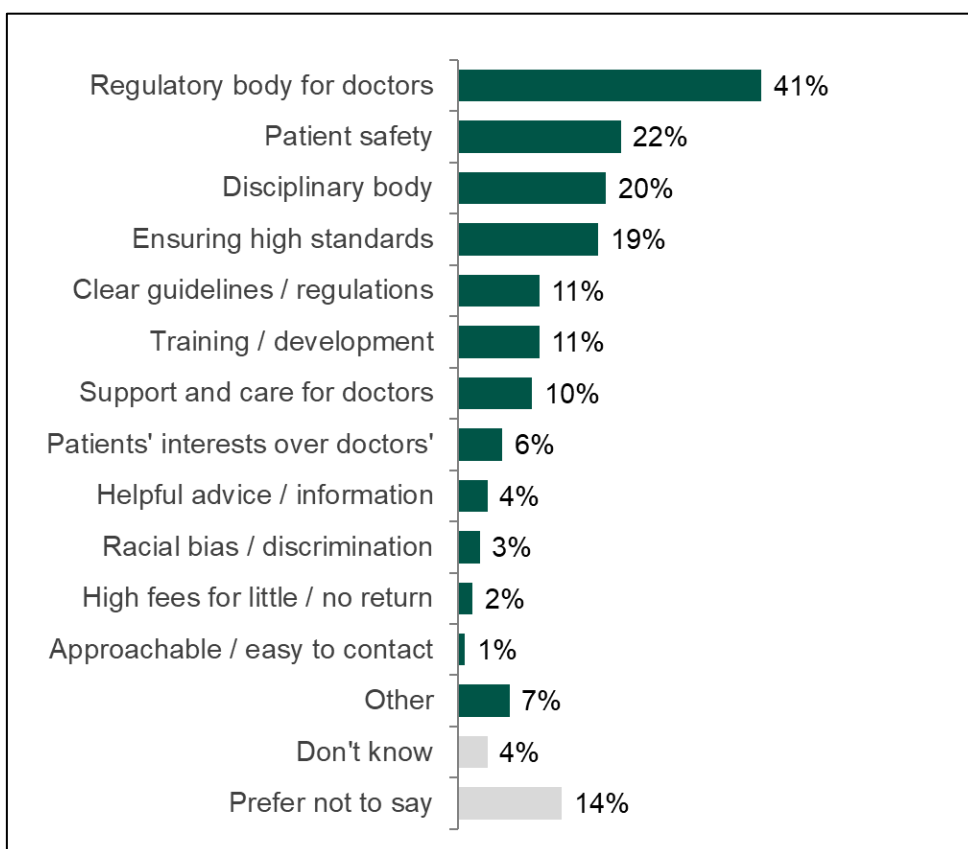
This chapter explores RMOs' views of the GMC. Firstly, it explores perceptions of the GMC and the roles and responsibilities that RMOs associate with it. It then covers how relevant the GMC feels to RMOs in their day-to-day work, and why. Following this, it covers the ways in which RMOs currently engage with the GMC and the GMC resources that they use. Finally, the chapter explores how RMOs find out about GMC-led training and guidance.

Perceptions of the GMC

Given that we know that working as an RMO is the first experience of practising medicine in the UK and therefore the GMC for many, it is helpful to understand the way in which perceptions of the GMC have formed in this group of doctors.

When asked what they associate the GMC with, RMOs most commonly mentioned that the GMC is a regulatory body for doctors (41%) (Figure 6.1). Around one in five RMOs also associate the GMC with ensuring patient safety (22%), acting as a disciplinary body (20%), and ensuring high standards (19%).

Figure 6.1 Associations with the GMC (unprompted)



D1. What do you associate the GMC with? Base: All RMOs (138)

RMOs who achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe are significantly more likely than RMOs who achieved their PMQ in Bulgaria, Greece, Hungary, Romania, Russia, Turkey or Ukraine to associate the GMC with being a regulatory body (46% vs. 22%), and a

disciplinary body (24% vs. 5%). Meanwhile, RMOs who achieved their PMQ in Bulgaria, Greece, Hungary, Romania, Russia, Turkey or Ukraine were significantly more likely to report that the GMC offers support and care for doctors (19%), compared with RMOs who achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe (6%). A few RMOs from a BME background associated the GMC with racial bias or discrimination (4% of BME RMOs, equivalent to 3% of all RMOs (with no white RMOs mentioning this).

When prompted with roles and responsibilities, RMOs most commonly associated the GMC with setting standards for medical practice in the UK (84%), providing ethical and professional guidance (83%), and determining who can practise medicine in the UK (82%) (Figure 6.2).

Overall, as Figure 6.2 shows, RMOs' awareness of most of the GMC's roles and responsibilities was high. However, there were also some 'false positives', where reasonably high proportions of RMOs believed the GMC to hold roles or responsibilities which it does not, such as serving as a membership body (45%) or campaigning for doctors (43%).

RMOs aged over 35 are significantly more likely to incorrectly associate the GMC with being an independent membership body for doctors (59%), compared with RMOs aged 35 or under (40%).

RMOs aged over 35 are also significantly more likely to associate the GMC with helping doctors to raise concerns about patient safety (72%), compared with RMOs aged 35 or under (51%).

Figure 6.2 Roles and responsibilities associated with the GMC (prompted)



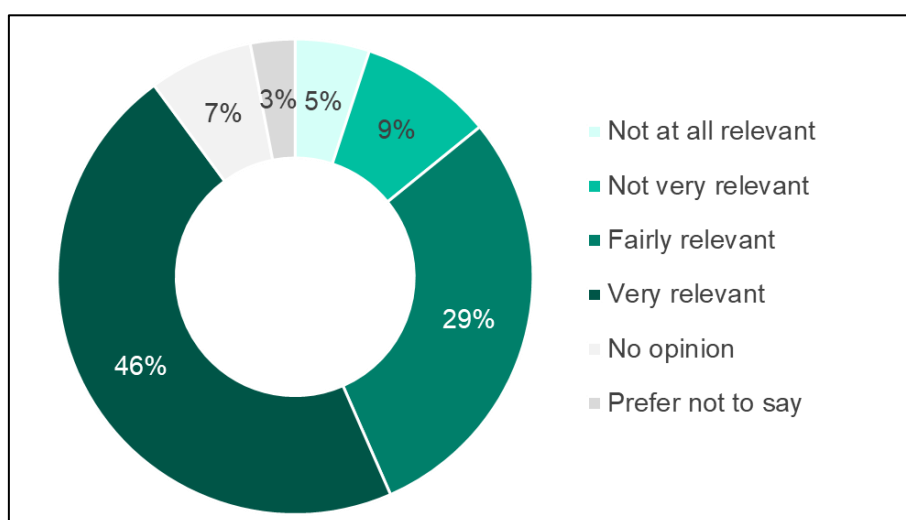
D4. Which of the following roles and responsibilities do you associate with the GMC? Base: All RMOs (138)

RMOs who achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe are significantly more likely than RMOs who achieved their PMQ in Bulgaria, Greece, Hungary, Romania, Russia, Turkey or Ukraine to view helping *patients* to raise concerns about doctors' practice as a responsibility of the GMC (78% vs. 59%). These RMOs were also *less* likely than other RMOs to view helping *doctors* to raise concerns about patient safety as a responsibility of the GMC (49%).

Relevance of the GMC to RMOs

Despite it being likely that many RMOs have only recently become familiar with the GMC, most feel the GMC is relevant to them in their everyday working life. Three out of four RMOs (75%) feel that the GMC is either very (46%) or fairly (29%) relevant (Figure 6.3). Only 14% of RMOs feel that the GMC is not very or not at all relevant in their day-to-day work.

Figure 6.3 Relevance of the GMC to RMOs



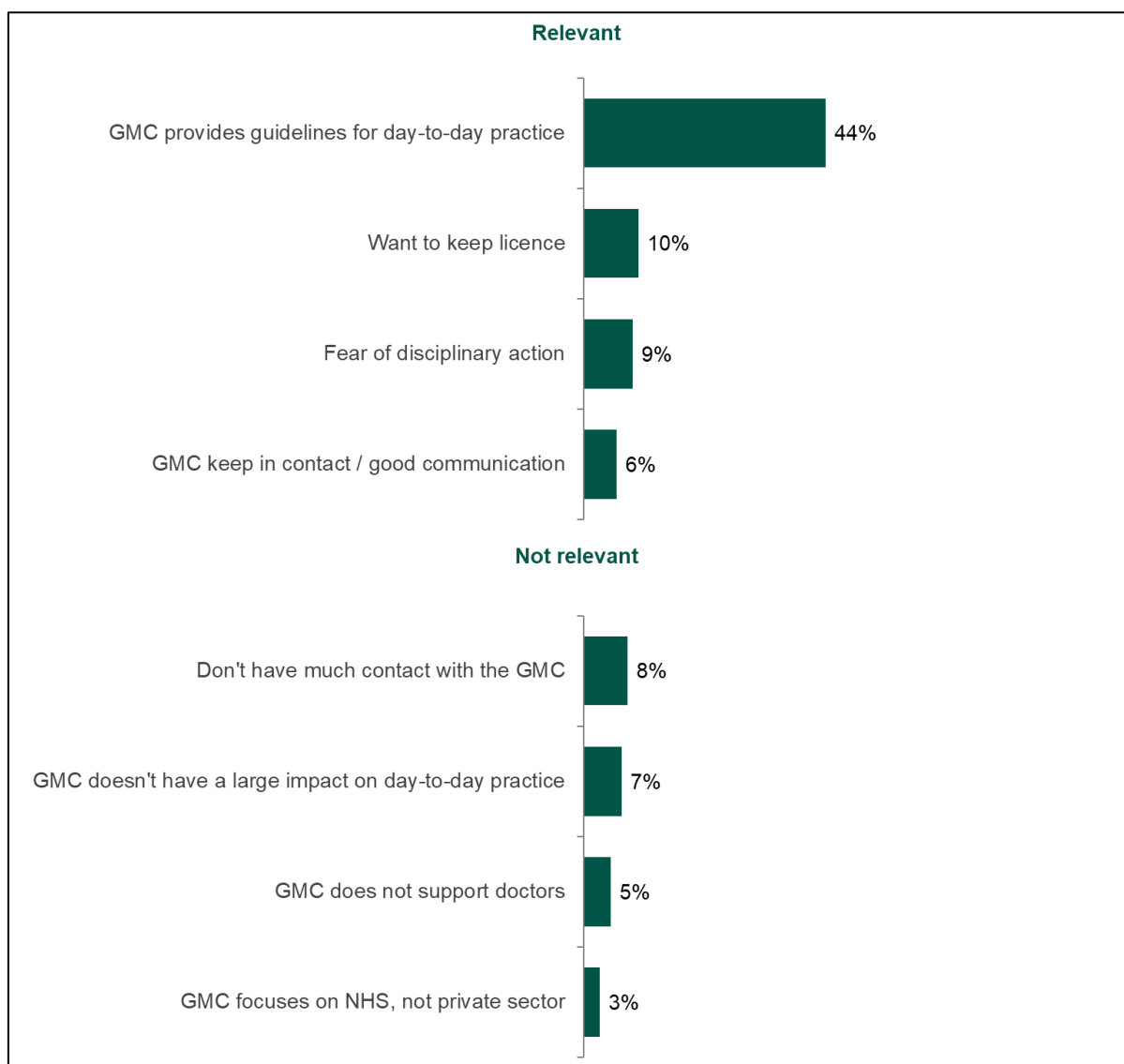
D2. In your day to day work, how relevant does the GMC feel to you? Base: All RMOs (138)

Female RMOs were significantly more likely to report that the GMC feels very relevant (61% vs. 40% males) and RMOs who achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe were also more likely to find the GMC very relevant (54% vs. 46% average).

The top reason why RMOs feel that the GMC is relevant is because it provides guidelines for day-to-day practice. This is reported by 44% of RMOs (Figure 6.4). The next two most common reasons cited for the GMC's relevance are that RMOs want to keep their licence (10%) and a fear of disciplinary action (9%).

RMOs who did not find the GMC relevant in their day to day work most commonly said that this is because they do not have much contact with the GMC (8%) or because they feel that the GMC does not have a large impact on their day-to-day practice (Figure 6.4).

Figure 6.4 Reasons for finding GMC relevant and not relevant (unprompted)



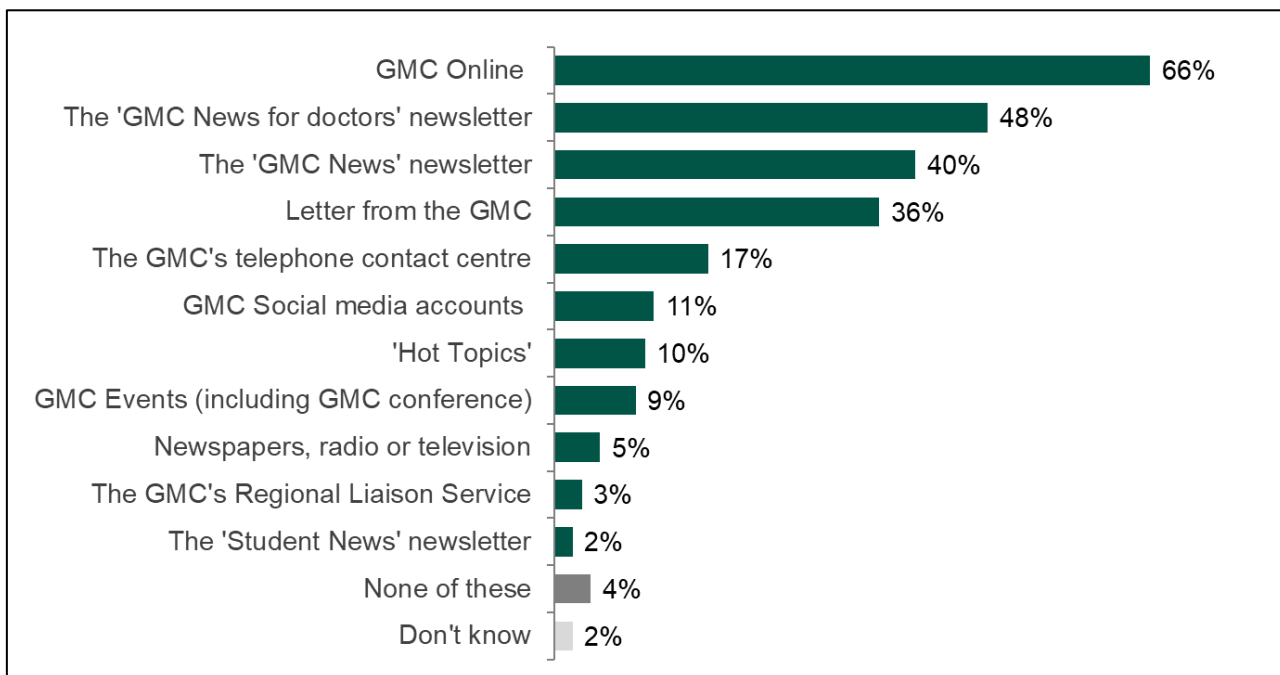
D3. Why do you say that? Base: Those who gave an answer to D2 (In your day to day work, how relevant does the GMC feel to you?) (124)

RMOs who achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe are significantly more likely than RMOs who achieved their PMQ in Bulgaria, Greece, Hungary, Romania, Russia, Turkey or Ukraine to report a fear of disciplinary action (12% vs. 0%).

Engagement with the GMC

The most common way RMOs engage with the GMC is through GMC online, with two out of three RMOs (66%) coming into contact with the GMC over the past 12 months through GMC Online (Figure 6.5). After this, the most common channels through which RMOs had come into contact with the GMC include the 'GMC News for Doctors' newsletter (48%), the 'GMC News' newsletter (40%) and having received a letter from the GMC (36%).

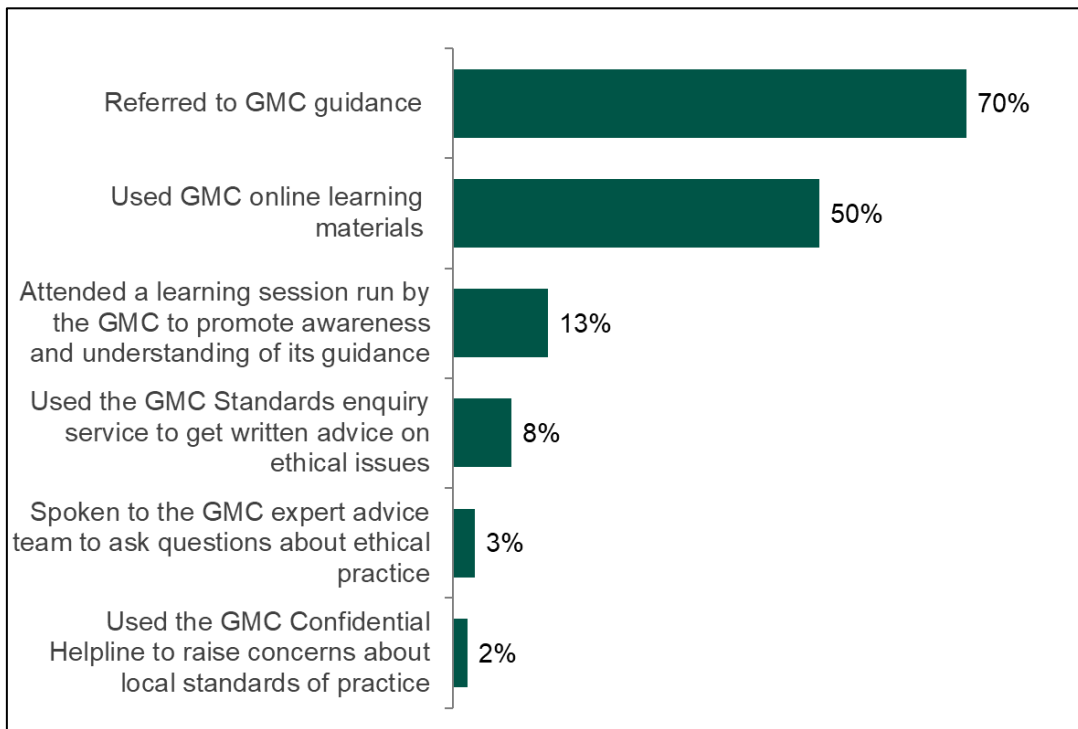
Figure 6.5 Channels of contact with the GMC



D6. Through which, if any, of the following channels have you come into contact with the GMC over the past 12 months? Base: All RMOs (138)

In terms of resources used over the past 12 months, more than two out of three RMOs had referred to GMC guidance (70%) (Figure 6.6). 50% of the RMOs had used GMC online learning materials, but few had attended learning sessions (13%), used the Standards enquiry service (8%), spoken to the GMC expert advice team (3%), or used the Confidential Helpline to raise concerns (2%). It is likely that access to some of these resources (such as learning sessions) has been lower than usual in 2020 due to the pandemic.

Figure 6.6 GMC resources used



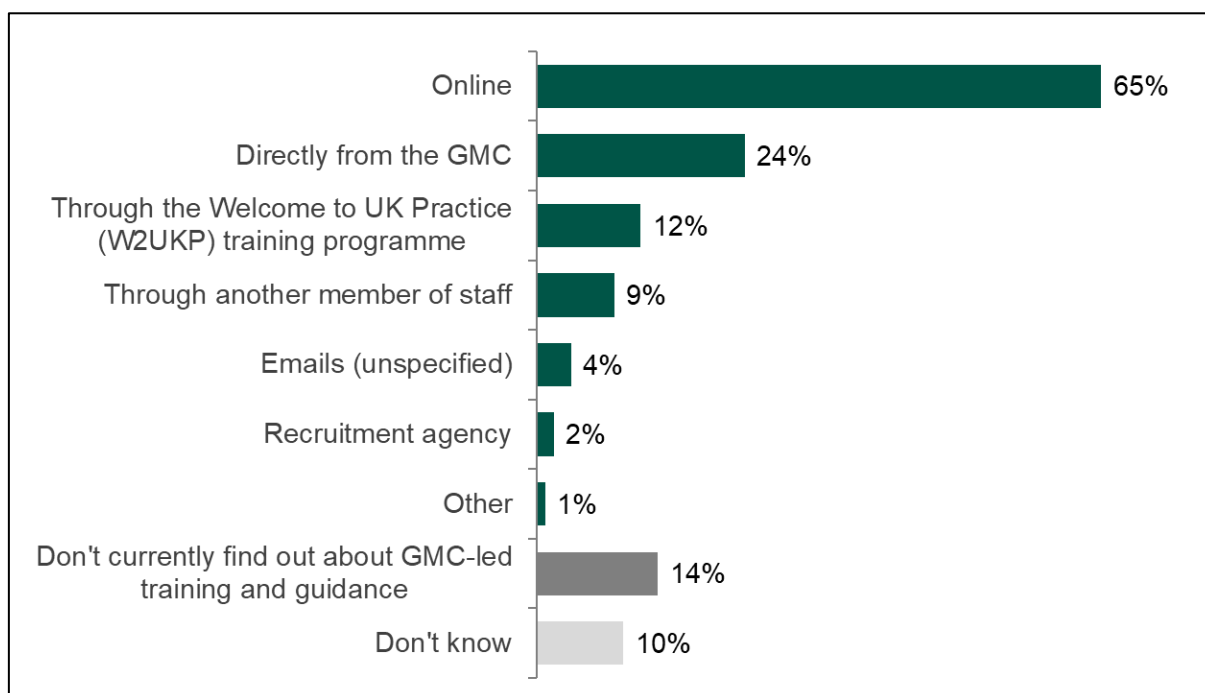
D7. Over the past 12 months have you...? Base: All RMOs (138)

RMOs who achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe were significantly more likely to have referred to GMC guidance than RMOs who achieved their PMQ in Bulgaria, Greece, Hungary, Romania, Russia, Turkey or Ukraine (77% vs. 54%).

GMC-led training and guidance

Most RMOs currently find out about GMC-led training and guidance online (65%), while 24% find out directly from the GMC, and 12% find out through the Welcome to UK Practice (W2UKP) training programme (Figure 6.7).

Figure 6.7 How RMOs find out about GMC-led training and guidance



D5. How, if at all, do you currently find out about GMC-led training and guidance? Base: All RMOs (138)

RMOs who achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe are significantly more likely to find out about training and guidance through the Welcome to UK Practice training programme (16%), compared with RMOs who achieved their PMQ in Bulgaria, Greece, Hungary, Romania, Russia, Turkey or Ukraine (3%). On the other hand, RMOs who achieved their PMQ in Bulgaria, Greece, Hungary, Romania, Russia, Turkey or Ukraine are more likely to find out about training and guidance through a recruitment agency (8%), compared with RMOs who achieved their PMQ in Cameroon, Ghana, Libya, Nigeria, South Africa or Zimbabwe (0%).

It is worth noting that recruitment agencies were mentioned spontaneously by RMOs rather than being an option they were presented with as part of the prompted list. The real proportion of RMOs who find out about GMC-led training and guidance through recruitment agencies may therefore be slightly higher than 2%.¹⁹

¹⁹ Where an option is prompted, it is easier for survey respondents to recall / select. Options which appear in open-ended survey fields can therefore be a slight under-estimate of the 'real' proportion.

7 Conclusions



The role of RMO is frequently seen as a transitional one, taken on by young doctors looking to start their UK career, following achieving their PMQ elsewhere. The majority of RMOs surveyed achieved their PMQ outside the UK and are 35 years or younger. Many were attracted to the role after struggling to gain employment in the NHS, and rather than a long-term career move, it's seen as a way to kickstart a career in UK medicine. This view persists after taking on the role, evidenced by the fact that only a minority anticipate still being an RMO in a year's time. Not all RMOs are at the start of their career however, there are also some older doctors attracted to the role. These older RMOs are more likely to anticipate staying in the role longer than a year, suggesting for them it's a longer-term planned career move rather than a stepping stone elsewhere.



The working pattern is an attractive feature of the role for some but can also be a source of challenges for RMOs. For some RMOs the working pattern of an extended shift followed by extended time off was a reason for taking on the role, as the time off provides opportunities for other priorities such as studying or being with family. However, being the only doctor on-site can at times be difficult and have a negative impact on RMO wellbeing. In addition, **the fact that senior colleagues are not always available to provide advice can leave RMOs feeling that too much responsibility falls on their shoulders.** To aid with these challenges, RMOs suggest introducing protected hours for rest into their shifts, more support managing their workloads, and having more than one RMO on shift at a time.



While RMOs generally feel supported and sufficiently trained, feedback, supervision and mentoring from senior colleagues is an area for improvement. For the most part, RMOs feel they receive sufficient support in their role, that they are given training opportunities, and feel confident they know what to do if they have a concern personally or about a patient. However, the quality of supervision and mentoring is viewed to be poor by too many and feedback from senior colleagues is infrequent for many. Because of the often transitional nature of the role, RMOs would benefit from more frequent feedback: it's likely a yearly appraisal would not provide much time for RMOs to implement feedback received before moving on to another role. RMOs would value more regularly scheduled meetings with senior doctors to provide the opportunity for ongoing feedback.

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Most RMOs feel the GMC is relevant to them, although some clarification of the GMC's role could be helpful. Most RMOs feel the GMC is relevant in their day to day working life, mostly in terms of providing guidelines for medical practice, and RMOs most frequently come into contact with the GMC through online sources. When prompted, awareness of the GMC's roles and responsibilities is high, although quite a large proportion reported some incorrect associations – this suggests some clarification could be helpful to avoid further misunderstanding. Additionally, although RMOs generally feel supported to deliver good quality patient care, many do have unmet support needs. The GMC may want to consider ways they could contribute to meeting these needs to further support RMOs.

“

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